

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2013
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NAME OF PROVIDER OR SUPPLIER OCCAZIO INC	STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383
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W000000	<p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Dates of Survey: February 19, 20, 21, 25, and March 11, 2013</p> <p>Facility Number: 000878 Provider Number: 15G364 AIMS Number: 100249230</p> <p>Surveyor: Vickie Kolb, RN, BSN, Public Health Nurse Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/18/13 by Ruth Shackelford, Medical Surveyor III.</p>	W000000		

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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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the governing body failed to exercise general policy and operating direction over the facility: __ To ensure the facility implemented its policies and procedures to prevent neglect/abuse/mistreatment of clients #1, #2, #3, #5, #6, #7, #8 in regard to client to client abuse due to client #4's behaviors. __ To ensure the facility implemented its policies and procedures to ensure all allegations of abuse/neglect/mistreatment and injuries of unknown origin were reported immediately to the administrator and thoroughly investigated, to ensure all allegations of abuse/neglect/mistreatment were reported to BDDS (Bureau of Developmental Disabilities Services) and to APS (Adult Protective Services) per state law and to ensure the results of all investigations were reported to the administrator within 5 working days from the date of the allegation and/or the discovery of the injury of unknown source in regards to clients #2, #4, #5, #6, #7 and #8. __ To ensure the facility's RC/QMRP (Residential Coordinator/Qualified</p>	W000104	<p>W 104 Governing Body The governing body must exercise general policy, budget, and operating direction over the facility. 1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · One on one staffing for Client #4 began on 2-25-13. · Two on one staffing for Client #4 began the week of 3-18-13 to help protect residents in the home. This staffing pattern will continue until Client #4 is no longer in the home. · Client #4 BSP has been updated. · Occazio served notice to terminate services for Client #4 on 3-22-13. Last day of services will be April 20th, 2013. · Client #4 has been taken to Ball Memorial Hospital for emergency psychiatric evaluation three times since 2-22-13. · Client #4 was seen by his 	04/10/2013			

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	<p>Mental Retardation Professional) integrated, coordinated and monitored client #1's, #2's, #3's, #4's, #5's, #6's, #7's and #8's treatment programs for clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>__To ensure adequate staffing numbers to provide supervision to prevent client to client abuse and to provide training per each client's identified needs for clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented written policy and procedures to prevent neglect of the clients in the group home in regard to client to client abuse. The governing body failed to put in place measures to prevent potential harm/abuse for clients #1, #2, #3, #4, #5, #6, #7 and #8 clients living in the group home. Please see W149.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the following: __immediately reporting to the administrator injuries of unknown source for clients #4, #6, #7 and #8. __reporting client to client abuse to the administrator for clients #4, #5, #6, #7 and #8.</p>		<p>new psychiatrist on 3-15-13. Several medication changes were made at that time.</p> <ul style="list-style-type: none"> · Client #4 has a follow up psych appointment on 4-5-13. · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure investigations are completed and reported to the administration within 5 business days. · The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. · Residential Coordinator and Site Manager will ensure there are adequate staffing numbers in the home at all times to prevent client to client abuse. · Staff will be retrained on Handle with Care and use of restraint for Client #4. · The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown 				

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	<p>__ reporting allegations of abuse/neglect to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for client #5. Please see W153.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to maintain a reproducible system of investigations and/or provide evidence of a thorough investigation regarding allegations of abuse/neglect, client to client abuse and/or injuries of unknown source for clients #2, #4, #5, #6, #7, #8 and #9. Please see W154.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to report the results of the investigations to the administrator within 5 days from the date of discovery of the injuries and/or incident for clients #2, #6, #7, #8 and #9. Please see W156.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure the RC/QMRP (Residential Coordinator/Qualified Mental Retardation Professional) integrated, coordinated and monitored client #1's, #2's, #3's, #4's, #5's, #6's, #7's</p>		<p>origin; along with the reporting and investigation process into these allegations.</p> <ul style="list-style-type: none"> · Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. · The RC will ensure that all incidents of abuse and neglect are reported to BDDS and APS timely. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure investigations are completed and reported to the administration within 5 business days. · The Area Residential Coordinator will ensure that the 				

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	<p>and #8's treatment programs. Please see W159.</p> <p>6. The governing body failed to exercise general policy and operating direction over the facility to ensure adequate staffing levels to prevent continued client to client abuse for clients #1, #2, #3, #4, #5, #6, #7 and #8. Please see W186.</p> <p>9-3-1(a)</p>		<p>Residential Coordinator is monitoring treatment programs for all 8 clients in the home.</p> <ul style="list-style-type: none"> · Residential Coordinator and Site Manager will ensure there are adequate staffing numbers in the home at all times to prevent client to client abuse. · Staff will be retrained on Handle with Care and use of restraint for Client #4. · The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting and investigation process into these allegations. · Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. · The RC will ensure that all incidents of abuse and neglect are reported to BDDS and APS timely. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, ISP and behavior 		

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			<p>plan.</p> <ul style="list-style-type: none"> · Additional staffing has been provided for Client #4 to help protect the rest of the clients in the home from peer to peer aggression. · In the event that an individual's needs become greater than the current staffing supports in the home, the IDT will meet to reevaluate the staffing pattern in the home and to develop a plan to meet the client's increased needs. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure investigations are completed and reported to the administration within 5 business days. · The Area Residential Coordinator will ensure that the 		

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			<p>Residential Coordinator is monitoring treatment programs for all 8 clients in the home.</p> <ul style="list-style-type: none"> · Residential Coordinator and Site Manager will ensure there are adequate staffing numbers in the home at all times to prevent client to client abuse. · Staff will be retrained on Handle with Care and use of restraint for Client #4. · The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting and investigation process into these allegations. · Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. · The RC will ensure that all incidents of abuse and neglect are reported to BDDS and APS timely. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, ISP and behavior 		

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			<p>plan.</p> <ul style="list-style-type: none"> · Additional staffing has been provided for Client #4 to help protect the rest of the clients in the home from peer to peer aggression. · In the event that an individual's needs become greater than the current staffing supports in the home, the IDT will meet to reevaluate the staffing pattern in the home and to develop a plan to meet the client's increased needs. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10 th , 2013</p>		

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W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client. Based on observation, record review and interview for 3 of 4 sampled clients attending outside services (#1, #2 and #3) and 3 additional clients (#6, #7 and #8), the facility failed to ensure the DP (Day Program) followed the clients' dining plans and provided the clients with their dining equipment. The facility failed to ensure the DP staff followed client #2's Approach Plan in regards to self injurious behaviors and failed to provide client #4's ISP (Individual Support Plan) and BSP (Behavior Support Plan) to client #4's teacher.</p> <p>Findings include:</p> <p>1. Observations were conducted at client #4's school on 2/20/13 between 9:10 AM and 9:45 AM. During this time client #4 paced around the room and grabbed at several of the other students. Client #4 targeted a student sitting alone at a cubicle. The student was wearing head phones and trying to study. Client #4 touched and poked the student several times. Client #4 then grabbed the headphones from the targeted student's head. Client #4's teacher instructed the other school staff in the room to evacuate</p>	W000120	<p>W 120 Services Provided with Outside Sources</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · RC will ensure that all client dining plans and adaptive equipment are given to outside agencies as they are needed. Adaptive equipment will be provided by the group home. · RC will ensure the approach plan for client #2 will be sent to his workshop and staff training will occur at the workshop in order to ensure the behavior plan is followed. · Client #4's behavior plan and ISP will be provided to the school so they have a copy for their records. · Client #4 has been given 30 day service notice and will remain 2 on 1 staffing while at the group home and will not be returning to the school during this 	04/10/2013			

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	<p>the other students in the room to the school gym until client #4 could calm down.</p> <p>E-mails dated 2/20/13 sent from client #4's teacher to this surveyor were reviewed on 2/21/13 at 9 PM. The e-mails indicated:</p> <p>On 1/15/13 while at the school gym, the school staff noted client #4 taking his shirt off, grabbing items off of the staffs' desks, taking things that belonged to other students, tapping other students, biting another student's hair, "moving very close" to other students' faces, taking a book from another student, refusing to give it up for about 10 minutes and hitting another student on the forehead. The teacher called the group home staff at 1:35 PM to come get him due to his behaviors.</p> <p>12/14/12 during physical education class, the class went to the weight room. While in the weight room client #4 picked up a weight and pushed it off the rack. Another student was standing near and told client #4 he wasn't supposed to do that. An aide asked client #4 to keep his hands off the weights. Client #4 pushed the student that asked him not to push the weights. Aides attempted to have client #4 return to class and client #4 tried to follow a student he had hit the day before. Client #4's teacher</p>		<p>30 day period.</p> <ul style="list-style-type: none"> · Client #3 will be provided adaptive equipment for her meals while at her workshop. · Client #6 will be provided the appropriate dining equipment while he is at workshop. · Appropriate food substitutions will be sent to the day program in the event that one of the client's refuses to eat what they have packed for lunch. · The Residential Coordinator will ensure that the day program staff are trained to ensure that Client #7 assists with meal set up, Client's #6 and # 8 assist with meal set up and feeding themselves, Client #2 assists with meal set up, using utensils and has appropriate supervision while eating, and Client #3 has appropriate supervision while eating, prompting to take small bites, and assists with meal set up · RC will ensure workshop staff is trained on all clients' dining plans and choking risk plans. · Group home staff will ensure that food containers that are sent with the lunches are properly labeled. 				

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	<p>was called to assist in taking client #4 back to the classroom. He refused to go and the assistant principal came to help. Client #4 refused to leave the weight room until the other student left first.</p> <p>12/10/12 after lunch, client #4 tried to grab a drink from another student. The school staff tried to redirect client #4 to another task when client #4 grabbed a plastic bag off the table and attempted to hit a student in the head. The student ran away and was "very scared." When trying to get client #4 to apologize, client #4 "kept moving quickly at the student as to intimidate him. The group home was called and [client #4] was then sent home."</p> <p>Interview with client #4's teacher on 2/20/13 at 9:10 AM at the school stated because of client #4's "constant behaviors of bothering the other students" and his "disruption" to the class, the school hired another staff to give client #4 one to one supervision while at the school. Client #4's teacher asked, "Can you help us? We don't know what to do anymore." Client #4's teacher indicated the RC (Residential Coordinator) was going to send client #4's ISP and BSP but the school had never received them.</p> <p>During interview with the RC and the PS</p>		<ul style="list-style-type: none"> · Clients #2, #3, #6, #7 and #8 will be assessed for the need for clothing protectors while eating. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · RC will ensure that all client dining plans and adaptive equipment are given to outside agencies as they are needed. Adaptive equipment will be provided by the group home. · The RC will ensure that the day program staff is properly trained to ensure that they follow behavior plans, dining plans and risk plans for the clients who attend day services. · The RC will ensure that copies of behavior plans and the ISP's are distributed to the day service providers in a timely basis. · Appropriate food substitutions will be sent to the day program in the event that one of the client's refuses to eat what they have packed for lunch. 		

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	<p>(Program Specialist) on 2/20/13 at 2:45 PM, the RC stated the school "did their own plans." The RC indicated he had not shared client #4's ISP and BSP with the school. The PS indicated client #4's ISP and BSP should have been given to the school.</p> <p>2. Observations were conducted at the DP on 2/20/13 between 10:10 AM and 12:15 PM. At 10:45 AM DP staff #2 unpacked client #7's lunch box and prepared client #7's food, warming 2 small plastic containers of food and placing them in front of client #7 on the table. Client #7 sat down to eat her food and ate only a few bites and got up from the table. Client #7 did not drink any of the water. DP Staff #2 stated client #7 "never" eats all of her meal or drinks her water while at the DP. When asked what the DP staff were to do when clients did not eat their food, DP staff #2 indicated the uneaten food and/or liquids were left in the plastic containers and replaced in the clients' lunch boxes and that way the group home staff knew how much the clients did or did not eat. DP staff #2 indicated the DP did not have food to offer clients substitutions for foods not eaten.</p> <p>At 11 AM DP staff #4 prepared client #6's food, warming the food up and placing it</p>		<ul style="list-style-type: none"> · Group home staff will ensure that food containers that are sent with the lunches are properly labeled. · The RC will monitor the needs of the individuals within the home and at their day service provider. As their needs change, appropriate assessments will be completed to determine if additional adaptive equipment, programming or clothing protectors are needed. · The RC and Site Managers will conduct random workshop observations to ensure that the day program staff is following behavior plans, dining plans and risk plans. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · RC will ensure that all client dining plans and adaptive equipment are given to outside agencies as they are needed. Adaptive equipment will be provided by the group home. · The RC will ensure that the day program staff is properly 				

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	<p>in a divided plate. DP staff #4 then placed an apron/clothing protector over client #6 and sat down with client #6. DP staff #4 fed client #6 his afternoon meal using a plastic disposable spoon. DP staff #4 did not provide client #6 with adaptive dining utensils. DP staff #4 did not prompt client #6 to assist in feeding himself. While eating, client #6 would doze off, his eyes closed and his head would drift to the side. DP staff #4 would wake client #6 and give him another bite of food or offer him a drink.</p> <p>At 11:15 AM DP staff #3 prompted client #2 to come to the table to eat his afternoon meal. DP staff #3 placed an apron/clothing protector over client #2 and then prepared his food, warming the food up, placing his food in a divided plate and setting it on the table in front of client #2. The DP staff did not sit with client #2 and/or provide client #2 direct supervision while the client ate his meal. Client #2 ate part of his meal using his hands to feed himself. During this observation client #2 bit his right wrist several times. The DP staff did not redirect client #2 each time client #2 bit himself.</p> <p>At 11:20 AM DP staff #6 prepared client #8's food and placed it in a divided dish. DP staff #6 prompted client #8 to come to</p>		<p>trained to ensure that they follow behavior plans, dining plans and risk plans for the clients who attend day services.</p> <ul style="list-style-type: none"> · The RC will ensure that copies of behavior plans and the ISP's are distributed to the day service providers in a timely basis. · Appropriate food substitutions will be sent to the day program in the event that one of the client's refuses to eat what they have packed for lunch. · Group home staff will ensure that food containers that are sent with the lunches are properly labeled. · The RC will monitor the needs of the individuals within the home and at their day service provider. As their needs change, appropriate assessments will be completed to determine if additional adaptive equipment, programming or clothing protectors are needed. · The RC and Site Managers will conduct random workshop observations to ensure that the day program staff is following behavior plans, dining plans and risk plans. <p>4. How will the corrective</p>				

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	<p>the table to eat her afternoon meal. DP staff #8 placed an apron/clothing protector over client #8 and sat down beside her to feed client #8 her afternoon meal. Client #8 ate only a few bites of her meal.</p> <p>At 11:45 AM DP staff #5 removed 4 small plastic containers from client #3's lunch box, warmed 2 of the containers of food in the microwave and set all 4 containers in front of client #3 along with a plastic juice box of water. DP staff #5 then got a plastic cup and poured client #3's water into the cup and set it in front of client #3. Client #3 looked at the containers and asked DP staff #5, "What's this?" DP staff stated, "I don't know, you taste it and let me know." Client #3 began eating, taking large bites and talking frequently with her mouth full. DP staff #5 stated, "You shouldn't be talking, you only have 30 minutes to eat." Client #3 was not provided a divided plate, adaptive silverware and/or a cup with a straw for her meal at the DP. The DP staff did not sit with client #3 while she ate her meal nor did the DP staff provide direct supervision or prompt client #3 to take small bites.</p> <p>Client #2's record was reviewed on 2/21/13 at 11:30 AM. Client #2's dining plan of 11/8/10 indicated client #2 was to</p>		<p>action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a regular basis when they are at the day program site. · The RC will monitor on a regular basis when they are at the day program site. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10th, 2013</p>				

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	<p>have hand over hand assistance from staff while eating. The plan indicated client #2 was able to feed himself with his utensils once the staff helped him scoop up the food. The plan indicated the staff were to sit on client #2's right side when they were assisting client #2 with his meals. Client #2's IPOP (Individual Plan of Protective Oversight) of 2/9/12 indicated client #2 "will stand biting his arm" if his environment got to loud or there were too many people. "He needs supervision at all times." Client #2's Approach Plan of 3/2/10 indicated client #2 chewed on his wrist, hand and fingers. The plan indicated staff were to approach client #2 calmly and ask client #2 to stop his behavior while at the same time, the staff were to touch client #2's arm. The plan indicated staff were to continue until client #2 stopped the behavior.</p> <p>Client #3's record was reviewed on 2/21/13 at 2 PM. Client #3's 10/2007 dining plan indicated client #3 was to use a divided plate and child size utensils for all meals and a sippy cup for all fluids.</p> <p>Client #6's record was reviewed on 2/21/13 at 3 PM. Client #6's dining plan of 6/1/12 indicated client #6 was to use built up utensils while eating and required training in using the built up silverware. Client #6's IPOP of 5/25/12 indicated</p>			

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	<p>client #6 "could benefit from a built up spoon and fork" and "He [client #6] has been working on feeding himself for years but has trouble due to the CP (Cerebral Palsy)." The IPOP indicated client #6 required hand over hand assistance to feed himself.</p> <p>Client #8's record was reviewed on 2/25/13 at 12:30 PM. Client #8's dining plan of 11/8/10 indicated client #2 did not use any adaptive dining equipment. The plan indicated the staff were to sit on client #8's right side and provide hand over hand assistance to load her spoon then client #8 would put the spoon in her mouth.</p> <p>Interview with DP staff #4 on 2/20/13 at 11:20 AM stated, "They (the group home staff) sometimes send his [client #6's] adaptive spoon for him to use, but not always." The DP staff indicated because all they had were the disposable plastic spoons and client #6 could not use a disposable plastic spoon so she had to feed client #6. DP staff #4 indicated the DP staff put clothing protectors/aprons on clients #2, #3, #6, #7 and #8 to protect their clothes from being stained while they were at the day program.</p> <p>Interview with DP staff #5 on 2/20/13 at 11:50 AM stated "it would be nice" if the</p>						

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	<p>group home staff labeled the containers for clients #2's, #3's, #6's, #7's and #8's lunch boxes so the staff would know what was in them, "especially the clients that have pureed and mechanical soft diets." DP staff #5 stated, "We mostly just have to guess since they (the containers of food) are not labeled. A lot of times I smell it and if it smells like meat or something that needs to be warmed up, I put it in the microwave." DP staff #5 indicated client #3 did not use any adaptive dining equipment at the DP. The DP staff indicated the DP staff did not sit with client #3 while she ate her meals.</p> <p>Interview with the RC (Residential Coordinator) and the PS (Program Specialist) on 2/20/13 at 2:45 PM indicated clients' dining plans were to be followed at the DP and all adaptive equipment was to be provided to the DP. The PS indicated she was not aware clients were wearing aprons/clothing protectors. The PS indicated client #2's Approach Plan was to be followed at the DP and the staff were to redirect client #2 when the client presented with self injurious behaviors.</p> <p>9-3-1(a)</p>						

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8). The facility failed to implement its written policies and procedures:</p> <p>___ To prevent client to client abuse in regards to client #4's behaviors toward clients #1, #2, #3, #5, #6, #7 and #8 and to ensure the IDT (Interdisciplinary Team) assessed and/or reassessed client #4's behavior needs.</p> <p>___ To ensure all allegations of neglect/abuse/mistreatment and injuries of unknown source were immediately reported to the administrator and thoroughly investigated with a reproducible system of investigation and the results of the investigation were reported to the administrator within 5 business days from the date of the allegation of neglect/abuse/mistreatment and/or the discovery of the injury of unknown origin for clients #2, #4, #5, #6, #7, #8 and #9.</p> <p>___ To ensure all allegations of neglect/abuse/mistreatment were reported to BDDS (Bureau of Developmental Disabilities Services) and to APS (Adult</p>	W000122	<p>W 122 Client Protections</p> <p>The facility must ensure that specific client protections requirements are met.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · One on one staffing for Client #4 began on 2-25-13. · Two on one staffing for Client #4 began the week of 3-18-13 to help protect residents in the home. This staffing pattern will continue until Client #4 is no longer in the home. · Client #4 BSP has been updated. · Occazio served notice to terminate services for Client #4 on 3-22-13. Last day of services will be April 20th, 2013. · Client #4 has been taken to Ball Memorial Hospital for emergency psychiatric evaluation three times since 2-22-13. · Client #4 was seen by his new psychiatrist on 3-15-13. Several medication changes were 	04/10/2013			

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	<p>Protective Services) per state law for clients #2, #6, #7, #8 and #9. ___To ensure adequate numbers of staff in the group home to provide supervision to prevent client to client abuse and provide active training for 8 of 8 clients in the group home. ___To ensure the clients in the group home had access to the knives/sharps, food/snacks and cleaning supplies.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure client #1's, #2's, #3's, #4's, #5's, #6's, #7's and #8's rights in regards to the locking of the sharps, cleaning supplies, food and/or snacks and the facility's use of door/window alarms. Please see W125. 2. The facility failed to provide clients #1 and #4 training in money management skills. Please see W126. 3. The facility failed to implement written policies and procedures to prevent client to client abuse in regards to client #4's behaviors toward clients #1, #2, #3, #5, #6, #7 and #8 and to ensure the IDT assessed and/or reassessed client #4's behavior needs. Please see W149. 4. The facility failed to ensure client #4's, #6's, #7's and #8's injuries of unknown 		<p>made at that time.</p> <ul style="list-style-type: none"> · Client #4 has a follow up psych appointment on 4-5-13. · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure investigations are completed and reported to the administration within 5 business days. · The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. · Residential Coordinator and Site Manager will ensure there are adequate staffing numbers in the home at all times to prevent client to client abuse. · Staff will be retrained on Handle with Care and use of restraint for Client #4. · The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting and investigation process into 		

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	<p>origin and allegations of client to client abuse were reported immediately to the administrator. The facility failed to report allegations of abuse/neglect to BDDS (Bureau of Developmental Disabilities Services) and to APS (Adult Protective Services) for client #5. Please see W153.</p> <p>5. The facility failed to maintain a reproducible system and/or failed to provide evidence of a thorough investigation regarding allegations of abuse/neglect, client to client abuse and/or injuries of unknown source for clients #2, #4, #5, #6, #7, #8 and #9. Please see W154.</p> <p>6. The facility failed to report the results of the investigations to the administrator within 5 days from the date of discovery of the injuries and/or incident for clients #2, #6, #7, #8 and #9. Please see W156.</p> <p>7. The facility failed to provide adequate staffing levels to ensure clients #1, #2, #3, #5, #6, #7 and #8 were not abused due to client #4's behaviors. Please see W186.</p> <p>9-3-2(a)</p>		<p>these allegations.</p> <ul style="list-style-type: none"> · Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. · The RC will ensure that all incidents of abuse and neglect are reported to BDDS and APS timely. · All 8 residents will be assessed to determine their ability to have access to knives/sharps and cleaning supplies. Guardian approval will be requested if resident is not found to be able to safely handle knives/sharps and cleaning supplies. If it is found that knives/sharps and cleaning supplies should be locked, those residents that can safely use said items will be provided a key in order to access them independently. · All food and snacks will be available to all residents at all times – no edible items will be locked at any time. · Clients #1 and #4 will be placed on programming to address their money management skills. <p>2. How will we identify other</p>				

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			<p>residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure investigations are completed and reported to the administration within 5 business days. · The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. · Residential Coordinator and Site Manager will ensure there are adequate staffing numbers in the home at all times to prevent client to client abuse. · Staff will be retrained on Handle with Care and use of restraint for Client #4. · The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and 		

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			<p>exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting and investigation process into these allegations.</p> <ul style="list-style-type: none"> · Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. · The RC will ensure that all incidents of abuse and neglect are reported to BDDS and APS timely. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, ISP and behavior plan. · Additional staffing has been provided for Client #4 to help protect the rest of the clients in the home from peer to peer aggression. · In the event that an individual's needs become greater than the current staffing supports in the home, the IDT will meet to reevaluate the staffing pattern in the home and to develop a plan to meet the client's increased needs. · All 8 residents will be 	

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			<p>assessed to determine their ability to have access to knives/sharps and cleaning supplies. Guardian approval will be requested if resident is not found to be able to safely handle knives/sharps and cleaning supplies. If it is found that knives/sharps and cleaning supplies should be locked, those residents that can safely use said items will be provided a key in order to access them independently.</p> <ul style="list-style-type: none"> · All food and snacks will be available to all residents at all times – no edible items will be locked at any time. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure investigations are completed and reported to the administration within 5 business days. · The Area Residential 		

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			<p>Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home.</p> <ul style="list-style-type: none"> · Residential Coordinator and Site Manager will ensure there are adequate staffing numbers in the home at all times to prevent client to client abuse. · Staff will be retrained on Handle with Care and use of restraint for Client #4. · The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting and investigation process into these allegations. · Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. · The RC will ensure that all incidents of abuse and neglect are reported to BDDS and APS timely. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their 	

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			<p>programming, ISP and behavior plan.</p> <ul style="list-style-type: none"> · Additional staffing has been provided for Client #4 to help protect the rest of the clients in the home from peer to peer aggression. · In the event that an individual's needs become greater than the current staffing supports in the home, the IDT will meet to reevaluate the staffing pattern in the home and to develop a plan to meet the client's increased needs. · All 8 residents will be assessed to determine their ability to have access to knives/sharps and cleaning supplies. Guardian approval will be requested if resident is not found to be able to safely handle knives/sharps and cleaning supplies. If it is found that knives/sharps and cleaning supplies should be locked, those residents that can safely use said items will be provided a key in order to access them independently. · All food and snacks will be available to all residents at all times – no edible items will be locked at any time. <p>4. How will the corrective</p>		

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			<p>action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10 th , 2013</p>		

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W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure client #1's, #2's, #3's, #4's, #5's, #6's, #7's and #8's rights in regards to locking the sharps, cleaning supplies, food and/or snacks and the use of door and window alarms.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/19/13 between 3:45 PM and 6:15 PM and on 2/20/13 between 5:35 AM and 8:05 AM. During both observations, the sharp knives, snack foods (cookies, pretzels, chips, graham crackers, cereal, cereal bars, etc.) and carbonated beverages were locked in a closet off of the kitchen by the rear exit door of the group home. The chemicals/cleaning supplies/laundry products were locked in a cupboard in the laundry/medication room. The keys to the locked items were hanging on a key ring inside of the staff office, the office door</p>	W000125	<p>W 125 Protection of Client Rights</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United states, including the right to file complaints, and the right to due process.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> All 8 residents will be assessed to determine their ability to have access to knives/sharps and cleaning supplies. Guardian approval will be requested if resident is not found to be able to safely handle knives/sharps and cleaning supplies. If it is found that knives/sharps and cleaning supplies should be locked, those residents that can safely use said items will be provided a key in order to access them 	04/10/2013			

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	<p>was open. Clients #1, #2, #3, #4, #5, #6, #7 and #8 did not have access to the keys to the locked items. Alarms were on the front and back doors of the group home as well as on the window in client #4's and #5's bedroom. When the doors were opened during both observations, no alarms were audible.</p> <p>The facility's reportable records from 2/1/12 through 2/19/13 were reviewed on 2/19/13 at 2 PM and again on 2/25/13 at 11:30 AM. The BDDS (Bureau of Developmental Disabilities Services) report of 7/19/12 indicated on 7/18/12 at 5 PM client #5 walked away from the group home to a nearby convenience food store and returned carrying a fountain drink and a bag of chips. The facility's reportable records did not indicate any incidents in regards to sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products requiring the need to lock these items within the group home for clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>Client #1's record was reviewed on 2/25/13 at 11:00 AM. Client #1's ISP (Individualized Support Plan) of 12/28/12 did not indicate a need for client #1 to be restricted from sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products. Client #1's</p>		<p>independently.</p> <ul style="list-style-type: none"> · All food and snacks will be available to all residents at all times – no edible items will be locked at any time. · The alarms on the doors and windows have been determined that they not needed at this time. They have been removed from the house. · Staff training will occur so they are aware of any restrictions regarding knives/sharps and cleaning supplies relevant to each resident at their team meeting. · Clients #1-#8's IPOP assessments and behavior plans will be reviewed and updated to reflect the necessary changes regarding their needs for access to knives/sharps, cleaning supplies, and use of chimes on the doors. · Client #3's programming regarding access to sharps/knives and cleaning supplies will be updated to reflect her abilities in her new home. · Client's #1, #2, #4, #5, #6, #8 and #8 will be placed on programming to address their needs regarding locked items in the home. · HRC approval will be obtained for all clients regarding 		

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	<p>record did not indicate a need for alarms to be on the front and back doors. Client #1's ISP indicated client #1 had a legal guardian. Client #1's record did not indicate client #1's guardian gave written informed consent to lock the sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products. Client #1's record did not indicate client #1's guardian gave written informed consent to use alarms on the front and back doors of the group home.</p> <p>Client #2's record was reviewed on 2/21/13 at 11:30 AM. Client #2's ISP of 2/14/12 and Approach Plan (BSP - Behavior Support Plan) of 3/2/10 did not indicate a need for client #2 to be restricted from sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products. Client #2's record did not indicate a need for alarms to be on the front and back doors. Client 2's ISP indicated client #2's sister served as client #2's legal guardian. Client #2's record did not indicate client #2's guardian gave written informed consent to lock the sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products. Client #2's record did not indicate client #2's guardian gave written informed consent to use alarms on the front and back doors of the group home.</p>		<p>the restrictions in the home.</p> <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · All 8 residents will be assessed to determine their ability to have access to knives/sharps and cleaning supplies. Guardian approval will be requested if resident is not found to be able to safely handle knives/sharps and cleaning supplies. If it is found that knives/sharps and cleaning supplies should be locked, those residents that can safely use said items will be provided a key in order to access them independently. · All food and snacks will be available to all residents at all times – no edible items will be 		

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	<p>Client #3's record was reviewed on 2/21/13 at 2 PM. Client #3's ISP of 10/16/12 indicated "The sharps are locked in a lock box with a code and the hazmats were locked in the closets. In the past [client #3] has not been responsible with her key and she has given it to individuals in the home that are not appropriate with sharps. [Client #3] is now on a program so she may access the sharps with a code." Client #3's BSP of 10/16/12 did not indicate a need for client #3 to be restricted from sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products. Client #3's record did not indicate a need for alarms to be on the front and back doors. Client #3's ISP indicated client #3 had a legal guardian. Client #3's record did not indicate client #3's guardian gave written informed consent to lock the sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products. Client #3's record did not indicate client #3's guardian gave written informed consent to use alarms on the front and back doors of the group home.</p> <p>Client #4's record was reviewed on 2/20/13 at 2 PM. Client #4's IPOP (Individual Plan of Protective Oversight) of 9/24/12 indicated client #4 "tends to overeat" and his parents locked the pantry</p>		<p>locked at any time.</p> <ul style="list-style-type: none"> · The alarms on the doors and windows have been determined that they not needed at this time. They have been removed from the house. · Staff training will occur so they are aware of any restrictions regarding knives/sharps and cleaning supplies relevant to each resident at their team meeting. · HRC approval will be obtained for all clients regarding the restrictions in the home. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · All 8 residents will be assessed to determine their ability to have access to knives/sharps and cleaning supplies. Guardian approval will be requested if resident is not found to be able to safely handle knives/sharps and cleaning supplies. If it is found that 		

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	<p>and refrigerator doors when the client was living at home. The BSP indicated client #4 "will eat constantly if not controlled. He (client #4) will eat whatever he can get his hands on. He needs closely supervised and cannot be left attended but for short periods of time." Client #4's ISP of 12/4/12 and/or BSP of 12/24/12 did not indicate the food or snacks were to be locked within the group home. Client #4's record did not indicate a need for client #4 to be restricted from sharp objects, chemicals, cleaning supplies and/or laundry products. Client #4's record did not indicate a need for alarms to be on the front and back doors and or his bedroom window. Client #4's ISP indicated client #4's parents served as his legal guardian. Client #4's record did not indicate client #4's parents gave the facility written informed consent to lock the sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products. Client #4's record did not indicate client #4's parents gave written informed consent to use alarms on the front and back doors of the home as well as client #4's bedroom window.</p> <p>Client #5's record was reviewed on 2/21/13 at 3:30 PM. Client #5's BSP of 7/30/12 indicated client #5 had a behavior of stealing food or eating out of the trash can. When client #5 was caught stealing</p>		<p>knives/sharps and cleaning supplies should be locked, those residents that can safely use said items will be provided a key in order to access them independently.</p> <ul style="list-style-type: none"> · All food and snacks will be available to all residents at all times – no edible items will be locked at any time. · The alarms on the doors and windows have been determined that they not needed at this time. They have been removed from the house. · Staff training will occur so they are aware of any restrictions regarding knives/sharps and cleaning supplies relevant to each resident at their team meeting. · HRC approval will be obtained for all clients regarding the restrictions in the home. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. 				

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	<p>food or eating out of the trash can, the staff were to redirect client #5 to his "free foods" in the cabinet in the kitchen. Client #5's ISP indicated client #5 "was not safe using hazardous materials in the home." The ISP indicated client #5 "has a history of walking off." Client #5's record did not indicate a need for client #5 to be restricted from sharp objects. Client #5's record did not indicate snacks, food and cleaning supplies were to be locked to prevent client #5 from access to these items. Client #5's record did not indicate the use of alarms on the front and back doors of the group home as well as on client #5's bedroom window. Client #5's record indicated client #5 served as his own representative. Client #5's record did not indicate client #5 had given the facility written informed consent to lock the sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products from client #5. Client #5's record did not indicate client #5 had given written informed consent for the facility to place alarms on the front and back doors of the group home.</p> <p>Client #6's record was reviewed on 2/21/13 at 3 PM. Client #6's ISP of 12/28/12 did not indicate a need for client #6 to be restricted from sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products. Client #6's</p>		<p>The ARC will monitor as they complete their audits.</p> <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10th, 2013</p>	

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	<p>record did not indicate a need for alarms to be on the front and back doors of the group home. Client #6's ISP record indicated client #6's mother served as client #6's legal guardian. Client #6's record did not indicate client #6's mother gave the facility written informed consent to lock the sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products. Client #6's record did not indicate client #6's mother gave written informed consent to use alarms on the front and back doors of the group home.</p> <p>Client #7's record was reviewed on 2/25/13 at 12:45 PM. Client #7's ISP of 4/30/12 did not indicate a need for client #7 to be restricted from sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products. Client #7's record did not indicate a need for alarms to be on the front and back doors. Client #7's record indicated client #7 served as her own representative. Client #7's record did not indicate client #7 had given the facility written informed consent to lock the sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products from client #7. Client #7's record did not indicate client #7 had given written informed consent for the facility to place alarms on the front and back doors of the group home.</p>						

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	<p>Client #8's record was reviewed on 2/25/13 at 12:30 PM. Client #8's ISP of 2/14/12 and BSP of 8/11/09 did not indicate a need for client #8 to be restricted from sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products. Client #8's IPOP of 2/9/12 indicated a behavior concern "That she [client #8] did not wander away from the group home" and needs to be monitored at all times. The IPOP indicated client #8 required a fenced in yard, but could sit outside unsupervised. Client #8's record did not indicate the use of alarms on the front and back doors of the group home. Client #8's record indicated client #8 had a legal guardian. Client #8's record did not indicate client #8's legal guardian gave the facility written informed consent to lock the sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products from client #8. Client #8's record did not indicate client #8's guardian had given written informed consent for the facility to place alarms on the front and back doors of the group home.</p> <p>The facility's Human Rights Committee (HRC) notes for the previous 12 months were reviewed on 2/25/13 at 12:15 PM. ___The HRC notes did not indicate the approval to lock the sharps and hazardous</p>				

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	<p>materials from clients #5, #6 and #7.</p> <p>__The HRC notes did not indicate the approval to use door alarms on the front and back doors for clients #1, #6 and #7.</p> <p>__The HRC notes did not indicate the approval to use window alarms on client #4's window.</p> <p>Interview with staff #2 on 2/19/13 at 5 PM stated she did not know why the knives and cleaning supplies were locked, "They just have always been locked up." Staff #2 stated the snacks were locked because "I think it's because of [client #4]. He grabs food and stuffs it in his mouth if you don't watch him." When asked why there were alarms on the doors and client #4's and #5's windows, staff #2 stated, "Oh, I don't know. We don't use them. I think the night shift turns them on at night in case anyone would get up and try to leave the home." Staff #2 indicated no clients in the group home had a key to the locked items within the home and had to ask staff for access whenever they wanted any of the locked items.</p> <p>Interview with staff #4 on 2/20/13 at 7:10 AM indicated the knives, food and snacks were locked in the closet near the back door of the home. Staff #4 indicated the cleaning supplies were locked in a cabinet in the medication/laundry room. Staff #4 indicated the clients had to ask staff to get</p>						

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	<p>those items for them if they wanted them. Staff #4 indicated the door/window alarms had not been used for a long time. Staff #4 indicated the night shift did not turn the alarms on the door at night as indicated by staff #2. Staff #4 indicated she did not know why the knives were being locked nor did she know why the alarms were on the doors/windows.</p> <p>Interview with the RC (Residential Coordinator) and the PS (Program Specialist) on 2/20/13 at 2:45 PM indicated the knives and the cleaning supplies had been locked within the group home for years. The RC stated the knives were locked up because "We have clients that cannot handle knives because of their intellect." The RC stated clients #3 and #8 "for example." The RC stated the group home was a "locked home because of the hazmat items (cleaning supplies)." The RC stated the cleaning supplies were locked because the potential for the clients with "lower intellect" to ingest liquid chemicals was higher and it was safer to keep them locked. The RC and the PS indicated they were not aware the staff were locking food and/or snacks. The PS indicated client #4 was supposed to have a "free basket" of food where he could select free snacks when he wanted. The RC indicated clients #4 and #5 had behavior problems related to food. The</p>				

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	<p>RC indicated the alarms were to be on 24/7. When asked who was monitoring the alarms to ensure they were on and working, the RC indicated he did not know. The RC indicated the alarms were on the front and back doors and on client #5's bedroom window because client #5 went AWOL in July of 2012. The PS indicated the alarms were placed on the front and back doors because client #8 has a history of wandering away from the group home. The PS stated "Not so much in the winter as in the summer." When asked if the locking of the items and the alarms on the doors and windows were in the clients' plans, the RC stated, "I think so."</p> <p>Interview with the PS on 2/25/13 at 2 PM indicated client #4's and #5's ISP and BSPs did not include locking food or snacks. The PS indicated client #5's ISP and/or BSP did not include the use of alarms on the doors and or windows in regard to his AWOL The PS indicated there were no written consents in place for locking the sharps, cleaning supplies, food and/or snacks and the use of door and window alarms. The PS indicated client #3's ISP refers to her previous placement. The PS indicated client #3 did not have a key or code to unlock the sharps and/or the cleaning supplies.</p>						

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W000126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on interview and record review for 2 of 4 sampled clients (#1 and #4), the facility failed to provide the clients training in money management skills.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 2/25/13 at 11:00 AM. Client #1's undated IPOP (Individual Plan of Protective Oversight) assessment indicated client #1 "has limited money management skills and easily taken advantage of...". Client #1's record indicated client #1 was not independent in managing her finances. Client #1's ISP (Individual Support Plan) of 12/28/12 did not indicate an objective in money management.</p> <p>Client #4's record was reviewed on 2/20/13 at 2 PM. Client #4's 9/24/12 IPOP assessment indicated client #4 required "total assistance with money management" and was to work on budgeting. The report indicated client #4 had difficulty with judgment/vulnerability in regard to money. Client #4's ISP of 12/4/12 did not indicate an objective in</p>	W000126	<p>W 126 Protection of Clients</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Formal programming has been put in place to address money management skills for clients #1 and #4. · The RC will ensure that money management programming is in place for all clients who have the identified need at all times. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the 	04/10/2013			

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	<p>money management.</p> <p>Interview with the PS (Program Specialist) on 2/25/13 at 2 PM indicated clients #1 and #4 were not independent in managing their finances and required staff assistance. The PS indicated clients #1 and #4 did not have a money management goal.</p> <p>9-3-2(a)</p>		<p>potential to be affected by the same deficient practice.</p> <ul style="list-style-type: none"> · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · The RC will ensure that money management programming is in place for all clients who have the identified need at all times. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · The RC will ensure that money management programming is in place for all clients who have the identified need at all times. 		

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			<p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10th, 2013</p>		

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 additional clients (clients #5, #6, #7 and #8), the facility neglected to implement its policy and procedures:</p> <p>__ To prevent client to client abuse in regards to client #4's behaviors toward clients #1, #2, #3, #5, #6, #7, #8 and to ensure the IDT (Interdisciplinary Team) assessed and/or reassessed client #4's behavior needs.</p> <p>__ To ensure an adequate number of staff in the group home to prevent client to client abuse in regards to client #4's behaviors and to provide supervision and training.</p> <p>__ To ensure all allegations of neglect/abuse/mistreatment and injuries of unknown source were immediately reported to the administrator and thoroughly investigated with a reproducible system of investigation and the results of the investigation were reported to the administrator within 5 business days from the date of the allegation of neglect/abuse/mistreatment and/or the discovery of the injury of unknown origin for clients #2, #3, #4, #5, #6, #7 and #8.</p>	W000149	<p>W 149 Staff Treatment of Clients</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · One on one staffing for Client #4 began on 2-25-13. · Two on one staffing for Client #4 began the week of 3-18-13 to help protect residents in the home. This staffing pattern will continue until Client #4 is no longer in the home. · Client #4 BSP has been updated. · Occazio served notice to terminate services for Client #4 on 3-22-13. Last day of services will be April 20th, 2013. · Client #4 has been taken to Ball Memorial Hospital for emergency psychiatric evaluation three times since 2-22-13. 	04/10/2013	

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	<p>__ To ensure all allegations of neglect/abuse/mistreatment were reported to BDDS (Bureau of Developmental Disabilities Services) and to APS (Adult Protective Services) per state law for clients #2, #6, #7, #8 and #9.</p> <p>Findings include:</p> <p>1. The facility's records were reviewed on 2/19/13 at 2 PM and on 2/25/13 at 11:30 AM. The BDDS report of 2/22/13 indicated on 2/22/13 at 7:30 AM during the preparation of the morning meal, client #4 became "agitated with his peer [client #6] for no apparent reason and began attacking the peer [client #6]." The report indicated client #4 scratched client #6 in the eye causing a small cut on client #6's eyelid with "a lot of redness and swelling." The report indicated the staff separated client #4 from client #6, but client #4 remained "agitated" and "kept going after [client #6]." Client #4 then slapped staff and pulled the glasses from staff's face. Staff called the RC and was instructed to call the sheriff's department for assistance. The police arrived "but was (sic) not able to offer any real assistance with [client #4] other than to suggest to transport him to [name of hospital] for an evaluation." The report indicated staff took client #6 to an urgent care facility to</p>		<ul style="list-style-type: none"> · Client #4 was seen by his new psychiatrist on 3-15-13. Several medication changes were made at that time. · Client #4 has a follow up psych appointment on 4-5-13. · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure investigations are completed and reported to the administration within 5 business days. · Residential Coordinator and Site Manager will ensure there are adequate staffing numbers in the home at all times to prevent client to client abuse. · Staff will be retrained on Handle with Care and use of restraint for Client #4. · The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting and investigation process into these allegations. 				

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	<p>be examined. "Urgent care determined [client #6] has a scratch on his cornea." The report indicated client #4 was taken to [name of hospital] for a psychiatric evaluation.</p> <p>The BDDS report of 2/20/13 indicated "It was reported by the State Surveyor that there was an incident of peer to peer aggression between [client #4] and [client #5], both residents at the [name of group home] group home. The surveyor reported that she observed [client #4] to be agitated and he grabbed a towel and snapped it at [client #5]. She also reported that [client #4] grabbed [client #5's] shirt. The staff redirected [client #4] out of the kitchen area where the incident occurred. Staff remained with [client #4] in the other room until he calmed down."</p> <p>The BDDS report of 12/25/12 indicated on 12/24/12 at 2:30 PM client #4 became physically aggressive with staff and took a curtain rod off the wall, trying to throw it at another consumer. Client #4 then tried to rip the other curtain rod from the wall while "yelling at another consumer while he was doing this." Staff engaged in a PRT (Primary Restraint Technique) using the standing position and going to a modified sitting position. The report indicated the restraint lasted "approximately 7 minutes."</p>		<ul style="list-style-type: none"> · The RC will ensure that all incidents of abuse and neglect are reported to BDDS and APS timely. · Occazio's policy #2105 regarding abuse, neglect and exploitation will be reviewed with all staff at their team meeting. · The importance of documenting behavior concerns and the appropriate place to document such concerns will be reviewed with staff their team meeting. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure investigations are completed and reported to the administration within 5 business days. 		

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	<p>The BDDS report of 2/13/13 indicated on 2/12/13 at 3:10 PM client #4 was "agitated" and waiting outside for staff to pick him up from school. On the way back from picking up client #4's housemates from the workshop, client #4 started to kick at the window of the van. Staff was sitting in the seat next to him but he continued to kick over the staff in an attempt to kick the window. The van was pulled over and the staff engaged in a PRT lasting 5 minutes.</p> <p>Observations were conducted at the group home on 2/20/13 between 5:35 AM and 8:05 AM. At 6:20 AM the staff woke client #4. As soon as client #4 got to the table client #4 started grabbing at the bowls of food on the table. Staff #4 redirected client #4 several times to leave the food alone and to sit down at the table. During the meal, client #4 continued to grab at the food, bowls and glasses near him. Staff #1 and #4 repeatedly redirected client #4 from grabbing items on the table and grabbing at other clients' food. Client #4 stood up from the table several times, grabbing the bowl of eggs and trying to eat the remainder of the eggs. After much redirection, client #4 sat back down for a short time and got right back up and grabbed the bowl of eggs. Staff #4</p>		<ul style="list-style-type: none"> · The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. · Residential Coordinator and Site Manager will ensure there are adequate staffing numbers in the home at all times to prevent client to client abuse. · Staff will be retrained on Handle with Care and use of restraint for Client #4. · The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting and investigation process into these allegations. · The RC will ensure that all incidents of abuse and neglect are reported to BDDS and APS timely. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, ISP and behavior plan. · Additional staffing has been provided for Client #4 to 		

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	<p>prompted client #4 to put the bowl down, sit down and to eat more oatmeal. After several prompts, client #4 put the bowl of eggs down and sat down and immediately reached across the table in front of client #7 and took the last 2 pieces of toast and stuffed them in his mouth. Client #4 then jumped up, grabbed the bowl of scrambled eggs and placed the ladle with scrambled eggs in his mouth. After much prompting from staff #1 and staff #4, client #4 took the bowl of eggs to the kitchen counter and set it down. Staff #1 took client #4 by the arm and prompted him to go to the living room where client #4 stayed for only a few minutes but returned to the dining room where client #4 picked up a hand towel and flipped it at client #5, hitting him on the left shoulder then grabbed client #8's glass of juice and drank it. Staff #4 tried to redirect client #4 but was not able to. Client #4 then grabbed client #5 by his clothing on his left shoulder. Client #5 stood from the table, took one step toward client #4 when staff #4 and #1 intervened. Client #4 was escorted to the living room where he sat with staff #1 throughout the remainder of the observation.</p> <p>Interview with staff #4 and staff #5 on 2/20/13 at 7:10 AM indicated client #4's behaviors during the morning observations were an everyday</p>		<p>help protect the rest of the clients in the home from peer to peer aggression.</p> <ul style="list-style-type: none"> · In the event that an individual's needs become greater than the current staffing supports in the home, the IDT will meet to reevaluate the staffing pattern in the home and to develop a plan to meet the client's increased needs. · Occazio's policy #2105 regarding abuse, neglect and exploitation will be reviewed with all staff at their team meeting. · The importance of documenting behavior concerns and the appropriate place to document such concerns will be reviewed with staff their team meeting. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure 		

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	<p>occurrence. Staff #4 indicated client #4 was left in bed until everyone was up and breakfast was on the table because of client #4's behaviors and stated "There is just not enough of us to handle it." Staff #4 stated client #4 "constantly" was touching, poking or instigating issues with his house mates. Staff #4 stated client #4 "mostly targeted [client #3 and client #5]." Staff #4 indicated there had been no major injuries to any of the clients in the home and stated client #4's behaviors were more "disruptive and intrusive." Staff #4 indicated redirection with client #4 did not always work. Staff #5 stated, "Yeah, it's like this most every morning."</p> <p>Observations were conducted at client #4's school on 2/20/13 between 9:10 AM and 9:45 AM. During this time client #4 paced around the room and grabbed at several of the other students. Client #4 targeted a student sitting alone at a cubicle. The student was wearing head phones and trying to study. Client #4 touched and poked the student several times. Client #4 then grabbed the headphones from the targeted student's head. Client #4's teacher instructed the other school staff in the room to evacuate the other students in the room to the school gym until client #4 could calm down.</p>		<p>investigations are completed and reported to the administration within 5 business days.</p> <ul style="list-style-type: none"> · The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. · Residential Coordinator and Site Manager will ensure there are adequate staffing numbers in the home at all times to prevent client to client abuse. · Staff will be retrained on Handle with Care and use of restraint for Client #4. · The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting and investigation process into these allegations. · The RC will ensure that all incidents of abuse and neglect are reported to BDDS and APS timely. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, ISP and behavior 				

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	<p>Interview with client #4's teacher on 2/20/13 at 9:10 AM at the school stated because of client #4's "constant behaviors of bothering the other students" and his "disruption" to the class, the school hired another staff to give client #4 one to one supervision while at the school. Client #4's teacher stated even with the one to one staff supervision client #4 "still disrupted the class" by physically touching other students and invading everyone's space. Client #4's teacher asked, "Can you help us? We don't know what to do anymore." Client #4's teacher indicated client #4 targeted a few of the other students as well as the staff they had hired to be with client #4. Client #4's teacher indicated the RC (Residential Coordinator) had not sent client #4's ISP (Individual Support Plan) and BSP (Behavior Support Plan) to the school.</p> <p>Client #4's record was reviewed on 2/20/13 at 2 PM and 2/25/13 at 1 PM.</p> <p>Client #4's Clinician Reports indicated: 12/4/12 from 5 PM to 5:35 PM, client #4 was touching other residents and taking other residents' things that did not belong to him. Client #4 took the dishes off the table and started throwing them. Client #4 was touching other residents that told him to stop.</p>		<p>plan.</p> <ul style="list-style-type: none"> · Additional staffing has been provided for Client #4 to help protect the rest of the clients in the home from peer to peer aggression. · In the event that an individual's needs become greater than the current staffing supports in the home, the IDT will meet to reevaluate the staffing pattern in the home and to develop a plan to meet the client's increased needs. · Occazio's policy #2105 regarding abuse, neglect and exploitation will be reviewed with all staff at their team meeting. · The importance of documenting behavior concerns and the appropriate place to document such concerns will be reviewed with staff their team meeting. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the 				

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	<p>12/4/12 from 5:30 PM to 6 PM, client #4 picked up a plate and glass and threw them to the floor. Client #4 was escorted to his bedroom.</p> <p>12/6/12 from 4 PM to 11 PM, client #4 slapped client #5 and tried to slap client #7. Client #4 was pulling at client #5's and client #7's shirts. Clients #5 and #7 were redirected to another room.</p> <p>12/7/12 from 4 PM to 11:59 PM, client #4 "pushed another resident." Client #4 stole another client's food at the dinner table and took another client's belongings, throwing them across the room. "It took a lot for [client #4] to settle down."</p> <p>12/9/12 from 5 PM to 7 PM, client #4 "went around the house and was trying to hit and push the other residents. Staff got all the residents away from him to keep them safe. After dinner he was in the living room and started throwing things, breaking the lamp and some of the Christmas decorations. Staff tried to take him to his room but he was non compliant. Again staff cleared the living room of all residents and moved things away from him so he had nothing else to throw...."</p> <p>12/11/12 from 6 AM to 8:30 AM, client</p>		<p>home.</p> <p>The ARC will monitor as they complete their audits.</p> <p>5. What is the date by which the systemic changes will be completed? April 10 th , 2013</p>		

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	<p>#4 "was very aggressive with one of his housemates this morning. His housemate wasn't doing anything to provoke him. [Client #4] grabbed his face, tried taking his belongings and threw a cup of juice at him." The report indicated client #4 paced around the group home most of the morning and "repeatedly took items out of the pantry and tried to eat them." The report indicated client #4 "repeatedly touched the other clients."</p> <p>12/11/12 from 2:30 PM to 8 PM, client #4 was eating his dinner and he had already been given thirds. Client #4 "kept getting up from the table and trying to get in the food on the shelves and in the refrigerator. Staff had already given him a few things he asked for. He was still trying to take stuff out of the fridge. Staff was trying to redirect him to something else and he started trying to hit them. He was pushing, punching, kicking, and slapping. He also tried hitting another client. Staff continued trying to redirect him while another staff got the other clients out of the room. He took a picture off the wall and threw it at staff shattering the glass. He continued trying to hit and punch people. He ripped staff's glasses off their face. He tried taking other things off the walls, but staff stopped him. This went on for about twenty minutes." The report indicated client #4 had touched</p>			

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	<p>other clients and their things "repeatedly" the staff were not able to redirect him. The report indicated client #4 "tried hitting one of his housemates. He [client #4] also kept trying to grab his housemate's things. He targets this housemate often."</p> <p>12/12/12 from 6 AM to 8:30 AM, client #4 "grabbed his housemate's face and tried shoving him into the table. His housemate did nothing to provoke him. [Client #4] targets this housemate quite often and for no apparent reason. His housemate will walk into a room and he will go after him. If the housemate is in a room and [client #4] goes in there most of the time he will try to take the client's things or hit and push him. [Client #4] will not usually calm down until the client is in another room and if the client comes back he will start in again." The report indicated client #4 was redirected several times from getting into the food and from touching others when they didn't want to be touched and from taking the other clients' things.</p> <p>12/14/12 from 6 AM to 8:30 AM, client #4 had finished eating his breakfast and gone into the living room. "A few minutes later he came back into the kitchen and tried to mess with others. Staff tried redirecting him back to the living room to</p>						

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	<p>read books or look at pictures and he would not go. He then pushed his housemate knocking her to the ground. Staff then tried redirecting him to his room while the other staff helped her up. He would not go to his bedroom. He just stood in the hallway. He came back into the kitchen even though staff was trying to redirect his attention to something elses (sic). He then threw a cup of milk at a client and into her plate. He pushed another client. Staff asked this client to go in the other room a couple of times but he didn't leave the room. [Client #4] finally went into the living room and while staff was trying to get the other clients out of there he was kicking the other staff."</p> <p>12/15/12 from 8 AM to 11:59 PM (sic), client #4 "was trying to hug and kiss the other residents this morning when they did not want to be touched. Also this afternoon, he was in the living room with some other residents and began pushing [client #5]. He threw some things around during his behavior."</p> <p>12/16/12 from 12 AM (sic) to 8:30 AM, client #4 "grabbed [client #5] under his arms and wa (sic) thrusting himself upon him." The report indicated the staff tried to redirect client #4 and "get him to let go... and eventually he did but continued to attempt to touch him."</p>			

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	<p>12/18/12 from 5:50 PM to 6:10 PM, client #4 hit staff several times. The report indicated client #4 threw a bowl of fruit across the dinner table and pushed another resident, preventing the resident from touching his own book.</p> <p>12/19/12 from 6 PM to 6:30 PM, client #4 "was hitting other residents, for no reason." The report indicated client #4 was "physically aggressive to the residents."</p> <p>1/7/13 from 6:45 AM to 7:15 AM, client #4 was "very talkative and loud this morning. He was also wanting to get into food before it was time to eat. He was asked by staff to please calm down and have a seat so that everyone could come to the table and eat. [Client #4] would not cooperate with staff. [Client #4] kept wanting to touch his roommate, staff tried to redirect [client #4] but he was not listening. Staff tried to move his roommate [client #5] but he just kept coming back around [client #4]." The report indicated staff "tried the whole time breakfast was being prepared to keep [client #4] occupied with other activities but [client #4] ignored most of staff requests. [Client #4] took a plate out of [client #5's] hand and when staff asked that he give it back, [client #4] threw it on</p>						

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	<p>the floor shattering it everywhere."</p> <p>1/14/13 from 5:30 PM to 6:30 PM, while preparing the evening meal, client #4 was grabbing his peers' clothes and grabbing plates from his peers. The report indicated client #4 grabbed his peer's shirt and "kept stealing other residents' dinner. He [client #4] wouldn't stop until he got what he wanted." Client #4 was escorted to the activity room to eat his evening meal. After eating, client #4 again grabbed at his peers' clothing. "He [client #4] has been hard to redirect tonight." The report indicated client #4 "hit 2 other residents for no reason."</p> <p>1/22/13 from 8:30 AM to 12 PM, client #4 was "trying to take other's plates at one point taking peers drinks and drinking them. He kept trying to kick at one peer, constantly moving. Refusing to sit on van, refusing to leave seat belt on van, trying to open emergency exit window. Staff had to hold onto the latch at the seat in front of us and he continued to try and bend staffs fingers backwards pulling and scratching at staffs hand the entire ride to workshop. This behavior continued with the window even after rest of the clients were off the van. Also refused to get off the van at school today. Constantly in the fridge, cabinets and pantry. At one point trying to get stuff out of the trash. So far</p>			

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	<p>not redirectable."</p> <p>2/7/13 from 2:30 PM to 8 PM, client #4 required several reminders not to touch others. "He [client #4] tried poking his housemate's eyes. He was also hitting the window."</p> <p>2/8/13 from 2:30 PM to 8 PM, client #4 had to be redirected several times from hitting and kicking at others. He also tried poking at his housemate's eyes. The report indicated client #4 was grabbing his housemates' things and touching others.</p> <p>2/11/13 from 6 AM to 8:30 AM, client #4 tried touching others. The report indicated client #4 laid down in the van seat and started kicking the window and opening the emergency windows.</p> <p>2/12/13 from 3:10 PM to 3:20 PM, while on the van, client #4 was "laying down in the seat trying to kick the window out." The report indicated "Once at the [name of workshop] he continued to push, hit, pull hair and try to bite staff. He was trying to pull two of the clients' hair and took two staff to keep him from getting the other clients on the van. He had to be restrained by two staff."</p> <p>2/13/13 from 6 AM to 8:30 AM, client #4 had to be redirected several times during</p>				

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	<p>breakfast to keep him from touching the other clients in the group home. The report indicated he tried to grab the other clients' plates and cups and would not stop and had to be removed from the dining room.</p> <p>On 2/20/13 from 6 AM to 8:20 AM, client #4 flipped a towel at another client and grabbed another client by his shirt. The report indicated the staff redirected client #4 "to no avail, he [client #4] kept coming back to the kitchen over and over."</p> <p>On 2/20/13 from 3:45 PM to 5 PM, "When the other clients returned home from work [client #4] started to become agitated. It started in the kitchen where staff had to place herself between [client #4] and a couple of his peers. He [client #4] was shoving and slapping at staff. Staff did get him out of the kitchen and he went to the living room. [Staff #6] could not get him to go to his room at all. Once in the living room he began to try and get to the peers that were in there. He would not stop trying to get to them and I [staff #6] could not get him to leave the room. He began to hit, shove and pull at staffs' clothing. Another staff tried to intervene and he began to pull on her clothes, picking up the lamp and tried to throw it. At that time another staff and myself tried</p>			

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	<p>taking him by the arm and walking him out of the room. He sat down in the floor and refused to get up. He started pulling on staff's clothes again and kicking out so staff again tried removing him and he punched this staff in the jaw and kicked at another staff knocking her over. We just stood back but stood around to make sure he didn't get to any of the other clients and he started to calm down and was sitting in the floor laughing when this staff clocked out."</p> <p>On 2/21/13 from 4:30 PM to 5:30 PM, client #4 hit, kicked, slapped, pinched and grabbed staff clothes and glasses. He pulled out a handful of staff #6's hair, ripped staff #1's shirt and pulled staff #3's glasses off her face. Client #4 pushed the big screen TV in the living room over and knocked the cable box and DVD player off of it. The report indicated the staff had to remove the lamps from the living room because he tried to use them as a weapon toward staff. The report indicated the staff had to redirect all other clients out of the living room when his yelling and screaming started. The report indicated "It took 4 staff to redirect him to his bedroom because of having to be restrained to remove him from the living room to a quiet area." The report indicated the staff "asked [client #4] numerous times to please stop touching us (the staff) to</p>			

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	<p>please calm down and be nice. Nothing we (the staff) tried worked. It just made him more and more angry. After staff got the other clients out of the living room [client #4] was the only one in there with staff who were trying to control the situation."</p> <p>On 2/22/13 from 6 AM to 8:30 AM, client #4 was in the living room watching TV and looking out the window. The report indicated the staff finished doing another client's hygiene (client #6) and took him to the living room. The report indicated the staff left the living room "for a few seconds" to return to the office to get some paper work and then returned to the living room. When the staff returned client #4 was "digging his fingers into the client's (client #6's) eyes." The report indicated the staff continued to redirect client #4 and client #4 continued to touch others. The report indicated client #4 calmed enough to eat his breakfast and after eating he "tried touching others and was redirected to the living room. He remained in there with staff and no other clients. He still tried going into the other room to get people. He was very loud and telling people to shut up and get out of his way. He tried grabbing and hitting staff. He finally calmed down and sat in the office with staff but staff had to sit right in front of</p>						

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	<p>him holding his hand for him to remain calm."</p> <p>E-mails dated 2/20/13 sent from client #4's teacher to this surveyor were reviewed on 2/21/13 at 9 PM. The e-mails indicated:</p> <p>On 1/15/13 while at the school gym, the school staff noted client #4 taking his shirt off, grabbing items off of the staffs' desks, taking things that belonged to other students, tapping other students, biting another student's hair, "moving very close" to other students' faces, taking a book from another student, refusing to give it up for about 10 minutes and hitting another student on the forehead. The teacher called the group home staff at 1:35 PM to come get him due to his behaviors.</p> <p>12/14/12 during physical education class, the class went to the weight room. While in the weight room client #4 picked up a weight and pushed it off the rack. Another student was standing near and told client #4 he wasn't supposed to do that. An aide asked client #4 to keep his hands off the weights. Client #4 pushed the student that asked him not to push the weights. Aides attempted to have client #4 return to class and client #4 tried to follow a student he had hit the day before. Client #4's teacher was called to assist in taking client #4</p>						

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	<p>back to the classroom. He refused to go and the assistant principal came to help. Client #4 refused to leave the weight room until the other student left first.</p> <p>12/10/12 after lunch, client #4 tried to grab a drink from another student. The school staff tried to redirect client #4 to another task when client #4 grabbed a plastic bag off the table and attempted to hit a student in the head. The student ran away and was "very scared." When trying to get client #4 to apologize, client #4 "kept moving quickly at the student as to intimidate him. The group home was called and [client #4] was then sent home."</p> <p>Interview with client #5 and staff #2 on 2/19/13 at 4:55 PM stated "I'm tired of him (client #4) touching me all the time. He does it with everyone." Client #5 stated when client #4 got in his space, client #5 tried to stay away from him, but "It's hard." Staff #2 indicated client #4 did a lot of touching, poking and grabbing and the other clients in the home didn't like it. Staff #2 indicated client #4 would target client #5 and a few others in the home depending on what was going on. Staff #2 stated the staff had reported the behaviors to the RC (Residential Coordinator), "but nothing ever gets done about it."</p>						

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	<p>Interview with the RC (Residential Coordinator) and the PS (Program Specialist) on 2/20/13 at 2:45 PM indicated client #4 was admitted to the group home on 11/5/12. The RC stated client #4 "has been a little out of sorts" since his admission. When asked if the staff had reported client #4 had hit client #5 with a hand towel and had pulled at his clothes during the morning observation, the RC stated, "I guess he had a bad morning." The RC indicated he had not reported any of client #4's aggression and abuse toward his housemates since client #4's admission to the house because he did not see it as client to client abuse. The PS indicated client #4's aggression toward his peers, client to client abuse, was to be reported to the PS, to BDDS and to APS (Adult Protective Services) and to be thoroughly investigated.</p> <p>Interview with the PS on 2/25/13 at 2 PM indicated the IDT did not meet to discuss client #4's behaviors of abuse toward the other clients in the home. The PS indicated the IDT did not assess and/or reassess client #4's needs in regards to his continued behaviors of disruption and/or how the facility was going to ensure the clients' safety and well being in the group home.</p>				

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	<p>2. The facility failed to implement its abuse/neglect policy for 32 of 41 incidents of alleged abuse/neglect, injuries of unknown origin and/or client to client abuse/reviewed, ___ To immediately report to the administrator injuries of unknown source for clients #4, #6, #7 and #8. ___ To immediately report to the administrator client to client abuse for clients #4, #5, #6, #7 and #8 ___ To report allegations of abuse/neglect to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for client #5. Please see W153.</p> <p>3. The facility failed for 28 of 41 allegations of abuse, neglect and/or injuries of unknown source reviewed, to maintain a reproducible system and/or failed to provide evidence of a thorough investigation regarding allegations of abuse/neglect, client to client abuse and/or injuries of unknown source for clients #2, #4, #5, #6, #7, #8 and #9. Please see W154.</p> <p>4. The facility failed for 5 of 6 investigations reviewed, to report the results of the investigations to the</p>			

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	<p>administrator within 5 days from the date of discovery of the injuries and/or incident for clients #2, #6, #7, #8 and #9. Please see W156.</p> <p>5. The facility failed to provide adequate staffing levels for clients #1, #2, #3, #4, #5, #6, #7 and #8 to ensure the clients were not abused due to client #4's behaviors, to ensure adequate supervision at meal time, and to ensure the clients received active treatment and supervision throughout the day. Please see W186.</p> <p>Review of the 1/1/11 facility policy of "Suspected Abuse, Neglect and Exploitation Reporting" on 2/19/13 at 2 PM indicated: ___ Employees must report immediately by phone to the RC any incident of suspected abuse, neglect and/or exploitation of a resident/consumer. The RC will report by Internet all allegations of abuse, neglect or exploitation to APS (Adult Protective Services) and the District and Central offices of the BDDS (Bureau of Developmental Disabilities Services) within 24 hours of receipt of suspected abuse, neglect and/or exploitation. ___ All injuries of unknown origin are to be reported to the Director and to be thoroughly investigated. The outcome of the investigation will be reported to the Director within 5 business days.</p>						

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	<p>__Neglect to be defined as the failure to provide the proper care for a resident/consumer, in a timely manner, causing the resident/consumer undue physical or emotional stress or injury; unreasonable delays in providing appropriate services, including medication errors, are considered neglect when they cause the resident/consumer undue physical or emotional stress or injury.</p> <p>9-3-2(a)</p>				

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS 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. Based on observation, interview and record review for 32 of 41 incidents of alleged abuse/neglect, injuries of unknown origin and/or client to client abuse reviewed, the facility failed: __To immediately report to the administrator injuries of unknown source for clients #4, #6, #7 and #8. __To immediately report to the administrator client to client abuse for clients #4, #5, #6, #7 and #8. __To report allegations of abuse/neglect to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for client #5.</p> <p>Findings include: The facility's records were reviewed on 2/19/13 at 2 PM and on 2/25/13 at 11:30 AM. The BDDS report of 7/19/12 indicated on 7/18/12 at 5 PM client #5 was "yelling and cussing at staff after he returned</p>	W000153	<p>W 153 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>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure investigations are completed and reported to the administration within 5 business days. · Residential Coordinator and Site Manager will ensure there are adequate staffing 	04/10/2013			

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	home from workshop. Staff redirected him to calm down per his behavior plan and he then went to his bedroom. Staff continued to assist other residents in the home to ensure their needs were met. A short time later, [client #5] walked in the front door carrying a fountain drink and a bag of chips. He reported he walked to the local pantry [convenience store] down the street and purchased said items." The report indicated the incident was to be investigated. Review of the facility investigative notes of 7/20/12 for the investigation of the AWOL (Absent Without Leave) incident in regard to client #5 on 7/18/12 indicated client #5 accused the staff of throwing away his chips he had just purchased, "She owes me \$1.00 and something cents. I bet she needs to pay up." When asked who threw his chips away, client #5 indicated it was "that lady who was pregnant." The client stated staff #1 "sent me into my room like I was a baby. They sat me down like I was a kid." The investigative notes indicated an interview between the PS (Program Specialist) and client #10 on 7/20/12. The notes indicated client #10 reported staff #3 took client #5's chips away from him and "tossed" them in the trash. The notes indicated the findings of the investigation to include "Some staff, [client #5] and another resident report that [staff #1] took the chips away from [client #5] and threw		<p>numbers in the home at all times to prevent client to client abuse.</p> <ul style="list-style-type: none"> The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting and investigation process into these allegations. The RC will ensure that all incidents of abuse and neglect are reported to BDDS and APS timely. Occazio's policy #2105 regarding abuse, neglect and exploitation will be reviewed with all staff at their team meeting. The importance of documenting behavior concerns and the appropriate place to document such concerns will be reviewed with staff their team meeting. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the same deficient practice. 				

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	<p>them in the trash. [Client #5] and another resident report that [staff #1] scolded [client #5] for leaving the house unsupervised." The facility records did not indicate the allegations of abuse reported during the investigation were reported to the State, to BDDS or APS (Adult Protective Services).</p> <p>The GER of 9/5/12 indicated at 5:40 PM the staff noted a "blister like spot" on the upper part of client #6's leg. The report indicated the cause of the blister was undetermined. The facility records did not indicate the administrator was notified of client #6's injury of unknown source.</p> <p>The GER (General Events Reports/Incident Report) of 9/24/12 at 6:15 PM indicated while getting client #6 up and dressed for the day, the staff discovered "a large bruise. The bruise runs from [client #6's] wrist to his elbow on his right forearm. There were also some scratches. Photos were taken and forwarded to the RC [Residential Coordinator]." The report did not indicate the source of the injury. The facility records did not indicate the administrator was notified of client #6's injury of unknown source.</p> <p>The GER of 9/30/12 indicated at 6:30 AM staff discovered a scratch on client</p>		<ul style="list-style-type: none"> · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure investigations are completed and reported to the administration within 5 business days. · Residential Coordinator and Site Manager will ensure there are adequate staffing numbers in the home at all times to prevent client to client abuse. · The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting and investigation process into these allegations. · The RC will ensure that all incidents of abuse and neglect are reported to BDDS and APS timely. · Occazio's policy #2105 regarding abuse, neglect and exploitation will be reviewed with all staff at their team meeting. · The importance of documenting behavior concerns and the appropriate place to 				

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	<p>#6's forehead. The report did not indicate the source of the injury. The facility records did not indicate the administrator was notified of client #6's injury of unknown source.</p> <p>The GER of 10/11/12 at 6 AM indicated the staff discovered a quarter size bruise on the heel of client #6's left hand by his thumb. The report indicated the source of the injury was undetermined. The facility records did not indicate the administrator was notified of client #6's injury of unknown source.</p> <p>The GER of 12/12/12 at 2:45 AM indicated the staff heard a loud noise and went to check on client #4 and found client #4 on the floor. The report indicated client #4 had a 4 centimeter "cut" on the left side of his forehead and an "egg shaped bruising about 6 cm (centimeter) by 3.5 cm surrounding the cut." The report indicated client #4 had fallen out of bed, but did not indicate how the client injured his head. The facility records did not indicate the administrator was notified of client #4's injury of unknown source.</p> <p>The GER of 12/14/12 at 7 AM indicated client #4 shoved client #7 down, knocking her into the file cabinet and onto the floor. The staff noted client #7's right</p>		<p>document such concerns will be reviewed with staff their team meeting.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure investigations are completed and reported to the administration within 5 business days. · Residential Coordinator and Site Manager will ensure there are adequate staffing numbers in the home at all times to prevent client to client abuse. · The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting and investigation process into these allegations. · The RC will ensure that all 				

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	<p>side, back and buttocks were red from being shoved and falling. The facility records did not indicate the administrator was notified of client #7's client to client abuse.</p> <p>The GER of 1/8/13 at 6:15 AM indicated the staff discovered 2 bruises on client #8. One bruise was noted below each elbow on the outer sides of client #8's arms. The report indicated "It appears to be from where she has bumped them against the table. The one on her right arm is 4 x 1 cm and the one on the left is 2 x 1 cm." The facility records did not indicate the administrator was notified of client #8's injury of unknown source.</p> <p>The GER of 1/30/13 at 8:20 PM indicated the staff noted a dime size bruise on client #7's left middle finger. The report did not indicate the source of the injury. The facility records did not indicate the administrator was notified of client #7's injury of unknown source.</p> <p>The GER of 2/6/13 at 4:15 PM indicated the staff discovered a blister on client #6's right foot. The report indicated the source of the injury was undetermined. The facility records did not indicate the administrator was notified of client #6's injury of unknown source.</p>		<p>incidents of abuse and neglect are reported to BDDS and APS timely.</p> <ul style="list-style-type: none"> · Occazio's policy #2105 regarding abuse, neglect and exploitation will be reviewed with all staff at their team meeting. · The importance of documenting behavior concerns and the appropriate place to document such concerns will be reviewed with staff their team meeting. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10 th , 2013</p>		

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	<p>The GER of 2/8/13 at 4:44 PM indicated client #7 "picked her wound" on her right leg. The report indicated the client was seen by the nurse for first aid. The report did not indicate the source of the injury. The facility records did not indicate the administrator was notified of client #7's injury of unknown source.</p> <p>The GER of 2/12/13 at 3:10 PM indicated while on the facility van, client #4 hit clients #2, #6 and #8 and pulled their hair and clothing. The facility records did not indicate the administrator was notified of client #2's, #6's and #8's client to client abuse.</p> <p>Observations were conducted at the group home on 2/20/13 between 5:35 AM and 8:05 AM. During the morning meal client #4 was up and down, grabbing food off of the table and grabbing at client #5's and #7's food and drinks. The staff redirected client #4 multiple times with no success. At 6:42 AM client #4 jumped up from the table, grabbed the large bowl of scrambled eggs and placed the ladle with eggs on it into his mouth. Staff #1 stated, "Now I have to make more eggs. [Client #7] hasn't ate yet." Client #4 was prompted 4 times by staff #4 to put the bowl of eggs on the counter and to return to his chair at the dining room table and sit down. Client #4 finally complied,</p>				

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	<p>talking loudly and laughing all the while. As soon as client #4 sat down, he jumped back up, leaned across the table and grabbed the last two slices of buttered toast and stuffed them into his mouth. At 6:50 AM staff #1 escorted client #4 to the living room, away from breakfast table and away from clients #1, #2, #3, #5, #6, #7 and #8. Client #4 immediately returned to the kitchen and grabbed a kitchen hand towel and flipped it at client #5. The staff verbally redirected client #4. Client #4 then grabbed client #5's shirt at the left shoulder and pulled at client #5's clothing. Staff #1 and #4 verbally and physically removed client #4 from the dining room into the living room where staff #1 remained with him until clients #1, #2, #3, #5, #6, #7 and #8 loaded the facility van to go to day services/workshop.</p> <p>Client #4's record was reviewed on 2/20/13 at 2 PM and 2/25/13 at 1 PM. Client #4's Clinician Reports indicated: 12/4/12 from 5 PM to 5:35 PM, client #4 was touching other residents that did not want to be touched and was taking their things.</p> <p>12/6/12 from 4 PM to 11 PM, client #4 slapped client #5 and tried to slap client #7. Client #4 was pulling at client #5's and client #7's shirts.</p>				

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	<p>12/7/12 from 4 PM to 11:59 PM, client #4 "pushed another resident." Client #4 stole another client's food at the dinner table and took another client's belongings, throwing them across the room.</p> <p>12/9/12 from 5 PM to 7 PM, "He [client #4] went around the house and was trying to hit and push the other residents. Staff got all the residents away from him to keep them safe. After dinner he was in the living room and started throwing things, breaking the lamp and some of the Christmas decorations. Staff tried to take him to his room but he was non compliant. Again staff cleared the living room of all residents and moved things away from him so he had nothing else to throw...."</p> <p>12/11/12 from 6 AM to 8:30 AM, client #4 "was very aggressive with one of his housemates this morning. His housemate wasn't doing anything to provoke him. [Client #4] grabbed his face, tried taking his belongings and threw a cup of juice at him." The report indicated client #4 "repeatedly touched the other clients."</p> <p>12/11/12 from 2:30 PM to 8 PM, client #4 was eating his dinner and he had already been given thirds. Client #4 "kept getting up from the table and trying to get in the food on the shelves and in the</p>				

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	<p>refrigerator. Staff had already given him a few things he asked for. He was still trying to take stuff out of the fridge. Staff was trying to redirect him to something else and he started trying to hit them. He was pushing, punching, kicking, and slapping. He also tried hitting another client. Staff continued trying to redirect him while another staff got the other client out of the room. He took a picture off the wall and threw it at staff shattering the glass. He continued trying to hit and punch people. He ripped staff's glasses off their face. He tried taking other things off the walls, but staff stopped him. This went on for about twenty minutes." The report indicated client #4 had touched other clients and their things "repeatedly" the staff were not able to redirect him. The report indicated client #4 "tried hitting one of his housemates. He [client #4] also kept trying to grab his housemate's things. He targets this housemate often."</p> <p>12/12/12 from 6 AM to 8:30 AM, client #4 "grabbed his housemate's face and tried shoving him into the table. His housemate did nothing to provoke him. [Client #4] targets this housemate quite often and for no apparent reason. His housemate will walk into a room and he will go after him. If the housemate is in a room and [client #4] goes in there most of</p>			

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	<p>the time he will try to take the clients things or hit and push him. [Client #4] will not usually calm down until the client is in another room and if the client comes back he will start in again." The report indicated client #4 had to be redirected several times from touching others when they didn't want to be touched and from taking the other clients' things.</p> <p>12/14/12 from 6 AM to 8:30 AM, client #4 had finished eating his breakfast and gone into the living room. A few minutes later he came back into the kitchen and tried to "mess with others. Staff tried redirecting him back to the living room to read books or look at pictures and he would not go. He then pushed his housemate knocking her to the ground. Staff then tried redirecting him [client #4] to his room while the other staff helped her [client #7] up. He would not go to his bedroom. He just stood in the hallway. He came back into the kitchen even though staff was trying to redirect his attention to something elses (sic). He then threw a cup of milk at a client and into her plate. He pushed another client. Staff asked this client to go in the other room a couple of times but he didn't leave the room. [Client #4] finally went into the living room and while staff was trying to get the other clients out of there he was kicking the other staff."</p>			

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	<p>12/15/12 from 8 AM to 11:59 PM (sic), client #4 "was trying to hug and kiss the other residents this morning when they did not want to be touched. Also this afternoon, he was in the living room with some other residents and began pushing [client #5]. He threw some things around during his behavior."</p> <p>12/16/12 from 12 AM (sic) to 8:30 AM, client #4 "grabbed [client #5] under his arms and wa (sic) thrusting himself upon him." The report indicated the staff tried to redirect client #4 and "get him to let go... and eventually he did but continued to attempt to touch him."</p> <p>12/18/12 from 5:50 PM to 6:10 PM, client #4 pushed another resident, preventing the resident from touching his own book.</p> <p>12/19/12 from 6 PM to 6:30 PM, client #4 "was hitting other residents, for no reason." The report indicated client #4 was "physically aggressive to the residents."</p> <p>1/7/13 from 6:45 AM to 7:15 AM, "[Client #4] was very talkative and loud this morning. He also wanted to get into food before it was time to eat. He was asked by staff to please calm down and</p>						

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	<p>have a seat so that everyone could come to the table and eat. [Client #4] would not cooperate with staff. [Client #4] kept wanting to touch his roommate, staff tried to redirect [client #4] but he was not listening. Staff tried to move his roommate [client #5] but he just kept coming back around [client #4]." The report indicated staff "tried the whole time breakfast was being prepared to keep [client #4] occupied with other activities but [client #4] ignored most of staff requests. [Client #4] took a plate out of [client #5's] hand and when staff asked that he give it back, [client #4] threw it on the floor shattering it everywhere."</p> <p>1/14/13 from 5:30 PM to 6:30 PM, while preparing the evening meal, client #4 was grabbing his peers' clothes and grabbing plates from his peers. The report indicated client #4 grabbed his peer's shirt and "kept stealing other residents' dinner. He [client #4] wouldn't stop until he got what he wanted." Client #4 was escorted to the activity room to eat his evening meal. After eating, client #4 again grabbed at his peers' clothing. "He [client #4] has been hard to redirect tonight." The report indicated client #4 "hit 2 other residents for no reason."</p> <p>1/22/13 from 8:30 AM to 12 PM, client #4 was "trying to take other's plates at one</p>			

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	<p>point taking peers drinks and drinking them. He kept trying to kick at one peer, constantly moving. Refusing to sit on van, refusing to leave seat belt on van, trying to open emergency exit window. Staff had to hold onto the latch at the seat in front of us and he continued to try and bend staffs fingers backwards pulling and scratching at staffs hand the entire ride to workshop. This behavior continued with the window even after the rest of the clients were off the van. Also refused to get off the van at school today. Constantly in the fridge, cabinets and pantry. At one point trying to get stuff out of the trash. So far not redirectable."</p> <p>2/7/13 from 2:30 PM to 8 PM, client #4 required several reminders not to touch others. "He [client #4] tried poking his housemate's eyes. He was also hitting the window."</p> <p>2/8/13 from 2:30 PM to 8 PM, client #4 had to be redirected several times from hitting and kicking at others. He also tried poking at his housemate's eyes. The report indicated client #4 was grabbing his housemates' things and touching others.</p> <p>2/11/13 from 6 AM to 8:30 AM, client #4 tried touching others. The report indicated client #4 laid down in the van seat and started kicking the window and opening</p>						

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	<p>the emergency windows.</p> <p>2/12/13 from 3:10 PM to 3:20 PM, while on the van, client #4 was "laying down in the seat trying to kick the window out." The report indicated "Once at the [name of workshop] he [client #4] continued to push, hit, pull hair and try to bite staff. He was trying to pull two of the clients' hair and took two staff to keep him from getting the other clients on the van. He had to be restrained by two staff."</p> <p>2/13/13 from 6 AM to 8:30 AM, client #4 had to be redirected several times during breakfast to keep him from touching the other clients in the group home. The report indicated he tried to grab the other clients' plates and cups and would not stop and had to be removed from the dining room.</p> <p>On 2/20/13 from 3:45 PM to 5 PM, "When the other clients returned home from work [client #4] started to become agitated. It started in the kitchen where staff had to place herself between [client #4] and a couple of his peers. He [client #4] was shoving and slapping at staff. Staff did get him out of the kitchen and he went to the living room. [Staff #6] could not get him to go to his room at all. Once in the living room he began to try and get to the peers that were in there. He would</p>						

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	<p>not stop trying to get to them and I [staff #6] could not get him to leave the room. He began to hit, shove and pull at staffs' clothing. Another staff tried to intervene and he began to pull on her clothes, picking up the lamp and tried to throw it. At that time another staff and myself tried taking him by the arm and walking him out of the room. He sat down in the floor and refused to get up. He started pulling on staff's clothes again and kicking out so staff again tried removing him and he punched this staff in the jaw and kicked at another staff knocking her over. We just stood back but stood around to make sure he didn't get to any of the other clients and he started to calm down and was sitting in the floor laughing when this staff clocked out."</p> <p>On 2/21/13 from 4:30 PM to 5:30 PM, client #4 hit, kicked, slapped, pinched and grabbed staff clothes and glasses. He pulled out a handful of staff #6's hair, ripped staff #1's shirt and pulled staff #3's glasses off her face. Client #4 pushed the big screen TV in the living room over and knocked the cable box and DVD player off of it. The report indicated the staff had to remove the lamps from the living room because he tried to use them as a weapon toward staff. The report indicated the staff had to redirect all other clients out of the living room when his yelling and</p>						

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	<p>screaming started. The report indicated "It took 4 staff to redirect him to his bedroom because of having to be restrained to remove him from the living room to a quiet area." The report indicated the staff "asked [client #4] numerous times to please stop touching us (the staff) to please calm down and be nice. Nothing we (the staff) tried worked. It just made him more and more angry. After staff got the other clients out of the living room [client #4] was the only one in there with staff who were trying to control the situation."</p> <p>Interview with the RC (Residential Coordinator) and the PS (Program Specialist) on 2/20/13 at 2:45 PM indicated client #4 was admitted to the group home on 11/5/12. The RC stated client #4 "has been a little out of sorts" since his admission. When asked if the staff had reported the events of the morning observation, the RC indicated he was not aware of any problems. The RC stated, "It sounds like he had a bad morning." The RC indicated he had not reported any of client #4's aggression and/or abuse toward his housemates since client #4's admission to the group home because he did not see it as client to client abuse. The PS indicated client #4's aggression toward his peers, client to client abuse, was to be reported to the</p>						

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	<p>PS/Administrator, to BDDS and to APS (Adult Protective Services).</p> <p>Interview with the PS on 2/25/13 at 1:30 PM indicated all allegations of abuse/neglect/mistreatment were to be immediately reported to the administrator. The PS indicated APS and BDDS were to be notified within 24 hours of any allegations of abuse/neglect. The PS indicated all injuries of unknown source were to be reported to the administrator.</p> <p>9-3-2(a)</p>				

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 28 of 41 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to maintain a reproducible system and/or failed to provide evidence of a thorough investigation regarding allegations of abuse/neglect, client to client abuse and/or injuries of unknown source for clients #2, #4, #5, #6, #7, #8 and #9.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 2/19/13 at 2 PM and on 2/25/13 at 11:30 AM.</p> <p>The BDDS (Bureau of Developmental Disabilities Services) report of 3/20/12 indicated on 3/19/12 at 5:14 PM the staff discovered 3 bruises on client #7's first three toes of her left foot. The bruise on her big toe "is about the size of a quarter and the bruises on the other two toes are about the size of a nickel." The report indicated the cause of the injury was unknown but "the pattern would appear that [client #7] may have dropped something on her foot that caused the bruising or someone may have stepped on the toe portion of her foot." The report</p>	W000154	<p>W 154 Staff Treatment of Clients</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure investigations are completed and reported to the administration within 5 business days. · The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting and investigation process into these allegations. · Occazio's policy #2105 	04/10/2013			

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	<p>indicated an investigation was conducted and completed on 3/20/12. The facility records indicated the RC interviewed 3 group home staff. The facility records did not indicate the RC interviewed all of the staff in the group home, any client interviews or any interviews of staff at the day program client #7 attended.</p> <p>The BDDS report of 4/19/12 indicated on 4/19/12 at 2:35 PM client #5 was hit with a plastic container on his right arm by a peer while at the workshop. The peer dropped the container and client #5 bent down and picked it up. The peer then "threw the container and hit [client #5] on the right arm again." The facility records did not indicate the peer to peer altercation in regard to client #5 was investigated.</p> <p>The BDDS report of 6/29/12 indicated on 6/28/12 at 3:05 PM client #9 punched a peer twice (once in the back and once on the shoulder) while at the workshop. The facility records did not indicate evidence a thorough investigation was conducted.</p> <p>The BDDS report of 7/2/12 indicated on 7/1/12 at 5 PM staff discovered two quarter size bruises on client #2's left upper arm. The report indicated the RC investigated the injury and was not able to determine the exact cause of the bruises.</p>		<p>regarding abuse, neglect and exploitation will be reviewed with all staff at their team meeting.</p> <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure investigations are completed and reported to the administration within 5 business days. · The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting and investigation process into these allegations. · Occazio's policy #2105 regarding abuse, neglect and exploitation will be reviewed with 				

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	<p>The facility records indicated the RC interviewed 2 of the group home staff. The facility records did not indicate the RC interviewed all of the group home staff, the clients and/or the staff at the day program client #2 attended.</p> <p>The GER (General Events Reports/Incident Report) of 9/5/12 indicated at 5:40 PM the staff noted a "blister like spot" on the upper part of client #6's leg. The report indicated the cause of the injury was undetermined. The facility records indicated the report was reviewed by the RC and an investigation was to be conducted. The facility records indicated the RC interviewed 2 of the facility staff. The facility records did not indicate the RC interviewed all of the group home staff, the clients and/or the staff at the day program client #6 attended.</p> <p>The GER of 9/24/12 at 6:15 PM indicated while getting client #6 up and dressed for the day, the staff discovered "a large bruise. The bruise runs from [client #6's] wrist to his elbow on his right forearm. There were also some scratches. Photos were taken and forwarded to the RC [Residential Coordinator]." The report indicated the RC will investigate. The report did not indicate the source of the injury. The facility records did not</p>		<p>all staff at their team meeting.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure investigations are completed and reported to the administration within 5 business days. · The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting and investigation process into these allegations. · Occazio's policy #2105 regarding abuse, neglect and exploitation will be reviewed with all staff at their team meeting. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p>		

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	<p>indicate the facility conducted an investigation of client #4's injury of unknown source.</p> <p>The GER of 9/30/12 indicated at 6:30 AM staff discovered a scratch on client #6's forehead. The report did not indicate the source of the injury. The facility records did not indicate the facility conducted an investigation of client #6's injury of unknown source.</p> <p>The GER of 10/11/12 at 6 AM indicated the staff discovered a quarter size bruise on the heel of client #6's left hand by his thumb. The report indicated the source of the injury was undetermined. The facility records did not indicate the facility conducted an investigation of client #6's injury of unknown source.</p> <p>The GER of 12/12/12 at 2:45 AM indicated the staff heard a loud noise and went to check on client #4. The report indicated the client had fallen out of bed and noted client #4 had a 4 centimeter "cut" on the left side of his forehead. "Egg shaped bruising about 6 cm by 3.5 cm surrounding the cut." The report did not indicate the source of the injury. The facility records did not indicate the facility conducted an investigation of client #4's injury of unknown source.</p>		<ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed? April 10 th , 2013</p>				

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	<p>The GER of 12/14/12 at 7 AM indicated client #4 shoved client #7 down, knocking her into the file cabinet and onto the floor. The staff noted client #7's right side, back and buttocks were red from being shoved and falling. The facility records did not indicate the client to client abuse was investigated.</p> <p>The GER of 1/8/13 at 6:15 AM indicated the staff discovered 2 bruises on client #8. One bruise was noted below each elbow on the outer sides of client #8's arms. The report indicated "It appears to be from where she has bumped them against the table. The one on her right arm is 4 x 1 cm and the one on the left is 2 x 1 cm." The facility records did not indicate the facility conducted an investigation of client #8's injury of unknown source.</p> <p>The GER of 1/30/13 at 8:20 PM indicated the staff noted a dime size bruise on the client #7's left middle finger. The report did not indicate the source of the injury. The facility records did not indicate the facility conducted an investigation of client #7's injury of unknown source.</p> <p>The GER of 2/6/13 at 4:15 PM indicated the staff discovered a blister on client #6's right foot. The report indicated the source of the injury was undetermined. The facility records did not indicate the</p>						

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	<p>facility conducted an investigation of client #6's injury of unknown source.</p> <p>The GER of 2/8/13 at 4:44 PM indicated client #7 "picked her wound" on her right leg. The report indicated the client was seen by the nurse for first aid. The report did not indicate the source of the injury. The facility records did not indicate the facility conducted an investigation of client #7's injury of unknown source.</p> <p>The GER of 2/12/13 at 3:10 PM indicated while on the facility van, client #4 hit clients #2, #6 and #8 and pulled their hair and clothing. The facility records did not indicate an investigation was conducted.</p> <p>Client #4's record was reviewed on 2/20/13 at 2 PM and 2/25/13 at 1 PM. Client #4's Clinician Reports indicated: 12/4/12 from 5 PM to 5:35 PM, client #4 was touching other residents that did not want to be touched and was taking their things.</p> <p>12/6/12 from 4 PM to 11 PM, client #4 slapped client #5 and tried to slap client #7. Client #4 was pulling at client #5's and client #7's shirts.</p> <p>12/7/12 from 4 PM to 11:59 PM, client #4 "pushed another resident." Client #4 stole another client's food at the dinner table</p>						

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	<p>and took another client's belongings, throwing them across the room.</p> <p>12/11/12 from 6 AM to 8:30 AM, client #4 "was very aggressive with one of his housemates this morning. His housemate wasn't doing anything to provoke him. [Client #4] grabbed his face, tried taking his belongings and threw a cup of juice at him." The report indicated client #4 "repeatedly touched the other clients."</p> <p>12/11/12 from 2:30 PM to 8 PM, client #4 had touched other clients and their things "repeatedly" the staff were not able to redirect him. The report indicated client #4 "tried hitting one of his housemates. He [client #4] also kept trying to grab his housemate's things. He targets this housemate often."</p> <p>12/12/12 from 6 AM to 8:30 AM, client #4 "grabbed his housemate's face and tried shoving him into the table. His housemate did nothing to provoke him. [Client #4] targets this housemate quite often and for no apparent reason. His housemate will walk into a room and he will go after him. If the housemate is in a room and [client #4] goes in there most of the time he will try to take the clients things or hit and push him. [Client #4] will not usually calm down until the client is in another room and if the client comes</p>						

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	<p>back he will start in again." The report indicated client #4 had to be redirected several times from touching others when they didn't want to be touched and from taking the other clients' things.</p> <p>12/14/12 from 6 AM to 8:30 AM, client #4 pushed client #7, knocking her to the ground. Staff then tried redirecting client #4 to his room while the other staff helped client #7 up. "He [client #4] would not go to his bedroom. He just stood in the hallway. He came back into the kitchen even though staff was trying to redirect his attention to something elses (sic). He then threw a cup of milk at a client and into her plate. He pushed another client. Staff asked this client to go in the other room a couple of times but he didn't leave the room. [Client #4] finally went into the living room and while staff was trying to get the other clients out of there he was kicking the other staff." The facility records did not indicate the client to client abuse was investigated</p> <p>12/15/12 from 8 AM to 11:59 PM (sic), client #4 "was trying to hug and kiss the other residents this morning when they did not want to be touched. Also this afternoon, he was in the living room with some other residents and began pushing [client #5]. He threw some things around during his behavior."</p>			

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	<p>12/16/12 from 12 AM (sic) to 8:30 AM, client #4 "grabbed [client #5] under his arms and wa (sic) thrusting himself upon him." The report indicated the staff tried to redirect client #4 and "get him to let go... and eventually he did but continued to attempt to touch him."</p> <p>12/18/12 from 5:50 PM to 6:10 PM, client #4 pushed another resident, preventing the resident from touching his own book.</p> <p>12/19/12 from 6 PM to 6:30 PM, client #4 "was hitting other residents, for no reason." The report indicated client #4 was "physically aggressive to the residents."</p> <p>1/14/13 from 5:30 PM to 6:30 PM, while preparing the evening meal, client #4 was grabbing his peers' clothes and grabbing plates from his peers. The report indicated client #4 grabbed his peer's shirt and "kept stealing other residents' dinner. He [client #4] wouldn't stop until he got what he wanted." Client #4 was escorted to the activity room to eat his evening meal. After eating, client #4 again grabbed at his peers' clothing. "He [client #4] has been hard to redirect tonight." The report indicated client #4 "hit 2 other residents for no reason."</p>			

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	<p>2/8/13 from 2:30 PM to 8 PM, client #4 was grabbing his housemates' things and touching others.</p> <p>Interview with the RC (Residential Coordinator) and the PS (Program Specialist) on 2/20/13 at 2:45 PM indicated client #4 was admitted to the group home on 11/5/12. The RC stated client #4 "has been a little out of sorts" since his admission. When asked if the staff had reported client #4 had hit client #5 with a hand towel and had pulled at his clothes during the morning observation, the RC stated, "Yeah, he had a bad morning." The RC indicated he had not conducted any investigations in regard to client #4's aggression and abuse toward his housemates since client #4's admission to the house because he did not see it as client to client abuse. The PS indicated client #4's behaviors toward his peers were client to client abuse and were to be investigated.</p> <p>Interview with the PS on 2/25/13 at 1:30 PM indicated all allegations of abuse/neglect/mistreatment and injuries of unknown source were to be thoroughly investigated.</p> <p>9-3-2(a)</p>						

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W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on interview and record review for 5 of 6 investigations reviewed, the facility failed to report the results of the investigations to the administrator within 5 days from the date of discovery of the injuries and/or incident for clients #2, #6, #7, #8 and #9.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 2/19/13 at 2 PM and on 2/25/13 at 11:30 AM.</p> <p>The BDDS report of 3/20/12 indicated on 3/19/12 at 5:14 PM the staff discovered 3 bruises on client #7's first three toes of her left foot. The bruise on her big toe "is about the size of a quarter and the bruises on the other two toes are about the size of a nickel." The report indicated the cause of the injury was unknown but "the pattern would appear that [client #7] may have dropped something on her foot that caused the bruising or someone may have stepped on the toe portion of her foot." The report indicated an investigation was conducted and completed on 3/20/12. The</p>	W000156	<p>W 156 Staff Treatment of Clients</p> <p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure investigations are completed and reported to the administration within 5 business days. · The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and exploitation; peer to peer 	04/10/2013			

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	<p>facility records did not indicate the administrator was notified of the results of the investigation within five working days from the date the unknown injury was discovered.</p> <p>The BDDS report of 6/29/12 indicated on 6/28/12 at 3:05 PM client #9 punched a peer twice (once in the back and once on the shoulder) while at the workshop. The report indicated an investigation was conducted. The facility records did not indicate the administrator was notified of the results of the investigation within five working days from the date the unknown injury was discovered.</p> <p>The BDDS report of 7/2/12 indicated on 7/1/12 at 5 PM staff discovered two quarter size bruises on client #2's left upper arm. The report indicated the RC investigated the injury and was not able to determine the exact cause of the bruises. The facility records did not indicate the administrator was notified of the results of the investigation within five working days from the date the unknown injury was discovered.</p> <p>The BDDS report of 8/14/12 indicated on 8/14/12 at 12:15 AM while at the day program, client #8 was sitting outside the women's restroom when she was hit on the top of her head by another consumer.</p>		<p>incidents; and injuries of unknown origin; along with the reporting and investigation process into these allegations.</p> <ul style="list-style-type: none"> · Occazio's policy #2105 regarding abuse, neglect and exploitation will be reviewed with all staff at their team meeting. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure investigations are completed and reported to the administration within 5 business days. · The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting 		

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	<p>The report indicated staff saw the incident and told the clients to "keep their hands to themselves. The other consumer then hit [client #8] three times on the right side of her nose with a fist. The other consumer hit the empty chair beside them, and hit [client #8] one more time before staff could intervene." The facility records indicated the incident was investigated. The facility records did not indicate the administrator was notified of the results of the investigation within five working days from the date of the incident.</p> <p>The GER (General Events Report) of 9/5/12 indicated at 5:40 PM the staff noted a "blister like spot" on the upper part of client #6's leg. The report indicated the cause of the injury was undetermined. The facility records indicated the report was reviewed by the RC and an investigation was conducted. The facility records did not indicate the administrator was notified of the results of the investigation within five working days from the date the unknown injury was discovered.</p> <p>The BDDS (Bureau of Developmental Disabilities Services) report of 9/14/12 indicated on 9/13/12 at 5:45 PM the staff discovered a 1/4 inch by 1 1/2 inch bruise on client #8's right hip. "During RC (Residential Coordinator) investigation,</p>		<p>and investigation process into these allegations.</p> <ul style="list-style-type: none"> · Occazio's policy #2105 regarding abuse, neglect and exploitation will be reviewed with all staff at their team meeting. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Staff will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting process into these allegations during their team meeting. · RC will ensure investigations are completed and reported to the administration within 5 business days. · The Residential Coordinator and Site Manager will receive additional training regarding abuse, neglect and exploitation; peer to peer incidents; and injuries of unknown origin; along with the reporting and investigation process into these allegations. · The RC will ensure that all incidents of abuse and neglect are reported to BDDS and APS timely. 		

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	<p>workshop reported that [client #8] had been very active and bouncing around in her chair earlier in the week. It is believed [client #8] her hip on the edge of the table when she was bouncing in her seat." The facility records did not indicate the administrator was notified of the results of the investigation within five working days from the date the unknown injury was discovered.</p> <p>Interview with the PS (Program Specialist) on 2/25/13 at 2 PM indicated she had not been notified of the results of the investigations in regard to the injuries of unknown source for clients #2, #6, #7 and #8 and for the client to client abuse for clients #8 and #9.</p> <p>9-3-2(a)</p>		<p>· Occazio's policy #2105 regarding abuse, neglect and exploitation will be reviewed with all staff at their team meeting.</p> <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <p>· The Site Manager will monitor on a daily basis when they are in the home.</p> <p>· The RC will monitor on a regular basis when they are in the home.</p> <p>· The ARC will monitor as they complete their audits.</p> <p>5. What is the date by which the systemic changes will be completed? April 10 th , 2013</p>		

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W000159	<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 observation, interview and record review for 4 of 4 sample clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the RC/QMRP (Residential Coordinator/Qualified Mental Retardation Professional) integrated, coordinated and monitored the clients' treatment programs.</p> <p>Findings include:</p> <p>1. The RC failed to ensure client #1's, #2's, #3's, #4's, #5's, #6's, #7's and #8's rights in regards to locking the sharps, cleaning supplies, food and/or snacks and the use of door and window alarms. Please see W125.</p> <p>2. The RC failed to ensure the Interdisciplinary Team assessed/re-assessed client #4's BSP (Behavior Support Plan) in regards to his behaviors at the group home/school and abuse toward his housemates. The IDT (Interdisciplinary Team) failed to assess clients #2, #3, #6, #7 and #8 in regards for the need for a clothing protector and failed to assess clients #2, #3, #4 and #8</p>	W000159	<p>W 159 Qualified Mental Retardation Professional</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. · The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. · The RC will ensure that programming is in place for all clients addressing their identified need at all times. · All 8 residents will be assessed to determine their ability to have access to knives/sharps and cleaning 	04/10/2013			

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	<p>for the ability to adjust the water temperatures within the group home. The IDT failed to assess clients #1, #2, #3, #4, #5, #6, #7 and #8 for the use of knives, cleaning and/or laundry products and the IDT failed to assess client #1 within 30 days after her admission to the group home. Please see W210.</p> <p>3. The RC failed to ensure client #1's, #2's, #3's #7's and #8's ISPs addressed the clients' leisure skills and food preparation needs. The RC failed to address client #7's need in regards to smoking. Please see W227.</p> <p>4. The RC failed to ensure client #2's and #3's ISPs addressed how the staff were to supervise and assist the clients while ambulating and to address when the clients were to use a walker and/or a gait belt. Please see W240.</p> <p>5. The RC failed to ensure client #1's, #2's, #3's and #4's ISPs addressed the clients' identified training needs in regards to dining, personal hygiene, hair care, bathing, dressing, tooth brushing and toileting. Please see W242.</p> <p>6. The RC failed to ensure clients #1, #2, #3, #4, #5, #6, #7 and #8 were provided choices of food as indicated on the facility menu. Please see W247.</p>		<p>supplies. Guardian approval will be requested if resident is not found to be able to safely handle knives/sharps and cleaning supplies. If it is found that knives/sharps and cleaning supplies should be locked, those residents that can safely use said items will be provided a key in order to access them independently.</p> <ul style="list-style-type: none"> · All food and snacks will be available to all residents at all times – no edible items will be locked at any time. · The alarms on the doors and windows have been determined that they not needed at this time. They have been removed from the house. · Staff training will occur so they are aware of any restrictions regarding knives/sharps and cleaning supplies relevant to each resident at their team meeting. · Clients #1-#8's IPOP assessments and behavior plans will be reviewed and updated to reflect the necessary changes regarding their needs for access to knives/sharps, cleaning supplies, and use of chimes on the doors. · Client #3's programming regarding access to sharps/knives and cleaning supplies will be updated to reflect 		

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	<p>7. The RC failed to ensure the staff implemented client #1's, #2's, #3's, #5's, #6's, #7's and #8's training objectives when formal and informal training opportunities existed. Please see W249.</p> <p>8. The RC failed to develop an active treatment schedule for clients #1 and #4 after admission and failed to ensure client ##2's, #3's #5's, #6's, #7's and #8's active treatment schedules were individualized. Please see W250.</p> <p>9. The RC failed to ensure the IDT reviewed and updated client #2's and client #8's IPOP/CFA (Individual Plan of Protective Oversight/Comprehensive Functional Assessment) annually and to ensure client #1 was assessed after her admission to the group home. Please see W259.</p> <p>10. The RC failed to revise client #2's and #8's ISPs within 365 days of the previous ISP. Please see W260.</p> <p>11. The RC failed to ensure the HRC (Human Rights Committee) reviewed and approved all of the restrictive practices within the home for clients #1, #2, #3, #4, #5, #6, #7 and #8. Please see W264.</p> <p>12. The RC failed to ensure the use of</p>		<p>her abilities in her new home.</p> <ul style="list-style-type: none"> · Client's #1, #2, #4, #5, #6, #8 and #8 will be placed on programming to address their needs regarding locked items in the home. · HRC approval will be obtained for all clients regarding the restrictions in the home. · One on one staffing for Client #4 began on 2-25-13. · Two on one staffing for Client #4 began the week of 3-18-13 to help protect residents in the home. This staffing pattern will continue until Client #4 is no longer in the home. · Client #4 BSP has been updated. · Occazio served notice to terminate services for Client #4 on 3-22-13. Last day of services will be April 20th, 2013. · Client #4 has been taken to Ball Memorial Hospital for emergency psychiatric evaluation three times since 2-22-13. · Client #4 was seen by his new psychiatrist on 3-15-13. Several medication changes were made at that time. · Client #4 has a follow up psych appointment on 4-5-13. 	

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	<p>standing as needed orders for the use of physical restraint was prohibited for clients #2, #7 and #8. Please see W290.</p> <p>13. The RC failed to develop medication objectives to provide medication training for client #1. Please see W371.</p> <p>14. The RC failed to ensure water temperatures did not exceed 110 degrees for clients #2, #3, #4, #6 and #8. Please see W426.</p> <p>15. The RC failed to ensure client #1's and #3's ISP addressed the clients' training needs to wear and take care of their eye glasses. Please see W436.</p> <p>16. The RC failed to ensure the staff held an evacuation drill quarterly for each shift of personnel in regards to clients #1, #2, #3, #4, #5, #6, #7 and #8. Please see W440.</p> <p>17. The RC failed to ensure the staff followed the facility menu and provided client substitutions for food not eaten for clients #1, #2, #3, #4, #5, #6, #7 and #8. Please see W460.</p> <p>18. The RC failed to ensure clients #1, #2, #3, #4, #5, #6, #7 and #8 were provided knives at meal time. Please see W484.</p>		<ul style="list-style-type: none"> · Clients #2, #3, #6, #7 and #8 will be assessed for the need for clothing protectors while eating. · Water temperature assessments will be completed with Client #2, #3, #4, and #8. · The IPOP assessments will be updated to reflect Client's #2, #3, #4, and #8's abilities to regulate water temperatures. · Upon admission client's needs will be assessed within 30 days and placed on appropriate programming. · Client #1 has now been put on programming to address her identified needs. · Client's #1, #2, #3, #7 and #8 will be put on programming to address their leisure skills and food preparation needs. · Client #1, #2, #3, #7 and #8's ISP's will be updated to reflect their leisure skill and food preparation needs. · Client #7 will be placed on programming to understand the consequences of smoking. · Client #7's ISP will be updated to reflect the need to understand the consequences of smoking. 				

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	<p>19. The RC failed to ensure clients #1, #2, #3, #4, #5, #6, #7 and #8 were provided training in family style dining and to provide supervision while the clients ate their morning meal. The RC failed to ensure the clients packed their own lunch boxes. Please see W488.</p> <p>20. Client #1's record was reviewed on 2/25/13 at 11:00 AM. Client #1's record indicated client #1 was admitted to the group home on 11/30/12. Client #1's ISP (Individual Support Plan) dated 12/28/12 did not indicate any program objectives for client #1. Client #1's record did not indicate the RC had implemented any program objectives for client #1 since her admission to the group home on 11/30/12.</p> <p>Client #2's record was reviewed on 2/21/13 at 11:30 AM. Client #2's ISP dated 2/14/12 indicated client #2 had the following objectives: ___ To pick up his pill crusher during med pass with hand over hand assistance. ___ To demonstrate opening his mouth for the dentist. ___ To brush his teeth. ___ To use a communication book to communicate his wants and needs with HOH assistance. ___ To identify a nickel. ___ To wash his hands with HOH (Hand over Hand) assistance.</p>		<ul style="list-style-type: none"> · Client #2 and #3's ISP and IPOP assessments will be updated to address how the staff is to supervise and assist the clients while ambulating and to address when the clients were to use a walker and/or gait belt. · The PCP for Client #2 and #3 has been contacted to obtain clarification for how the staff is to assist the two residents with their ambulation needs and to identify how their ambulation adaptive equipment is to be utilized. · Programming will be put in place for Clients #1, #2, #3, and #4 to address their identified needs in regards to dining, personal hygiene, hair care, bathing, dressing, tooth brushing, and toileting. · Staff will be retrained on how to provide appropriate food substitutions and the importance of following the menu at their team meeting. · Regular meal observations will be completed by the RC and/or the Site Manager for the home to ensure that the menu is being followed, that staff is encouraging the residents to follow their prescribed dining plans and that appropriate food substitutions are being offered. · Staff will be retrained on 		

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	<p>Client #2's record indicated no RC/QMRP review of client #2's objectives from 1/2012 through 7/2012 and for 12/2012 and 1/2013.</p> <p>Client #3's record was reviewed on 2/21/13 at 2 PM. Client #3's ISP dated 10/16/12 indicated client #3 had the following objectives: ___ To independently state/point to a nickel. ___ To understand her rights and recognize abuse/report abuse. ___ To be able to select her Advair from the cart. ___ To allow staff to assist her with the use of a gait belt if needed. ___ To increase independence in using lock box code to access the sharps. ___ To increase independence in using own key to access hazmat. ___ To do standing balance exercises for 10 min.</p> <p>Client #3's record indicated no RC/QMRP reviews of client #3's objectives from 1/2012 through 7/2012 and for 12/2012 and 1/2013.</p> <p>Client #4's record was reviewed on 2/20/13 at 2 PM. Client #4's record indicated client #4 was admitted to the group home on 11/30/12. Client #4's ISP dated 12/4/12 indicated client #4 had the following objectives:</p>		<p>the importance of ensuring active treatment at all times during their team meeting.</p> <ul style="list-style-type: none"> · Active treatment schedules will be developed for Client's #1 and #4. · The active treatment schedules for Clients #2, #3, #5, #6, #7 and #8 will be individualized. · Staff will be trained on the active treatment schedules for Client's #1-#8 at their next team meeting. · Client #1's IPOP assessments will be completed to determine her needs. · Client #2 and #8's IPOP assessments will be updated to reflect their changed needs over the past year. · Client #2 and #8's ISP's have been updated. · The standing order for restraints has been removed from Client #2, #7, and #8's Medication Administration Record. · Occazio's policy regarding Behavior Change Interventions in Crisis will be reviewed will all staff during their team meeting. · Programming regarding medication training will be 				

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	<p>__ To gather items needed for the med pass.</p> <p>__ To understand his rights and recognize abuse by pointing to body parts.</p> <p>Client #4's record indicated no RC/QMRP review of client #4's objectives for 12/2012 and/or 1/2013.</p> <p>Interview with the PS (Program Specialist) on 2/25/13 at 2 PM indicated the RC was to complete monthly reviews of each client's objectives and revise the objectives depending on each client's progress toward obtaining the objective. The PS indicated she was not able to locate any monthly reviews for clients #2 and #3 from 1/2012 through 7/2012 and/or for clients #2, #3 and #4 for 12/2012 and 1/2013. The PS indicated client #3 was transferred from one of the facility's other group homes on 9/19/12. The PS indicated client #3's objectives to use a lock box and a key to unlock the hazmat (hazardous chemicals) pertained to the group home client #3 was transferred from. The PS indicated the RC should have reviewed her objectives and updated them upon admission to the new group home. The PS indicated the RC/QMRP did not implement any objectives for client #1 since her admission to the group home on 11/30/12.</p> <p>9-3-3(a)</p>		<p>implemented for Client #1.</p> <ul style="list-style-type: none"> · The water temperature in the home has been adjusted back to 110 degrees Fahrenheit. · Staff is to complete water temperature checks three times a week and document the findings on the water temperature check sheet in Therap. Temperatures above 110 degrees Fahrenheit are reported to the RC for the home. · Staff will be retrained on the importance of checking the water temperature and reporting temperature concerns to the RC during their team meeting. · Programming will be implemented for Client's #1 and #3 to wear and take care of their glasses. · A day shift (7am-3pm), an evening shift (3pm-11pm) and night shift (11pm-7am) drill will be run by 4-10-13. · The importance of ensuring that evacuation drills are ran at least quarterly for each shift of personnel will be reviewed with the staff and RC during their team meeting. · A drill tracking sheet will be utilized by the RC and DSA to ensure that drills for each shift of personnel are being conducted. 		

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			<ul style="list-style-type: none"> · Client's #1-#8 will be placed on programming for them to assist with packing their lunches for day program. · Staff will be retrained on the importance of ensuring the table is set properly, including knives to utilize during the meal. · Client's #1-#8 will be placed on programming to participate in family style dining. · Staff will be retrained on the importance of ensuring family style dining and proper supervision of the client's needs during the meal. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. 		

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			<ul style="list-style-type: none"> · The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. · Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. · All 8 residents will be assessed to determine their ability to have access to knives/sharps and cleaning supplies. Guardian approval will be requested if resident is not found to be able to safely handle knives/sharps and cleaning supplies. If it is found that knives/sharps and cleaning supplies should be locked, those residents that can safely use said items will be provided a key in order to access them independently. · All food and snacks will be available to all residents at all times – no edible items will be locked at any time. · The alarms on the doors and windows have been determined that they not needed at this time. They have been removed from the house. · Staff training will occur so they are aware of any restrictions regarding knives/sharps and 		

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			<p>cleaning supplies relevant to each resident at their team meeting.</p> <ul style="list-style-type: none"> · HRC approval will be obtained for all clients regarding the restrictions in the home. · Additional staffing has been provided for Client #4 to help protect the rest of the clients in the home from peer to peer aggression. · In the event that an individual's needs become greater than the current staffing supports in the home, the IDT will meet to reevaluate the staffing pattern in the home and to develop a plan to meet the client's increased needs. · The RC will monitor the needs of the individuals within the home and at their day service provider. As their needs change, appropriate assessments will be completed to determine if additional adaptive equipment, programming or clothing protectors are needed. · Upon admission client's needs will be assessed within 30 days and placed on appropriate programming. · Staff will be retrained on how to provide appropriate food substitutions and the importance of following the menu at their team meeting. 		

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			<ul style="list-style-type: none"> · Regular meal observations will be completed by the RC and/or the Site Manager for the home to ensure that the menu is being followed, that staff is encouraging the residents to follow their prescribed dining plans and that appropriate food substitutions are being offered. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. · Staff will be trained on the active treatment schedules for Client's #1-#8 at their next team meeting. · The RC will ensure that each client's ISP and assessments are updated at least on an annual basis. · The ARC will review with the RC the importance of ensuring that the active treatment schedules are individualized. · The ARC will review with the RC the importance of ensuring that client's ISP's and assessments are updated at least on an annual basis. · The standing order for restraints has been removed from all of the Client's Medication Administration Records where restraint is not warranted in their 	

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			<p>behavior plan.</p> <ul style="list-style-type: none"> · Occazio's policy regarding Behavior Change Interventions in Crisis will be reviewed will all staff during their team meeting. · Staff is to complete water temperature checks three times a week and document the findings on the water temperature check sheet in Therap. Temperatures above 110 degrees Fahrenheit are reported to the RC for the home. · Staff will be retrained on the importance of checking the water temperature and reporting temperature concerns to the RC during their team meeting. · The importance of ensuring that evacuation drills are ran at least quarterly for each shift of personnel will be reviewed with the staff and RC during their team meeting. · A drill tracking sheet will be utilized by the RC and Site Manager to ensure that drills for each shift of personnel are being conducted. · Staff will be retrained on the importance of ensuring the table is set properly, including knives to utilize during the meal. · Client's #1-#8 will be placed on programming to 		

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			<p>participate in family style dining.</p> <ul style="list-style-type: none"> Staff will be retrained on the importance of ensuring family style dining and proper supervision of the client's needs during the meal. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. All 8 residents will be assessed to determine their ability to have access to knives/sharps and cleaning supplies. Guardian approval will 		

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			<p>be requested if resident is not found to be able to safely handle knives/sharps and cleaning supplies. If it is found that knives/sharps and cleaning supplies should be locked, those residents that can safely use said items will be provided a key in order to access them independently.</p> <ul style="list-style-type: none"> · All food and snacks will be available to all residents at all times – no edible items will be locked at any time. · The alarms on the doors and windows have been determined that they not needed at this time. They have been removed from the house. · Staff training will occur so they are aware of any restrictions regarding knives/sharps and cleaning supplies relevant to each resident at their team meeting. · HRC approval will be obtained for all clients regarding the restrictions in the home. · Additional staffing has been provided for Client #4 to help protect the rest of the clients in the home from peer to peer aggression. 		

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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3, and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to provide adequate staffing levels to ensure the clients were not abused due to client #4's behaviors, to ensure adequate supervision at meal time, and to ensure the clients received active treatment and supervision throughout the day.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/19/13 between 3:45 PM and 6:15 PM. The following was observed: Three direct care staff (staff #1, #2 and #3) were in the home with the RC. Upon entering the group home, the RC (Residential Coordinator) opened the front door with client #4 beside him and stated, "I want to tell you before you get started, [client #4] has Autism. You have to forgive him because he is a little out of sorts." The RC stayed with client #4,</p>	W000186	<p>W 186 Direct Care Staff</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · One on one staffing for Client #4 began on 2-25-13. · Two on one staffing for Client #4 began the week of 3-18-13 to help protect residents in the home. This staffing pattern will continue until Client #4 is no longer in the home. · Occazio served notice to terminate services for Client #4 on 3-22-13. Last day of services 	04/10/2013			

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	<p>taking client #4 by the hand and trying to keep him away from the kitchen area and the other clients in the home. At 4:45 PM, the RC left the group home. Client #4 walked into the dining room and was prompted back into the living room by staff #1. Staff #1 put a movie on for client #4 to watch. At 5:15 PM staff #1 left client #4 to assist client #8 to the bathroom. Client #4 returned to the dining room, was loud and grabbing things on the table. Staff #2 escorted client #4 back to the living room. From 3:45 PM until 5:17 PM staff #3 was with client #6 bathing and dressing him. At 5:17 PM staff #3 was with client #6 and wheeled him to the living room with clients #4, #7 and #8 and prompted client #4 to work a puzzle or watch television. Staff #1 stayed with clients #4, #6, #7 and #8 in the living room until time for the PM meal.</p> <p>Client #1 - At 3:45 PM client #1 walked the halls, stood in the dining room and kitchen without activity. At 4:45 PM, client #1 stood in the dining room, watching staff #2 and client #5 preparing the evening meal. At 4:50 PM client #1 sat at the dining room table and drank a soda she had brought home from the work shop and then got up to shower. After showering, client #1 was in her bedroom and/or the dining room until time for the evening meal at 5:40 PM. Client #1 was</p>		<p>will be April 20th, 2013.</p> <ul style="list-style-type: none"> · Residential Coordinator and Site Manager will ensure there are adequate staffing numbers in the home at all times to prevent client to client abuse. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. · <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Residential Coordinator and Site Manager will ensure there are adequate staffing numbers in the home at all times to prevent client to client abuse. · Additional staffing has been provided for Client #4 to help protect the rest of the clients in the home from peer to peer aggression. · In the event that an individual's needs become greater than the current staffing supports in the home, the IDT will meet to reevaluate the staffing 		

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	<p>not involved with the evening meal, offered activities or training during this observation.</p> <p>Client #2 - At 3:50 PM client #2 was sitting at the dining room table eating puffed corn. After finishing his snack, client #2 walked to the medication room to get his PM medications. Client #2 walked at a fast pace with a walker, his right shoe lace was untied and dangling between his feet. After getting his medication client #2 went to his bedroom, walked the hallway to the dining room/kitchen, stood for a few minutes and returned to his bedroom. At 4:35 PM client #2 laid down in his bed, not sleeping, occasionally biting on his right wrist. At 5:42 PM staff #1 prompted client #2 to get out of bed and go to the dining room. Staff assisted client #2 filling his plate with food. At 6 PM client #2 got up from the table and walked back to his bedroom. Client #2 did not eat the broccoli, bread with margarine or pineapple. Client #2 bit his right wrist frequently throughout this observation. Client #2's right wrist was red and scarred. The staff did not redirect client #2 from biting his wrist. Client #2 was not involved with the evening meal, offered activities or training during this observation</p>		<p>pattern in the home and to develop a plan to meet the client's increased needs.</p> <ul style="list-style-type: none"> · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Residential Coordinator and Site Manager will ensure there are adequate staffing numbers in the home at all times to prevent client to client abuse. · Additional staffing has been provided for Client #4 to help protect the rest of the clients in the home from peer to peer aggression. · In the event that an individual's needs become greater than the current staffing supports in the home, the IDT will meet to reevaluate the staffing pattern in the home and to develop a plan to meet the client's increased needs. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. 				

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	<p>Client #3 - At 3:45 PM, client #3 was in her bedroom, rummaging through her closet. Client #3 walked from her bedroom to the living room to the kitchen and back again. Client #3 stood watching the meal preparation and then went to the living room to sit in the recliner with a box of popsicle sticks on her lap until time for the evening meal at 5:40 PM when she walked to the dining room and sat down. At 5:45 PM, staff #2 helped client #3 place the food on her plate and client #3 immediately began eating at a fast pace, taking large bites. Client #3 was not involved with the evening meal, offered activities or training during this observation</p> <p>Client #7 - At 3:45 PM until 5:40 PM client #7 was observed in her bedroom lying in her bed. The staff did not offer client #7 a choice of leisure activities and/or training objectives during this observation.</p> <p>Client #8 - At 4 PM client #8 was curled up on the couch in a sitting position with her face in her arms, leaning on the back of the couch. The television was on but client #8 was not interested or watching what was on. At 5:15 PM staff #1 went with client #8 to the bathroom for client #8 to shower. After showering, client #8 returned to the couch until time for the</p>		<p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10th, 2013</p>		

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	<p>evening meal at 5:40 PM. The staff did not offer client #8 a choice of leisure activities and/or training objectives during this observation.</p> <p>While dining, staff #2 sat between clients #3 and #8 and fed client #8. Staff #1 sat between clients #4 and #1 and fed client #1. Staff #3 sat between clients #7 and #6 and fed client #6. During the meal client #4 required constant supervision and redirection. Client #4 ate at a fast pace, took large bites and grabbed at the food and items around him. Staff #1, #2 and #3 redirected client #4 throughout the meal. The staff were unaware client #3 was taking large bites and eating at a fast pace, client #8 was eating with her fingers when not being fed fast enough due to distraction, client #2 was biting his wrist, got up from the table and returned to his bedroom. Client #1 did not finish his meal.</p> <p>Observations were conducted at the group home on 2/20/13 between 5:35 AM and 8:05 AM. Upon entering the home, two staff (staff #4 and #5) were in the home with 8 clients. Staff #5 was in the bathroom with client #6. The dining room table was set for the morning meal. Staff #4 indicated the staff set the table prior to the clients getting up. Client #1 was in her bedroom getting dressed, client #2 was</p>			

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	<p>sitting at the dining room table biting his wrist and clients #3 and #8 were in the living room, client #3 in the recliner and client #8 sitting curled up on the couch facing the back of the couch with her head in her arms.</p> <p>5:40 AM - 6 AM Client #2 got up from the table and went back to his bedroom to lay down. Staff #4 woke client #7 and prompted her to go to the bathroom for her AM care. Staff #1 arrived and began the morning meal. Client #1 came out of her bedroom to assist in the kitchen. Clients #4 and #5 were still in bed.</p> <p>6:10 AM - Staff #5 finished toileting and dressing client #6 and wheeled him to the dining room table.</p> <p>6:20 AM - The food was prepared for breakfast and sitting on the dining room table. Staff #5 woke clients #4 and #5 up. Staff #4 assisted client #4 to get dressed. As soon as client #4 got to the table he started grabbing at the bowls of food and the plate of toast on the table. Staff #4 redirected client #4 several times to leave the food alone and to sit down at the table. Client #7 was still in the bathroom. Staff #4 stated, "She always takes a long time."</p> <p>6:25 AM - Clients #1, #2, #3, #4, #5, #6</p>						

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	<p>and #8 were sitting at the dining room table. On the table was a large bowl of oatmeal, a large bowl of scrambled eggs and a platter of toast. Staff #4 assisted clients #3 and #4 in filling their plates while staff #1 assisted client #2 and staff #5 assisted client #6. Clients #3 and #4 began eating immediately as soon as the food was on their plates, taking large bites and eating at a fast pace. Client #4 continued to grab at the food, bowls and glasses near him with staff #4 and staff #1 redirecting him multiple times. Due to client #4's need for constant supervision and redirection, client #8 sat without food on her plate, picking her nose, until staff #4 could assist her with filling her plate. Client #4 continued to grab food, glasses, bowls of food, the other clients' food and whatever else he could reach during the morning meal. Staff #4 sat between clients #3 and #7 and staff #4 fed client #7. Staff #1 sat between clients #4 and #1 and fed client #1. Staff #5 sat beside client #6 and fed client #6.</p> <p>6:35 AM - Client #4 stood up from the table and grabbed the bowl of scrambled eggs. Staff #1 and #4 asked client #4 to put the eggs down and to sit back down. After several prompts, client #4 complied. Client #7 came from her bedroom, wearing her coat to go outside to smoke a cigarette. Clients #4 and #5 ate all the</p>						

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	<p>food on their plate and wanted more. Client #5 asked for more eggs and was told no because not everyone had gotten their food yet. Staff #5 fed client #6 while staff #1 and #4 redirected client #4. Client #8 began eating her eggs with her hands and client #2 sat biting his wrist.</p> <p>6:40 AM - Client #4 got up from the table and grabbed the bowl of eggs again. Staff #4 prompted client #4 to put the bowl down, sit down and to eat more oatmeal. After several prompts, client #4 put the bowl of eggs down and he sat down. Client #7 returned from smoking and sat down at the table. Client #4 reached across the table in front of client #7 and took the last 2 pieces of toast and stuffed them in his mouth.</p> <p>6:45 AM - Client #4 jumped up, grabbed the bowl of scrambled eggs and placed the ladle with scrambled eggs in his mouth. Staff #4 stood up and stated, "Now I have to make more eggs, [client #7] still hasn't ate." Staff #4 got up from the table to fix more eggs for client #7 and client #8 began eating her food with her hands again. After much prompting from staff #1 and staff #4, client #4 took the bowl of eggs to the kitchen counter and set them down. Staff #1 took client #4 by the arm and prompted him to go to the living room where client #4 stayed for</p>			

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	<p>only a few minutes and quickly returned to the dining room.</p> <p>6:50 AM - Client #4 picked up a hand towel and flipped it at client #5, hitting him on the left shoulder. Client #2 was biting his wrist. Client #2 got up from the table and returned to his bedroom. Client #2 had not finished his meal. Staff #4 tried to redirect client #4 without success. Client #4 grabbed client #5 by his clothing on his left shoulder. Client #5 had an angry look on his face, stood up and stepped toward client #4. Staff #4 and #1 intervened. Client #4 was escorted to the living room where client #4 stayed with staff #1 throughout the remainder of the observation.</p> <p>The facility's records were reviewed on 2/19/13 at 2 PM and on 2/25/13 at 11:30 AM. The BDDS (Bureau of Developmental Disabilities Services) report of 2/22/13 indicated on 2/22/13 at 7:30 AM during the preparation of the morning meal, client #4 became "agitated with his peer [client #6] for no apparent reason and began attacking the peer [client #6]." The report indicated client #4 scratched client #6 in the eye causing a small cut on client #6's eyelid with "a lot of redness and swelling." The report indicated the staff separated client #4 from client #6, but client #4 remained</p>				

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	<p>agitated and "kept going after [client #6]." Client #4 then slapped staff and pulled the glasses from staff's face. Staff called the RC and was instructed to call the sheriff's department for assistance. The police arrived "but was not able to offer any real assistance with [client #4] other than to suggest to transport him to [name of hospital] for an evaluation." The report indicated staff took client #6 to an urgent care facility to be examined. "Urgent care determined [client #6] has a scratch on his cornea." The report indicated client #4 was taken to (name of hospital) for a psych evaluation.</p> <p>The BDDS report of 2/20/13 indicated "It was reported by the State Surveyor that there was an incident of peer to peer aggression between [client #4] and [client #5], both residents at the [name of group home] group home. The surveyor reported that she observed [client #4] to be agitated and he grabbed a towel and snapped it at [client #5]. She also reported that [client #4] grabbed [client #5's] shirt. The staff redirected [client #4] out of the kitchen area where the incident occurred. Staff remained with [client #4] in the other room until he calmed down."</p> <p>The BDDS report of 12/25/12 indicated on 12/24/12 at 2:30 PM client #4 became physically aggressive with staff and took</p>						

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	<p>a curtain rod off the wall, trying to throw it at another consumer. Client #4 then tried to rip the other curtain rod from the wall while "yelling at another consumer while he was doing this." Staff engaged in a PRT (Primary Restraint Technique) using the standing position and going to a modified sitting position. The report indicated the restraint lasted "approximately 7 minutes."</p> <p>The BDDS report of 2/13/13 indicated on 2/12/13 at 3:10 PM client #4 was "agitated" and waiting outside for staff to pick him up from school. On the way back from picking up client #4's housemates from the workshop, client #4 started to kick at the window of the van. Staff was sitting in the seat next to him but he continued to kick over the staff in an attempt to kick the window. The van was pulled over and the staff engaged in a PRT lasting 5 minutes.</p> <p>Client #4's record was reviewed on 2/20/13 at 2 PM and 2/25/13 at 1 PM. Client #4's Clinician Reports indicated: 12/4/12 from 5 PM to 5:35 PM, client #4 was touching other residents and taking other residents things that did not belong to him. Client #4 took the dishes off the table and started throwing them. Client #4 was touching other residents that told him to stop.</p>				

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	<p>12/4/12 from 5:30 PM to 6 PM, client #4 picked up a plate and glass and threw them to the floor. Client #4 was escorted to his bedroom.</p> <p>12/6/12 from 4 PM to 11 PM, client #4 slapped client #5 and tried to slap client #7. Client #4 was pulling at client #5's and client #7's shirts. Clients #5 and #7 were redirected to another room.</p> <p>12/7/12 from 4 PM to 11:59 PM, client #4 "pushed another resident." Client #4 stole another client's food at the dinner table and took another client's belongings, throwing them across the room. "It took a lot for [client #4] to settle down."</p> <p>12/9/12 from 5 PM to 7 PM, "He [client #4] went around the house and was trying to hit and push the other residents. Staff got all the residents away from him to keep them safe. After dinner he was in the living room and started throwing things, breaking the lamp and some of the Christmas decorations. Staff tried to take him to his room but he was non compliant. Again staff cleared the living room of all residents and moved things away from him so he had nothing else to throw...."</p> <p>12/11/12 from 6 AM to 8:30 AM, client</p>				

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	<p>#4 "was very aggressive with one of his housemates this morning. His housemate wasn't doing anything to provoke him. [Client #4] grabbed his face, tried taking his belongings and threw a cup of juice at him." The report indicated client #4 paced around the group home most of the morning and "repeatedly took items out of the pantry and tried to eat them." The report indicated client #4 "repeatedly touched the other clients."</p> <p>12/11/12 from 2:30 PM to 8 PM, client #4 was eating his dinner and he had already been given thirds. Client #4 "kept getting up from the table and trying to get in the food on the shelves and in the refrigerator. Staff had already given him a few things he asked for. He was still trying to take stuff out of the fridge. Staff was trying to redirect him to something else and he started trying to hit them. He was pushing, punching, kicking, and slapping. He also tried hitting another client. Staff continued trying to redirect him while another staff got the other client out of the room. He took a picture off the wall and threw it at staff shattering the glass. He continued trying to hit and punch people. He ripped staff's glasses off their face. He tried taking other things off the walls, but staff stopped him. This went on for about twenty minutes." The report indicated client #4 had touched</p>			

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	<p>other clients and their things "repeatedly" the staff were not able to redirect him. The report indicated client #4 "tried hitting one of his housemates. He [client #4] also kept trying to grab his housemate's things. He targets this housemate often."</p> <p>12/12/12 from 6 AM to 8:30 AM, client #4 "grabbed his housemate's face and tried shoving him into the table. His housemate did nothing to provoke him. [Client #4] targets this housemate quite often and for no apparent reason. His housemate will walk into a room and he will go after him. If the housemate is in a room and [client #4] goes in there most of the time he will try to take the clients things or hit and push him. [Client #4] will not usually calm down until the client is in another room and if the client comes back he will start in again." The report indicated client #4 was redirected several times from getting into the food and from touching others when they didn't want to be touched and from taking the other clients' things.</p> <p>12/14/12 from 6 AM to 8:30 AM, client #4 had finished eating his breakfast and gone into the living room. "A few minutes later he came back into the kitchen and tried to mess with others. Staff tried redirecting him back to the living room to</p>						

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	<p>read books or look at pictures and he would not go. He then pushed his housemate knocking her to the ground. Staff then tried redirecting him to his room while the other staff helped her up. He would not go to his bedroom. He just stood in the hallway. He came back into the kitchen even though staff was trying to redirect his attention to something elses (sic). He then threw a cup of milk at a client and into her plate. He pushed another client. Staff asked this client to go in the other room a couple of times but he didn't leave the room. [client #4] finally went into the living room and while staff was trying to get the other clients out of there he was kicking the other staff."</p> <p>12/15/12 from 8 AM to 11:59 PM (sic), client #4 "was trying to hug and kiss the other residents this morning when they did not want to be touched. Also this afternoon, he was in the living room with some other residents and began pushing [client #5]. He threw some things around during his behavior."</p> <p>12/16/12 from 12 AM (sic) to 8:30 AM, client #4 "grabbed [client #5] under his arms and wa (sic) thrusting himself upon him." The report indicated the staff tried to redirect client #4 and "get him to let go... and eventually he did but continued to attempt to touch him."</p>				

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	<p>12/18/12 from 5:50 PM to 6:10 PM, client #4 hit staff several times. The report indicated client #4 threw a bowl of fruit across the dinner table and pushed another resident, preventing the resident from touching his own book.</p> <p>12/19/12 from 6 PM to 6:30 PM, client #4 "was hitting other residents, for no reason." The report indicated client #4 was "physically aggressive to the residents."</p> <p>1/7/13 from 6:45 AM to 7:15 AM, "[Client #4] was very talkative and loud this morning. He also wanted to get into food before it was time to eat. He was asked by staff to please calm down and have a seat so that everyone could come to the table and eat. [Client #4] would not cooperate with staff. [Client #4] kept wanting to touch his roommate, staff tried to redirect [client #4] but he was not listening. Staff tried to move his roommate [client #5] but he just kept coming back around [client #4]." The report indicated staff "tried the whole time breakfast was being prepared to keep [client #4] occupied with other activities but [client #4] ignored most of staff requests. [Client #4] took a plate out of [client #5's] hand and when staff asked that he give it back, [client #4] threw it in</p>						

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	<p>the floor shattering it everywhere."</p> <p>1/14/13 from 5:30 PM to 6:30 PM, while preparing the evening meal, client #4 was grabbing his peers' clothes and grabbing plates from his peers. The report indicated client #4 grabbed his peer's shirt and "kept stealing other residents' dinner. He [client #4] wouldn't stop until he got what he wanted." Client #4 was escorted to the activity room to eat his evening meal. After eating, client #4 again grabbed at his peers' clothing. "He [client #4] has been hard to redirect tonight." The report indicated client #4 "hit 2 other residents for no reason."</p> <p>1/22/13 from 8:30 AM to 12 PM, client #4 was "trying to take other's plates at one point taking peers drinks and drinking them. He kept trying to kick at one peer, constantly moving. Refusing to sit on van, refusing to leave seat belt on van, trying to open emergency exit window. Staff had to hold onto the latch at the seat in front of us and he continued to try and bend staffs fingers backwards pulling and scratching at staffs hand the entire ride to workshop. This behavior continued with the window even after the rest of the clients were off the van. Also refused to get off the van at school today. Constantly in the fridge, cabinets and pantry. At one point trying to get stuff out of the trash.</p>				

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	<p>So far not redirectable."</p> <p>2/7/13 from 2:30 PM to 8 PM, client #4 required several reminders not to touch others. "He [client #4] tried poking his housemate's eyes. He was also hitting the window."</p> <p>2/8/13 from 2:30 PM to 8 PM, client #4 had to be redirected several times from hitting and kicking at others. He also tried poking at his housemate's eyes. The report indicated client #4 was grabbing his housemates' things and touching others.</p> <p>2/11/13 from 6 AM to 8:30 AM, client #4 tried touching others. The report indicated client #4 laid down in the van seat and started kicking the window and opening the emergency windows.</p> <p>2/12/13 from 3:10 PM to 3:20 PM, while on the van, client #4 was "laying down in the seat trying to kick the window out." The report indicated "Once at the [name of workshop] he continued to push, hit, pull hair and try to bite staff. He was trying to pull two of the clients' hair and took two staff to keep him from getting the other clients on the van. He had to be restrained by two staff."</p> <p>2/13/13 from 6 AM to 8:30 AM, client #4 had to be redirected several times during</p>				

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	<p>breakfast to keep him from touching the other clients in the group home. The report indicated he tried to grab the other clients' plates and cups and would not stop and had to be removed from the dining room.</p> <p>On 2/20/13 from 6 AM to 8:20 AM, client #4 flipped a towel at another client and grabbed another client by his shirt. The report indicated the staff redirected client #4 "to no avail, he [client #4] kept coming back to the kitchen over and over."</p> <p>On 2/20/13 from 3:45 PM to 5 PM, "When the other clients returned home from work [client #4] started to become agitated. It started in the kitchen where staff had to place herself between [client #4] and a couple of his peers. He [client #4] was shoving and slapping at staff. Staff did get him out of the kitchen and he went to the living room. [Staff #6] could not get him to go to his room at all. Once in the living room he began to try and get to the peers that were in there. He would not stop trying to get to them and I [staff #6] could not get him to leave the room. He began to hit, shove and pull at staffs' clothing. Another staff tried to intervene and he began to pull on her clothes, picking up the lamp and tried to throw it. At that time another staff and myself tried</p>			

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	<p>taking him by the arm and walking him out of the room. He sat down in the floor and refused to get up. He started pulling on staff's clothes again and kicking out so staff again tried removing him and he punched this staff in the jaw and kicked at another staff knocking her over. We just stood back but stood around to make sure he didn't get to any of the other clients and he started to calm down and was sitting in the floor laughing when this staff clocked out."</p> <p>On 2/21/13 from 4:30 PM to 5:30 PM, client #4 hit, kicked, slapped, pinched and grabbed staff clothes and glasses. He pulled out a handful of staff #6's hair, ripped staff #1's shirt and pulled staff #3's glasses off her face. Client #4 pushed the big screen TV in the living room over and knocked the cable box and DVD player off of it. The report indicated the staff had to remove the lamps from the living room because he tried to use them as a weapon toward staff. The report indicated the staff had to redirect all other clients out of the living room when his yelling and screaming started. The report indicated "It took 4 staff to redirect him to his bedroom because of having to be restrained to remove him from the living room to a quiet area." The report indicated the staff "asked [client #4] numerous times to please stop touching us (the staff) to</p>						

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	<p>please calm down and be nice. Nothing we (the staff) tried worked. It just made him more and more angry. After staff got the other clients out of the living room [client #4] was the only one in there with staff who were trying to control the situation."</p> <p>On 2/22/13 from 6 AM to 8:30 AM, client #4 was in the living room watching TV and looking out the window. The report indicated the staff finished doing another client's hygiene (client #6) and took him to the living room. The report indicated the staff left the living room "for a few seconds" to return to the office to get some paper work and then returned to the living room. When the staff returned client #4 was "digging his fingers into the client's (client #6's) eyes." The report indicated the staff continued to redirect client #4 and client #4 continued to touch others. The report indicated client #4 calmed enough to eat his breakfast and after eating he "tried touching others and was redirected to the living room. He remained in there with staff and no other clients. He still tried going into the other room to get people. He was very loud and telling people to shut up and get out of his way. He tried grabbing and hitting staff. He finally calmed down and sat in the office with staff but staff had to sit right in front of</p>						

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	<p>him holding his hand for him to remain calm."</p> <p>Interview with staff #2 on 2/19/13 at 4:55 PM indicated client #7 would come home from the day program and then would go straight to bed. Staff #2 indicated clients #2 and #8 would also go to bed after coming home from the day program. Staff #2 indicated client #4 required constant supervision due to his behaviors. Staff #2 stated client #4 touched/poked all the clients and was "very intrusive." Staff #2 indicated client #4 targeted client #5 and often client #5 would not stay out of client #4's area causing client #4 to get upset and agitated. Staff #2 stated, "sometimes there is just not enough of us."</p> <p>Interview with staff #4 on 2/20/13 at 7:10 AM stated clients #4 and #5 were not woken up until breakfast was made and on the table "because they [clients #4 and #5] won't leave anything alone and will eat anything that is sitting out, so we just leave them in bed because there's just not enough of us to handle it." Staff #4 stated client #4's behavior in the AM observation was typical and happened "almost every day." Staff #4 indicated there was not enough staff to offer training to the other clients in the mornings because of client #4's behaviors.</p>				

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	<p>Staff #4 indicated for several weeks she was the only staff on the night shift and had to get the clients up and dressed, prepare the breakfast and give their medications by herself. Staff #4 stated a second staff "usually came in around 7 AM, but that still isn't enough." Staff #4 indicated staff had to feed clients #2, #6 and #8 which made it difficult to supervise clients #3, #4 and #5 while they ate again because of client #4's behaviors during the morning meals.</p> <p>Interview with the RC (Residential Coordinator) and the PS (Program Specialist) on 2/20/13 at 2:45 PM indicated client #4 was admitted to the group home on 11/5/12. The RC stated client #4 "has been a little out of sorts" since his admission. When asked if the staff had reported the incidents observed in the AM observation of 2/20/13 and of the abuse observed of client #4 hitting client #5 with a hand towel and pulling at client #5's clothing, the RC stated, "Yeah, he [client #4] must have had a bad morning." The RC indicated he had not reported client #4's aggression and abuse toward his housemates to the PS because he did not see it as client to client abuse. The PS indicated client #4's aggression toward his peers, behaviors and client to client abuse should have been reported to her. The PS indicated she was not aware</p>						

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	<p>of the extent of the problems in the house caused by client #4. The RC indicated the normal staffing for the night shift were 2 staff and 3 to 4 staff for the day/evening shifts. The RC stated when client #4 was "having a bad day" the staff were to separate him from the other clients in a quiet area and stay with him till he calms down.</p> <p>9-3-3(a)</p>			

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, interview, and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and 3 additional clients (#6, #7 and #8), the facility failed:</p> <p>__ To ensure the Interdisciplinary Team (IDT) assessed/re-assessed client #4's BSP (Behavior Support Plan) in regards to his behaviors at the group home, school and abuse toward his housemates.</p> <p>__ To assess clients #2, #3, #6, #7 and #8 for the need for a clothing protector.</p> <p>__ To assess clients #2, #3, #4 and #8 for the ability to adjust the water temperatures within the group home.</p> <p>__ To assess clients #1, #2, #3, #4, #5, #6, #7 and #8 for the ability to use sharp knives and/or table knives and the use of cleaning/laundry supplies.</p> <p>__ To assess client #1 within 30 days after admission to the group home in regards to client #1's needs and objectives.</p> <p>Findings include:</p> <p>1. The facility's records were reviewed on 2/19/13 at 2 PM and on 2/25/13 at 11:30 AM. The BDDS (Bureau of Developmental</p>	W000210	<p>W 210 Individual Program Plan</p> <p>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. · The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. · The RC will ensure that programming is in place for all clients addressing their identified need at all times. · All 8 residents will be assessed to determine their 	04/10/2013			

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	<p>Disabilities Services) report of 2/22/13 indicated on 2/22/13 at 7:30 AM during the preparation of the morning meal, client #4 became "agitated with his peer [client #6] for no apparent reason and began attacking the peer [client #6]." The report indicated client #4 scratched client #6 in the eye causing a small cut on client #6's eyelid with "a lot of redness and swelling." The report indicated the staff separated client #4 from client #6, but client #4 remained agitated and "kept going after [client #6]." Client #4 then slapped staff and pulled the glasses from staff's face. Staff called the RC and was instructed to call the sheriff's department for assistance. The police arrived "but was not able to offer any real assistance with [client #4] other than to suggest to transport him to [name of hospital] for an evaluation." The report indicated staff took client #6 to an urgent care facility to be examined. "Urgent care determined [client #6] has a scratch on his cornea." The report indicated client #4 was taken to (name of hospital) for a psych evaluation.</p> <p>The BDDS report of 2/20/13 indicated "It was reported by the State Surveyor that there was an incident of peer to peer aggression between [client #4] and [client #5], both residents at the [name of group home] group home. The surveyor reported</p>		<p>ability to have access to knives/sharps and cleaning supplies. Guardian approval will be requested if resident is not found to be able to safely handle knives/sharps and cleaning supplies. If it is found that knives/sharps and cleaning supplies should be locked, those residents that can safely use said items will be provided a key in order to access them independently.</p> <ul style="list-style-type: none"> · Staff will be retrained on the identified restrictions for each client in the home during their team meeting. · Clients #1-#8's IPOP assessments and behavior plans will be reviewed and updated to reflect the necessary changes regarding their needs for access to knives/sharps, cleaning supplies, and use of chimes on the doors. · Client #3's programming regarding access to sharps/knives and cleaning supplies will be updated to reflect her abilities in her new home. · Client's #1, #2, #4, #5, #6, #8 and #8 will be placed on programming to address their needs regarding locked items in the home. · Client #4 BSP has been updated. 				

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	<p>that she observed [client #4] to be agitated and he grabbed a towel and snapped it at [client #5]. She also reported that [client #4] grabbed [client #5's] shirt. The staff redirected [client #4] out of the kitchen area where the incident occurred. Staff remained with [client #4] in the other room until he calmed down."</p> <p>The BDDS report of 2/13/13 indicated on 2/12/13 at 3:10 PM client #4 was "agitated" and waiting outside for staff to pick him up from school. On the way back from picking up client #4's housemates from the workshop, client #4 started to kick at the window of the van. Staff was sitting in the seat next to him but he continued to kick over the staff in an attempt to kick the window. The van was pulled over and the staff engaged in a PRT lasting 5 minutes.</p> <p>The BDDS report of 12/25/12 indicated on 12/24/12 at 2:30 PM client #4 became physically aggressive with staff and took a curtain rod off the wall, trying to throw it at another consumer. Client #4 then tried to rip the other curtain rod from the wall while "yelling at another consumer while he was doing this." Staff engaged in a PRT (Primary Restraint Technique) using the standing position and going to a modified sitting position. The report indicated the restraint lasted</p>		<ul style="list-style-type: none"> · The IDT has met multiple times since 2-25-13 to discuss Client #4's behavioral needs. · Clients #2, #3, #6, #7 and #8 will be assessed for the need for clothing protectors while eating. · Water temperature assessments will be completed with Client #2, #3, #4, and #8. · The IPOP assessments will be updated to reflect Client's #2, #3, #4, and #8's abilities to regulate water temperatures. · Upon admission client's needs will be assessed within 30 days and placed on appropriate programming. · Client #1 has now been put on programming to address her identified needs. · Client #1's IPOP assessments will be completed to determine her needs. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the 				

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	<p>"approximately 7 minutes."</p> <p>Client #4's record was reviewed on 2/20/13 at 2 PM and 2/25/13 at 1 PM.</p> <p>Client #4's Clinician Reports indicated: 12/4/12 from 5 PM to 5:35 PM, client #4 was touching other residents and taking other residents things that did not belong to him. Client #4 took the dishes off the table and started throwing them. Client #4 was touching other residents that told him to stop.</p> <p>12/4/12 from 5:30 PM to 6 PM, client #4 picked up a plate and glass and threw them to the floor. Client #4 was escorted to his bedroom.</p> <p>12/6/12 from 4 PM to 11 PM, client #4 slapped client #5 and tried to slap client #7. Client #4 was pulling at client #5's and client #7's shirts. Clients #5 and #7 were redirected to another room.</p> <p>12/7/12 from 4 PM to 11:59 PM, client #4 "pushed another resident." Client #4 stole another client's food at the dinner table and took another client's belongings, throwing them across the room. "It took a lot for [client #4] to settle down."</p> <p>12/9/12 from 5 PM to 7 PM, "He [client #4] went around the house and was trying</p>		<p>same deficient practice.</p> <ul style="list-style-type: none"> · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. · Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. · All 8 residents will be assessed to determine their ability to have access to knives/sharps and cleaning supplies. Guardian approval will be requested if resident is not found to be able to safely handle knives/sharps and cleaning supplies. If it is found that knives/sharps and cleaning supplies should be locked, those residents that can safely use said items will be provided a key in order to access them independently. · Staff training will occur so they are aware of any restrictions regarding knives/sharps and 				

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	<p>to hit and push the other residents. Staff got all the residents away from him to keep them safe. After dinner he was in the living room and started throwing things, breaking the lamp and some of the Christmas decorations. Staff tried to take him to his room but he was non compliant. Again staff cleared the living room of all residents and moved things away from him so he had nothing else to throw...."</p> <p>12/11/12 from 6 AM to 8:30 AM, client #4 "was very aggressive with one of his housemates this morning. His housemate wasn't doing anything to provoke him. [Client #4] grabbed his face, tried taking his belongings and threw a cup of juice at him." The report indicated client #4 paced around the group home most of the morning and "repeatedly took items out of the pantry and tried to eat them. The report indicated client #4 "repeatedly touched the other clients."</p> <p>12/11/12 from 2:30 PM to 8 PM, client #4 was eating his dinner and he had already been given thirds. Client #4 "kept getting up from the table and trying to get in the food on the shelves and in the refrigerator. Staff had already given him a few things he asked for. He was still trying to take stuff out of the fridge. Staff was trying to redirect him to something</p>		<p>cleaning supplies relevant to each resident at their team meeting.</p> <ul style="list-style-type: none"> · In the event that an individual's needs become greater than the current staffing supports in the home, the IDT will meet to reevaluate the staffing pattern in the home and to develop a plan to meet the client's increased needs. · The RC will monitor the needs of the individuals within the home and at their day service provider. As their needs change, appropriate assessments will be completed to determine if additional adaptive equipment, programming or clothing protectors are needed. · Upon admission client's needs will be assessed within 30 days and placed on appropriate programming. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. · The RC will ensure that each client's ISP and assessments are updated at least on an annual basis. · The ARC will review with the RC the importance of ensuring that client's ISP's and assessments are updated at least on an annual basis. 				

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	<p>else and he started trying to hit them. He was pushing, punching, kicking, and slapping. He also tried hitting another client. Staff continued trying to redirect him while another staff got the other client out of the room. He took a picture off the wall and threw it at staff shattering the glass. He continued trying to hit and punch people. He ripped staff's glasses off their face. He tried taking other things off the walls, but staff stopped him. This went on for about twenty minutes." The report indicated client #4 had touched other clients and their things "repeatedly" the staff were not able to redirect him. The report indicated client #4 "tried hitting one of his housemate's. He [client #4] also kept trying to grab his housemates things. He targets this housemate often."</p> <p>12/12/12 from 6 AM to 8:30 AM, client #4 "grabbed his housemate's face and tried shoving him into the table. His housemate did nothing to provoke him. [Client #4] targets this housemate quite often and for no apparent reason. His housemate will walk into a room and he will go after him. If the housemate is in a room and [client #4] goes in there most of the time he will try to take the clients things or hit and push him. [Client #4] will not usually calm down until the client is in another room and if the client comes</p>		<ul style="list-style-type: none"> · Staff is to complete water temperature checks three times a week and document the findings on the water temperature check sheet in Therap. Temperatures above 110 degrees Fahrenheit are reported to the RC for the home. · Staff will be retrained on the importance of checking the water temperature and reporting temperature concerns to the RC during their team meeting. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. · Regular monitoring, integration, and coordination of treatment programs will be 				

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	<p>back he will start in again." The report indicated client #4 was redirected several times from getting into the food and from touching others when they didn't want to be touched and from taking the other clients' things.</p> <p>12/14/12 from 6 AM to 8:30 AM, client #4 had finished eating his breakfast and gone into the living room. "A few minutes later he came back into the kitchen and tried to mess with others. Staff tried redirecting him back to the living room to read books or look at pictures and he would not go. He then pushed his housemate knocking her to the ground. Staff then tried redirecting him to his room while the other staff helped her up. He would not go to his bedroom. He just stood in the hallway. He came back into the kitchen even though staff was trying to redirect his attention to something elses (sic). He then threw a cup of milk at a client and into her plate. He pushed another client. Staff asked this client to go in the other room a couple of times but he didn't leave the room. [client #4] finally went into the living room and while staff was trying to get the other clients out of there he was kicking the other staff."</p> <p>12/15/12 from 8 AM to 11:59 PM (sic), client #4 "was trying to hug and kiss the other residents this morning when they</p>		<p>completed for Clients #1-#8 by the Residential Coordinator.</p> <ul style="list-style-type: none"> · All 8 residents will be assessed to determine their ability to have access to knives/sharps and cleaning supplies. Guardian approval will be requested if resident is not found to be able to safely handle knives/sharps and cleaning supplies. If it is found that knives/sharps and cleaning supplies should be locked, those residents that can safely use said items will be provided a key in order to access them independently. · Staff training will occur so they are aware of any restrictions regarding knives/sharps and cleaning supplies relevant to each resident at their team meeting. · In the event that an individual's needs become greater than the current staffing supports in the home, the IDT will meet to reevaluate the staffing pattern in the home and to develop a plan to meet the client's increased needs. · The RC will monitor the needs of the individuals within the home and at their day service provider. As their needs change, appropriate assessments will be completed to determine if additional adaptive equipment, programming or clothing 		

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	<p>did not want to be touched. Also this afternoon, he was in the living room with some other residents and began pushing [client #5]. He threw some things around during his behavior."</p> <p>12/16/12 from 12 AM (sic) to 8:30 AM, client #4 "grabbed [client #5] under his arms and wa (sic) thrusting himself upon him." The report indicated the staff tried to redirect client #4 and "get him to let go... and eventually he did but continued to attempt to touch him."</p> <p>12/18/12 from 5:50 PM to 6:10 PM, client #4 hit staff several times. The report indicated client #4 threw a bowl of fruit across the dinner table and pushed another resident, preventing the resident from touching his own book.</p> <p>12/19/12 from 6 PM to 6:30 PM, client #4 "was hitting other residents, for no reason." The report indicated client #4 was "physically aggressive to the residents."</p> <p>1/7/13 from 6:45 AM to 7:15 AM, "[Client #4] was very talkative and loud this morning. He also wanted to get into food before it was time to eat. He was asked by staff to please calm down and have a seat so that everyone could come to the table and eat. [Client #4] would not</p>		<p>protectors are needed.</p> <ul style="list-style-type: none"> · Upon admission client's needs will be assessed within 30 days and placed on appropriate programming. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. · The RC will ensure that each client's ISP and assessments are updated at least on an annual basis. · The ARC will review with the RC the importance of ensuring that client's ISP's and assessments are updated at least on an annual basis. · Staff is to complete water temperature checks three times a week and document the findings on the water temperature check sheet in Therap. Temperatures above 110 degrees Fahrenheit are reported to the RC for the home. · Staff will be retrained on the importance of checking the water temperature and reporting temperature concerns to the RC during their team meeting. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p>		

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	<p>cooperate with staff. [Client #4] kept wanting to touch his roommate, staff tried to redirect [client #4] but he was not listening. Staff tried to move his roommate [client #5] but he just kept coming back around [client #4]. The report indicated staff "tried the whole time breakfast was being prepared to keep [client #4] occupied with other activities but [client #4] ignored most of staff requests. [Client #4] took a plate out of [client #5's] hand and when staff asked that he give it back, [client #4] threw it in the floor shattering it everywhere."</p> <p>1/14/13 from 5:30 PM to 6:30 PM, while preparing the evening meal, client #4 was grabbing his peers' clothes and grabbing plates from his peers. The report indicated client #4 grabbed his peer's shirt and "kept stealing other residents' dinner. He [client #4] wouldn't stop until he got what he wanted." Client #4 was escorted to the activity room to eat his evening meal. After eating, client #4 again grabbed at his peers' clothing. "He [client #4] has been hard to redirect tonight." The report indicated client #4 "hit 2 other residents for no reason."</p> <p>1/22/13 from 8:30 AM to 12 PM, client #4 was "trying to take other's plates at one point taking peers drinks and drinking them. He kept trying to kick at one peer,</p>		<ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed? April 10 th , 2013</p>				

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	<p>constantly moving. Refusing to sit on van, refusing to leave seat belt on van, trying to open emergency exit window. Staff had to hold onto the latch at the seat in front of us and he continued to try and bend staffs fingers backwards pulling and scratching at staffs hand the entire ride to workshop. This behavior continued with the window even after the rest of the clients were off the van. Also refused to get off the van at school today. Constantly in the fridge, cabinets and pantry. At one point trying to get stuff out of the trash. So far not redirectable."</p> <p>2/7/13 from 2:30 PM to 8 PM, client #4 required several reminders not to touch others. "He [client #4] tried poking his housemate's eyes. He was also hitting the window."</p> <p>2/8/13 from 2:30 PM to 8 PM, client #4 had to be redirected several times from hitting and kicking at others. He also tried poking at his housemate's eyes. The report indicated client #4 was grabbing his housemates' things and touching others.</p> <p>2/11/13 from 6 AM to 8:30 AM, client #4 tried touching others. The report indicated client #4 laid down in the van seat and started kicking the window and opening the emergency windows.</p>						

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	<p>2/12/13 from 3:10 PM to 3:20 PM, while on the van, client #4 was "laying down in the seat trying to kick the window out." The report indicated "Once at the [name of workshop] he continued to push, hit, pull hair and try to bite staff. He was trying to pull two of the client's hair and took two staff to keep him from getting the other clients on the van. He had to be restrained by two staff."</p> <p>2/13/13 from 6 AM to 8:30 AM, client #4 had to be redirected several times during breakfast to keep him from touching the other clients in the group home. The report indicated he tried to grab the other clients' plates and cups and would not stop and had to be removed from the dining room.</p> <p>On 2/20/13 from 6 AM to 8:20 AM, client #4 flipped a towel at another client and grabbed another client by his shirt. The report indicated the staff redirected client #4 "to no avail, he [client #4] kept coming back to the kitchen over and over."</p> <p>On 2/20/13 from 3:45 PM to 5 PM, "When the other clients returned home from work [client #4] started to become agitated. It started in the kitchen where staff had to place herself between [client #4] and a couple of his peers. He [client</p>						

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	<p>#4] was shoving and slapping at staff. Staff did get him out of the kitchen and he went to the living room. [Staff #6] could not get him to go to his room at all. Once in the living room he began to try and get to the peers that were in there. He would not stop trying to get to them and I [staff #6] could not get him to leave the room. He began to hit, shove and pull at staffs' clothing. Another staff tried to intervene and he began to pull on her clothes, picking up the lamp and tried to throw it. At that time another staff and myself tried taking him by the arm and walking him out of the room. He sat down in the floor and refused to get up. He started pulling on staff's clothes again and kicking out so staff again tried removing him and he punched this staff in the jaw and kicked at another staff knocking her over. We just stood back but stood around to make sure he didn't get to any of the other clients and he started to calm down and was sitting in the floor laughing when this staff clocked out."</p> <p>On 2/21/13 from 4:30 PM to 5:30 PM, client #4 hit, kicked, slapped, pinched and grabbed staff clothes and glasses. He pulled out a handful of staff #6's hair, ripped staff #1's shirt and pulled staff #3's glasses off her face. Client #4 pushed the big screen TV in the living room over and knocked the cable box and DVD player</p>						

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	<p>off of it. The report indicated the staff had to remove the lamps from the living room because he tried to use them as a weapon toward staff. The report indicated the staff had to redirect all other clients out of the living room when his yelling and screaming started. The report indicated "It took 4 staff to redirect him to his bedroom because of having to be restrained to remove him from the living room to a quiet area." The report indicated the staff "asked [client #4] numerous times to please stop touching us (the staff) to please calm down and be nice. Nothing we (the staff) tried worked. It just made him more and more angry. After staff got the other clients out of the living room [client #4] was the only one in there with staff who were trying to control the situation."</p> <p>On 2/22/13 from 6 AM to 8:30 AM, client #4 was in the living room watching TV and looking out the window. The report indicated the staff finished doing another client's hygiene (client #6) and took him to the living room. The report indicated the staff left the living room "for a few seconds" to return to the office to get some paper work and then returned to the living room. When the staff returned client #4 was "digging his fingers into the client's (client #6's) eyes." The report indicated the staff continued to</p>			

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	<p>redirect client #4 and client #4 continued to touch others. The report indicated client #4 calmed enough to eat his breakfast and after eating he "tried touching others and was redirected to the living room. He remained in there with staff and no other clients. He still tried going into the other room to get people. He was very loud and telling people to shut up and get out of his way. He tried grabbing and hitting staff. He finally calmed down and sat in the office with staff but staff had to sit right in front of him holding his hand for him to remain calm."</p> <p>Client #4's 12/24/12 BSP indicated client #4's targeted behaviors were physical aggression, touching, hitting, kicking and slapping. The BSP indicated when client #4 displayed his targeted behaviors, the staff were to remove "others from the area," to block client #4's attempts "to strike others" and to direct client #4 to calm area. The report indicated "if physical aggression continues, the staff were to place client #4 in the "HWC (Handle With Care) Primary Restraint Technique if safe."</p> <p>Observations were conducted at client #4's school on 2/20/13 between 9:10 AM and 9:45 AM. During this time client #4 paced around the room and grabbed at</p>				

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	<p>several of the other students. Client #4 targeted a student sitting alone at a cubicle. The student was wearing head phones and trying to study. Client #4 touched and poked the student several times. Client #4 then grabbed the headphones from the targeted student's head. Client #4's teacher instructed the other school staff in the room to evacuate the other students in the room to the school gym until client #4 could calm down.</p> <p>Review of the email notes from client #4's teacher on 2/21/13 at 9 PM indicated: 12/10/12 after lunch, client #4 tried to grab a drink from another student. The school staff tried to redirect client #4 to another task when client #4 grabbed a plastic bag off the table and attempted to hit a student in the head. The student ran away and was "very scared." When trying to get client #4 to apologize, client #4 "kept moving quickly at the student as to intimidate him. The group home was called and [client #4] was then sent home."</p> <p>12/14/12 during physical education class, the class went to the weight room. While in the weight room client #4 picked up a weight and pushed it off the rack. Another student was standing near and told client #4 he wasn't supposed to do that. An aide</p>						

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	<p>asked client #4 to keep his hands off the weights. Client #4 pushed the student that asked him not to push the weights. Aides attempted to have client #4 return to class and client #4 tried to follow a student he had hit the day before. Client #4's teacher was called to assist in taking client #4 back to the classroom. He refused to go and the assistant principal came to help. Client #4 refused to leave the weight room until the other student left first.</p> <p>1/15/13 While at the school gym, staff noted client #4 taking his shirt off, grabbing items off of staffs' desks, taking things that belonged to other students, tapping other students, biting another student's hair, moving very close to other student's faces, taking a book from another student and refusing to give it up for about 10 minutes, hitting another student on the forehead. The teacher called the group home staff at 1:35 PM to come get him due to his behaviors.</p> <p>Interview with client #4's teacher on 2/20/13 at 9:10 AM at the school stated because of client #4's "constant behaviors" of "bothering the other students" and his "disruption to the class," the school hired another staff to give client #4 one to one supervision while at the school. Client #4's teacher indicated even with the one to one staff supervision</p>				

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	<p>client #4 still disrupted the class, physically touching other students and invading everyone's space. Client #4's teacher asked, "Can you help us? We don't know what to do anymore." Client #4's teacher indicated client #4 targeted a few of the other students as well as the staff they had hired to be with client #4. Client #4's teacher indicated the RC (Residential Coordinator) had not sent client #4's program plans (ISP and BSP) to the school.</p> <p>Interview with the RC (Residential Coordinator) and the PS (Program Specialist) on 2/20/13 at 2:45 PM indicated client #4 was admitted to the group home on 11/5/12. The RC stated client #4 "has been a little out of sorts" since his admission. When asked if the staff had reported client #4 had hit client #5 with a hand towel and had pulled at his clothes during the morning observation, the RC stated, "I guess he had a bad morning."</p> <p>Interview with the PS (Program Specialist) on 2/25/13 at 1:30 PM indicated the IDT did not meet to discuss client #4's continued behaviors and client to client abuse.</p> <p>Client #4's record did not indicate the IDT had assessed and/or reassessed client #4</p>						

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	<p>in regards to his continued behaviors of aggression toward clients #1, #2, #3, #5, #6, #7 and #8.</p> <p>2. During observations at the group home on 2/19/13 between 3:45 PM and 6:15 PM and on 2/20/13 between 5:35 AM and 8:05 AM client #2 wore a large cloth over his chest while eating his meals. Client #2 did not spill his food during this observation.</p> <p>During observations at the DP (Day Program) on 2/20/13 between 10:10 AM and 12:15 PM while eating their afternoon meals, clients #2, #6, #7 and #8 wore an apron around their neck that covered their chest, abdomen and the front of their legs. Clients #2, #6, #7 and #8 did not spill their food during this observation.</p> <p>Client #2's record was reviewed on 2/21/13 at 11:30 AM. Client #2's record did not indicate client #2 had been assessed for food spillage and the need to wear a clothing protector while dining.</p> <p>Client #6's record was reviewed on 2/21/13 at 3 PM. Client #6's record did not indicate client #6 had been assessed for food spillage and the need to wear a clothing protector while dining.</p>						

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	<p>Client #7's record was reviewed on 2/25/13 at 12:45 PM. Client #7's record did not indicate client #7 had been assessed for food spillage and the need to wear a clothing protector while dining.</p> <p>Client #8's record was reviewed on 2/25/13 at 12:30 PM. Client #8's record did not indicate client #8 had been assessed for food spillage and the need to wear a clothing protector while dining.</p> <p>Interview with DP staff #4 on 2/20/13 at 11:20 AM indicated the DP used aprons/clothing protectors on clients #2, #6, #7 and #8 while they ate their meals to protect the clients' clothing from food spillage.</p> <p>Interview with the RC (Residential Coordinator) and the PS (Program Specialist) on 2/20/13 at 2:45 PM indicated clients #2, #6, #7 and #8 had not been assessed for excessive food spillage and the need to wear a clothing protector while dining.</p> <p>3. Observations were conducted at the group home on 2/20/13 between 5:35 AM and 8 AM. At 7:15 AM client #5 was in the medication room washing his hands prior to taking his AM medications. While washing his hands, client #5 stated, "This water is really hot" and steam was</p>			

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	<p>seen rising from the sink. The water temperature was taken at 7:30 AM in the sink of the medication room and found to be 126 degrees Fahrenheit. The water temperature was taken in the sinks in the two bathrooms off of the medication room at 8 AM and was found to be 122 degrees Fahrenheit.</p> <p>Client #2's record was reviewed on 2/21/13 at 11:30 AM. Client #2's IPOP (Individual Plan of Protective Oversight) of 2/9/12/12 did not indicate client #2 could adjust the water temperature within the group home.</p> <p>Client #3's record was reviewed on 2/21/13 at 2 PM. Client #3's IPOP of 9/17/12 did not indicate client #3 could adjust the water temperature within the group home.</p> <p>Client #4's record was reviewed on 2/20/13 at 2 PM. Client #4's IPOP of 9/24/12 did not indicate client #4 could adjust the water temperature within the group home.</p> <p>Client #8's record was reviewed on 2/25/13 at 12:30 PM. Client #8's IPOP of 2/9/12 did not indicate client #8 was capable of adjusting the water temperature within the group home.</p>						

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	<p>Review of the SCS (Safety Check Sheets) for October 2012 through February 2013 on 2/25/13 at 2 PM indicated water temperatures of:</p> <p>10/04/12 - 112 degrees Fahrenheit. 10/18/12 - 112 degrees Fahrenheit. 10/28/12 - 114 degrees Fahrenheit. 11/01/12 - 116 degrees Fahrenheit. 11/02/12 - 112 degrees Fahrenheit. 11/03/12 - 112 degrees Fahrenheit. 11/09/12 - 116 degrees Fahrenheit. 11/15/12 - 111 degrees Fahrenheit. 11/16/12 - 118 degrees Fahrenheit. 11/17/12 - 118 degrees Fahrenheit. 11/18/12 - 116 degrees Fahrenheit. 11/19/12 - 112 degrees Fahrenheit. 11/24/12 - 114 degrees Fahrenheit. 11/29/12 - 118 degrees Fahrenheit.</p> <p>Interview with staff #4 on 2/20/13 at 7:50 AM stated "Ever since they worked on the sprinkler system a couple of weeks ago, the temperature of the water has been a lot hotter." Staff #4 indicated clients #2, #3, #4 and #8 required assistance with regulating the water temperatures in the group home.</p> <p>Interview with the PS (Program Specialist) on 2/25/13 at 1:30 PM indicated clients #2, #3, #4 and #8 required assistance regulating the water temperature in the home. The PS indicated if an assessment had been</p>				

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	<p>completed it would be in the clients' IPOP assessments under hygiene.</p> <p>4. Observations were conducted at the group home on 2/19/13 between 3:45 PM and 6:15 PM and on 2/20/13 between 5:35 AM and 8:05 AM. During both observations, the sharp knives were locked in a closet off of the kitchen by the rear exit door of the group home. The cleaning/laundry supplies were locked in a cabinet in the laundry/medication room. During the observation of the evening meal and the morning meal, clients #1, #2, #3, #4, #5, #6, #7 and #8 were not provided a table knife to butter their own bread and to cut their food into smaller pieces.</p> <p>The facility's reportable records 2/1/12 through 2/19/13 were reviewed on 2/19/13 at 2 PM and again on 2/25/13 at 11:30 AM. The facility's reportable records did not indicate any incidents in regards to sharp objects, chemicals, cleaning supplies and/or laundry products requiring the need to lock these items within the group home in regards to clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>Client #1's record was reviewed on 2/25/13 at 11:00 AM. Client #1's record did not indicate client #1 had been assessed for the need to restrict sharp</p>						

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	<p>objects, knives, cleaning and/or laundry products.</p> <p>Client #2's record was reviewed on 2/21/13 at 11:30 AM. Client #2's record did not indicate client #2 had been assessed for the need to restrict sharp objects, knives, cleaning and/or laundry products.</p> <p>Client #3's record was reviewed on 2/21/13 at 2 PM. Client #3's record did not indicate client #3 had been assessed for the need to restrict sharp objects, knives, cleaning and/or laundry products.</p> <p>Client #4's record was reviewed on 2/20/13 at 2 PM. Client #4's record did not indicate client #4 had been assessed for the need to restrict sharp objects, knives, cleaning and/or laundry products.</p> <p>Client #5's record was reviewed on 2/21/13 at 3:30 PM. Client #5's record did not indicate client #5 had been assessed for the need to restrict sharp objects, knives, cleaning and/or laundry products.</p> <p>Client #6's record was reviewed on 2/21/13 at 3 PM. Client #6's record did not indicate client #6 had been assessed for the need to restrict sharp objects, knives, cleaning and/or laundry products.</p>						

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	<p>Client #7's record was reviewed on 2/25/13 at 12:45 PM. Client #7's record did not indicate client #7 had been assessed for the need to restrict sharp objects, knives, cleaning and/or laundry products.</p> <p>Client #8's record was reviewed on 2/25/13 at 12:30 PM. Client #8's record did not indicate client #8 had been assessed for the need to restrict sharp objects, knives, cleaning and/or laundry products.</p> <p>Interview with staff #2 on 2/19/13 at 5 PM stated she did not know why the knives and cleaning supplies were locked, "They just have always been locked up."</p> <p>Interview with staff #4 on 2/20/13 at 7:10 AM indicated the knives were locked in the closet near the back door of the home. Staff #4 indicated all the clients in the group home had to ask staff to get those items for them if they wanted them. Staff #4 indicated she did not know why the knives and cleaning supplies were locked.</p> <p>Interview with the RC (Residential Coordinator) and the PS (Program Specialist) on 2/20/13 at 2:45 PM indicated the knives and the cleaning supplies had been locked within the group home for years. The RC stated the knives</p>				

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	<p>were locked up because "We have clients that cannot handle knives because of their intellect." The RC stated clients #3 and #8 "for example." The RC stated the group home was a "locked home because of the hazmat items (cleaning supplies)." The RC stated the cleaning supplies were locked because the potential for the clients with "lower intellect" to ingest liquid chemicals was higher and it was safer to keep them locked. The RC indicated he was not aware of specific assessments for the clients in the group home in regards to the use of knives, cleaning and/or laundry products.</p> <p>5. Client #1's record was reviewed on 2/25/13 at 11 AM. Client #1 had an undated IPOP in her record. The IPOP indicated information prior to client #1's admission to the group home.</p> <p>Interview with the PS on 2/25/13 at 1:30 PM indicated the IDT (Interdisciplinary Team) did not conduct accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The PS indicated the IDT had not conducted assessments for client #1 since her admission to the group home on 11/30/12. The PS indicated the undated IPOP in client #1's record was done prior to client #1's admission. The PS indicated the IDT</p>						

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	did not assess and/or reassess client #1 after her admission to the facility. 9-3-4(a) -				

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, record review and interview for 3 of 4 sampled clients (#1, #2 and #3) and 2 additional clients (#7 and #8), the ISP (Individual Support Plan) failed to include objectives to address the clients' leisure skills and food preparation and to educate client #7 on the hazards of cigarette smoking.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/19/13 between 3:45 PM and 6:15 PM. The following was observed: Client #1 - At 3:45 PM client #1 walked the halls and stood in the dining room and kitchen without activity. At 4:45 PM, client #1 stood in the dining room, watching staff #2 and client #5 preparing the evening meal. At 4:50 PM client #1 sat at the dining room table and drank a soda she had brought home from the work shop and then got up to shower. After showering, client #1 was in her bedroom and/or dining room until time for the evening meal at 5:40 PM. Client #1 was not involved with the evening meal. In client #1's room there were clothes and</p>	W000227	<p>W 227 Individual Program Plan</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. · The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. · The RC will ensure that programming is in place for all clients addressing their identified need at all times. 	04/10/2013			

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	<p>personal items laying on the floor and on her bed mixed in with her dirty clothes and shoes. Client #1 stated, "My room is a mess."</p> <p>Client #2 - At 3:50 PM client #2 was sitting at the dining room table eating puffed corn. After finishing his snack, client #2 walked to the medication room to get his PM medications. After getting his medication client #2 went to his room, walked the hallway to the dining room/kitchen, stood for a few minutes and returned to his room. At 4:35 PM client #2 laid down in his bed, not sleeping. At 5:42 PM staff #1 prompted client #2 to get out of bed and go to the dining room. Client #2 got up, walked to the dining room and sat down at the dining room table. The staff assisted client #2 in filling his plate with portions of tuna noodle casserole and broccoli. At 6 PM client #2 got up from the table and walked back to his room. Client #2 did not eat all of his meal.</p> <p>Client #3 - At 3:45 PM, client #3 was in her bedroom, rummaging through her closet. Client #3 walked from her bedroom to the living room to the kitchen and back again. Client #3 stood watching the meal preparation and then went to the living room to sit in the recliner with a box of popsicle sticks on her lap until</p>		<ul style="list-style-type: none"> · Client #1 will be put on programming to maintain her bedroom. · Client's #1, #2, #3, #7 and #8 will be put on programming to address their leisure skills and food preparation needs. · Client #1, #2, #3, #7 and #8's ISP's will be updated to reflect their leisure skill and food preparation needs. · Client #7 will be placed on programming to understand the consequences of smoking. · Client #7's ISP will be updated to reflect the need to understand the consequences of smoking. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The RC will monitor the residents programming and 				

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	<p>time for the evening meal at 5:40 PM when she walked to the dining room and sat down at the end of the table by the window. Client #3 asked staff #2 if she was coming to sit with her and staff #2 stated, "In a minute, I have to make your pineapple first." Staff #1 put a tablespoon of chocolate instant powder in client #3's milk and prompted her to mix it up. Client #3 had a divided dish, a toddler spoon and fork with rubber handles and 3 cups with straws. Staff #2 pureed client #3's food for her and brought it to the table in dishes and set it in front of client #3. At 5:45 PM, client #3 placed the food on her plate and immediately began eating at a fast pace, taking large bites. By 5:50 PM client #3 was finished with her food, asked for more and was given another serving of tuna noodle casserole, broccoli and pineapple. The toddler spoon did not prevent client #3 from taking large bites and the staff did not prompt client #3 to take smaller bites or to slow her pace of eating. Client #3 did not participate in the evening meal preparation. The staff did not offer client #3 a choice of leisure activities and/or training objectives.</p> <p>Client #7 - At 3:45 PM until 5:40 PM client #7 was observed in her bedroom lying in her bed. Client #7 was observed to come out of her room for the evening meal and to go outside to smoke a</p>		<p>behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan.</p> <ul style="list-style-type: none"> · The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. · Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. · The RC will monitor the needs of the individuals within the home and at their day service provider. As their needs change, appropriate assessments will be completed to determine if additional adaptive equipment, programming or clothing protectors are needed. · Upon admission client's needs will be assessed within 30 days and placed on appropriate programming. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. · Staff will be trained on the active treatment schedules for Client's #1-#8 at their next team 				

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	<p>cigarette. The staff did not offer client #7 a choice of leisure activities and/or training objectives during this observation.</p> <p>Client #8 - At 4 PM client #8 was curled up on the couch in a sitting position with her face in her arms, leaning on the back of the couch. The television was on but client #8 did not watch it. At 5:15 PM staff #1 went with client #8 to the bathroom for client #8 to shower. After showering, client #8 returned to the couch until time for the evening meal at 5:40 PM. The staff did not offer client #8 a choice of leisure activities and/or training objectives during this observation.</p> <p>During the PM observation period, staff did not offer clients #1, #2, #3, #7 and #8 a choice of leisure time activities. The staff did not involve or prompt clients #1, #2, #3, #7 and or #8 in the meal preparation.</p> <p>Observations were conducted at the group home on 2/20/13 between 5:35 AM and 8:05 AM. 5:35 AM - The dining room table was set for the morning meal. Staff #4 indicated the staff set the table prior to the clients getting up. Client #8 sat curled up on the couch, client #3 was in the recliner and client #2 was sitting at the dining room</p>		<p>meeting.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. · Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. · The RC will monitor the needs of the individuals within the home and at their day service provider. As their needs change, appropriate assessments will be completed to determine if additional adaptive equipment, programming or clothing protectors are needed. · Upon admission client's 		

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	<p>table. Client #1 was in her room getting dressed.</p> <p>5:40 AM - Client #2 got up from the table and went back to his bedroom to lie down.</p> <p>5:50 AM - Staff #4 woke client #7 and prompted her to go to the bathroom for her AM care. Staff #1 arrived and began the morning meal.</p> <p>6:20 AM - Client #7 was still in the bathroom. Staff #4 stated, "She always takes a long time."</p> <p>6:25 AM - Everyone sat down for the morning meal except client #7 who was still in the bathroom. On the table was a large bowl of oatmeal, a large bowl of scrambled eggs and a platter of toast. Staff #4 assisted clients #3 and #4 to fill their plates while staff #1 assisted client #2 and staff #5 assisted client #6. Clients #3 and #4 began eating immediately, taking large bites and eating at a fast pace. Client #4 continued to grab at the food, bowls and glasses near him. Staff #1 and #4 were constantly redirecting client #4 from grabbing items on the table and grabbing at other clients' food.</p> <p>During the AM observation period, staff did not involve or prompt clients #2, #3, #7 and #8 with the morning meal preparation. Client #3's food was prepared and pureed by staff #1. Client #3 did not assist to puree her food. Client #7 was in</p>		<p>needs will be assessed within 30 days and placed on appropriate programming.</p> <ul style="list-style-type: none"> · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. · Staff will be trained on the active treatment schedules for Client's #1-#8 at their next team meeting. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10 th , 2013</p>				

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	<p>the bathroom from 5:45 AM until 6:35 AM at which time she walked outside to smoke a cigarette.</p> <p>During observations at the DP (Day Program) on 2/20/13 between 10:10 AM and 12:15 PM, client #7 was not observed to smoke a cigarette. Interview with DP staff #2 on 2/20/13 at 11 AM indicated the DP was non smoking and client #7 did not smoke while at the DP.</p> <p>1. Client #1's record was reviewed on 2/25/13 at 11:00 AM. Client #1's undated IPOP (Individual Plan of Protective Oversight) indicated client #1 required assistance with meal preparation and leisure skills. Client #1's ISP dated 12/28/12 did not indicate any objectives to assist client #1 in meal preparation, leisure skills and maintaining her bedroom.</p> <p>2. Client #2's record was reviewed on 2/21/13 at 11:30 AM. Client #2's IPOP of 2/9/12 indicated client #2 required staff assistance in meal preparation and participation of leisure activities. Client #2's ISP of 2/14/13 not indicate any objectives to assist client #2 in meal preparation and leisure skills.</p> <p>3. Client #3's record was reviewed on 2/21/13 at 2 PM. Client #3's ISP dated</p>			

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	<p>10/16/12 indicated client #3 required assistance with meal preparation and leisure skills. Client #3's ISP did not indicate any objectives to assist client #3 in meal preparation and leisure skills.</p> <p>4. Client #7's record was reviewed on 2/25/13 at 12:45 PM. Client #7's ISP dated 4/30/12 indicated client #7 required assistance with meal preparation and leisure skills. Client #7's ISP did not indicate any objectives to assist client #7 in meal preparation and leisure skills. Client #7's record did not indicate any objectives to educate client #7 on the harms of cigarette smoking.</p> <p>5. Client #8's record was reviewed on 2/25/13 at 12:30 PM. Client #8's IPOP of 2/9/12 indicated client #8 "tends to sit in the livingroom most of time or walks the hall." Client #8's ISP dated 2/14/12 indicated client #8 required assistance with meal preparation and leisure skills. Client #8's ISP did not indicate any objectives to assist client #8 in meal preparation and leisure skills.</p> <p>Interview with staff #4 on 2/20/13 at 7:10 AM indicated clients #1, #2, #3, #7 and #8 required assistance with meal preparation. Staff #4 indicated clients #2, #7 and #8 usually came home from the day program and would go to bed and</p>				

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	<p>stay there until time for the evening meal. Staff #4 indicated client #1 was shy and would stay to herself. Staff #4 indicated client #1 needed to clean her room.</p> <p>Interview with the PS (Program Specialist) on 2/25/13 at 2 PM indicated clients #1, #2, #3, #7 and #8 did not have formal objectives for meal preparation and/or leisure skills. The PS indicated staff were to offer the clients choices for leisure time activities whenever possible.</p> <p>Interview with the PS (Program Specialist) on 2/25/13 at 2 PM indicated the RC (Residential Coordinator) had not implemented any objectives for client #1 since her admission to the facility on 11/30/12. The PS indicated clients #1, #2, #3, #7 and #8 did not have formal objectives for meal preparation and/or leisure skills. The PS indicated staff were to offer the clients choices for leisure time activities whenever possible.</p> <p>9-3-4(a)</p>						

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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview for 2 of 4 sampled clients (#2 and #3), the clients' ISPs (Individualized Support Plans) failed to address how the staff were to supervise and assist the clients while ambulating and to address when the clients were to use a walker and/or a gait belt.</p> <p>Findings include:</p> <p>1. During observations at the group home on 2/19/13 between 3:45 PM and 6:15 PM and on 2/20/13 between 5:35 AM and 8:05 AM, client #2 ambulated at a slow unsteady pace, using a walker, with and without staff assistance. The staff at the group home did not directly supervise client #2 while ambulating.</p> <p>During observations at the DP (Day Program) on 2/20/13 between 10:10 AM and 12:15 PM, client #2 ambulated at a slow unsteady pace, using a walker, with and without staff assistance. The staff at the DP did not directly supervise client #2 while ambulating.</p> <p>Client #2's record was reviewed on 2/21/13 at 11:30 AM.</p>	W000240	<p>W 240 Individual Program Plan</p> <p>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Client #2 and #3's ISP and IPOP assessments will be updated to address how the staff is to supervise and assist the clients while ambulating and to address when the clients were to use a walker and/or gait belt. · The PCP for Client #2 and #3 has been contacted to obtain clarification for how the staff is to assist the two residents with their ambulation needs and to identify how their ambulation adaptive equipment is to be utilized. · Staff will be trained on how to assist Client #2 and #3 while ambulating and how to ensure their adaptive equipment for ambulation is utilized properly at their team meeting. 	04/10/2013			

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	<p>Client #2's ISP of 2/14/12 indicated client #2 used a walker sometimes and "must be supervised and assisted by staff. He crawls most of the time when he is at the home, despite staff prompting to utilize his walker." Client #2's physician's orders of 1/28/13 indicated client #2 could use a wheel chair, walker and a gait belt when needed. Client #2's ISP did not indicate the use of a wheel chair or a gait belt. Client #2's ISP did not indicate the level of supervision staff were to provide client #2 and how the staff were to assist client #2 when ambulating inside and outside the group home.</p> <p>Interview with staff #4 on 2/20/13 at 7:10 AM indicated client #2 ambulated independently with the use of a walker and did not require staff assistance.</p> <p>2. During observations at the group home on 2/19/13 between 3:45 PM and 6:15 PM, client #3 wore a gait belt beneath her clothing. The end of the gait belt dangled in front of client #3 from beneath her clothing. The staff were not observed to supervise and/or assist client #3 while ambulating.</p> <p>During observations at the group home on 2/20/13 between 5:35 AM and 8:05 AM and at the day services between 10:10</p>		<p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, adaptive equipment needs and behavior plan. · The RC will ensure that the client's IPOP's and ISP's reflect information on how the staff is to assist the client's with identified ambulation needs. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP, 				

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	<p>AM and 12:15 PM, client #3 wore a gait belt over her clothing. The staff at the group home and at the DP were not observed to supervise and/or assist client #3 while ambulating.</p> <p>Client #3's record was reviewed on 2/21/13 at 2 PM. Client #3's ISP dated 10/16/12 did not indicate the use of a gait belt. Client #3's physician's orders of 1/1/13 indicated client #3 may use a gait belt as needed. Client #3's Physical Therapy assessment of 7/3/12 indicated client #3 was to use a gait belt when ambulating to help prevent falls.</p> <p>Interview with staff #4 on 2/20/13 at 7:10 AM indicated client #3 wore a gait belt all day except when sleeping. Staff #4 stated client #3 "could be shaky on her feet" and at times needed staff assistance while ambulating. Staff #4 indicated the gait belt gave the staff something to grab onto.</p> <p>Interview with the PS (Program Specialist) on 2/25/13 at 2 PM stated, "I think she wears it because she wants to, not because she has to." The PS indicated client #3's ISP did not address the use of a gait belt.</p> <p>9-3-4(a)</p>		<p>adaptive equipment needs and behavior plan.</p> <ul style="list-style-type: none"> · The RC will ensure that the client's IPOP's and ISP's reflect information on how the staff is to assist the client's with identified ambulation needs. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10th, 2013</p>				

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W000242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the clients' ISPs (Individual Support Plans) failed to address:</p> <p>__ Client #1's identified training needs in regards to personal hygiene and hair care.</p> <p>__ Client #2's identified training needs in regards to bathing, dressing, hygiene, toileting and dining.</p> <p>__ Client #3's identified training needs in regards to her dining, bathing, dressing, personal hygiene, hair care, tooth brushing and toileting needs.</p> <p>__ Client #4's identified training needs in regards to dining, bathing, dressing, personal hygiene, toileting and tooth brushing needs.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 2/25/13 at 11:00 AM. Client #1's undated IPOP (Individual Plan of Protective Oversight) indicated client #1 required</p>	W000242	<p>W 242 Individual Program Plan</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Programming will be implemented for Client #1 in regards to personal hygiene and hair care. · Programming will be implemented for Client #2 in regards to bathing, dressing, 	04/10/2013			

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	<p>assistance with her personal hygiene and hair care. Client #1's ISP dated 12/28/12 did not indicate any objectives to assist client #1 in regards to personal hygiene and hair care.</p> <p>2. Client #2's record was reviewed on 2/21/13 at 11:30 AM. Client #2's IPOP of 2/9/12 indicated client #2 wore a "depends" (an adult brief) and had no toileting skills. The IPOP indicated client #2 was to be taken to the bathroom every 2 hours during the night. Client #2's physician's orders indicated client #2 was to be toileted every 2 hours during the day and once at night at 2 AM. Client #2's ISP of 2/14/12 indicated client #2 could feed himself, but staff had to physically assist him in order for him to eat his meals with utensils; otherwise he would leave the table without eating. The ISP indicated the staff had to physically assist client #2 with bathing, dressing and toileting. Client #2's ISP did not indicate any training objectives to assist client #2 with his bathing, dressing, hygiene, toileting and dining.</p> <p>3. Client #3's record was reviewed on 2/21/13 at 2 PM. Client #3's ISP dated 10/16/12 indicated client #3 required assistance with bathing, dressing, personal hygiene, hair care and tooth brushing. Client #3's IPOP indicated</p>		<p>hygiene, toileting and dining.</p> <ul style="list-style-type: none"> · Programming will be implemented for Client #3 in regards to her dining, bathing, dressing, personal hygiene, hair care, tooth brushing and toileting needs. · Programming will be implemented for Client #4 in regards to dining, bathing, dressing, personal hygiene, toileting and tooth brushing needs. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. 		

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	<p>client #3 required total assistance to care for her hair and has a nursing order for staff assistance for brushing and flossing her teeth. The IPOP indicated client #3 required staff assistance with "toileting issues." Client #3's Risk Plan of 9/17/12 indicated client #3 "will sometimes take large bites and will need prompts to slow her pace of eating. The plan indicated client #3 was to use a sippy cup and smaller utensils to feed herself to ensure smaller bites. Client #3's ISP did not indicate any training objectives to assist client #3 with her dining issues, bathing, dressing, personal hygiene, hair care, tooth brushing and toileting needs.</p> <p>4. Client #4's record was reviewed on 2/20/13 at 2 PM. Client #4's 9/24/12 IPOP indicated client #4 required assistance with personal hygiene, bathing, dressing and tooth brushing. Client #4's Dining Plan of 12/4/12 indicated client #4 "will eat very fast" and consumes large amounts of food if not supervised. Client #4's IPOP indicated client #4 will eat whatever he can get his hands on. He needs close supervision and cannot be left unsupervised but for short periods of time. Client #4's ISP dated 12/4/12 indicated client #4 needed staff assistance with cleaning himself properly after toileting. Client #4's ISP did not indicate any training objectives to assist client #4</p>		<p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. 				

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	<p>with slowing his pace of eating, bathing, dressing, personal hygiene, toileting and tooth brushing needs.</p> <p>Interview with staff #4 on 2/20/13 at 7:10 AM indicated clients #2, #3 and #4 required assistance with dressing, bathing, tooth brushing and hygiene. Staff #4 indicated client #2 wore a depends 24/7 due to incontinence.</p> <p>Interview with the PS (Program Specialist) on 2/25/13 at 2 PM indicated the RC (Residential Coordinator) had not implemented any objectives for client #1 since her admission to the facility on 11/30/12. The PS indicated clients that were not independent with their bathing, dressing, personal hygiene, toileting, tooth brushing and/or hair care should have training objectives in place to assist the clients with their training needs.</p> <p>9-3-4(a)</p>		<p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10 th , 2013</p>		

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W000247	<p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. Based on observation, record review, and interview, for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7 and #8) who lived in the group home, the facility failed to encourage client choices at meal time.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/20/13 between 5:35 AM and 8:05. Clients #1, #2, #3, #4, #5, #6, #7 and #8 ate their morning meal. The morning meal consisted of scrambled eggs, oatmeal and toast with juice and milk. The staff did not offer the clients a choice of eggs, cereal or juice for the morning meal.</p> <p>The facility's menus were reviewed on 2/19/13 at 5 PM. The facility's Fall/Winter regular adult menu dated 10/7/09 indicated for the morning meal on 2/20/13 the clients were to have: ___ 3/4 cup of apple juice ___ 1 egg (any style) ___ 3/4 cup of whole grain cereal or 1/2 cup of cereal of client's choice ___ 2 slices of whole wheat toast with 1 teaspoon of margarine and 1 teaspoon of low sugar jelly</p>	W000247	<p>W 247 Individual Program Plan</p> <p>The individual program plan must include opportunities for client choice and self management.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Regular meal observations will be completed by the RC and/or the Site Manager for the home to ensure that the menu is being followed, that staff is encouraging the residents to follow their prescribed dining plans and that appropriate food substitutions are being offered. · Client's #1-#8 will be placed on programming for them to assist with packing their lunches for day program. · Client's #1-#8 will be placed on programming for them to assist with making appropriate food choices. · Staff will be trained on the importance of offering food choices to the clients based on the menu and the client's dietary plans. 	04/10/2013			

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	<p>__ 1 cup of water __ 1 cup of skim or 1/2 % milk</p> <p>Interview with the RC (Residential Coordinator) and the PS (Program Specialist) on 2/20/13 at 2:45 PM indicated the staff were to provide the clients choices with each meal as indicated on the facility menus.</p> <p>9-3-4(a)</p>		<p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · Regular meal observations will be completed by the RC and/or the Site Manager for the home to ensure that the menu is being followed, that staff is encouraging the residents to follow their prescribed dining plans and that appropriate food substitutions are being offered. · Staff will be trained on the importance of offering food choices to the clients based on the menu and the client's dietary plans. <p>3. What measures will be put into place or what systemic</p>		

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			<p>changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · Regular meal observations will be completed by the RC and/or the Site Manager for the home to ensure that the menu is being followed, that staff is encouraging the residents to follow their prescribed dining plans and that appropriate food substitutions are being offered. · Staff will be trained on the importance of offering food choices to the clients based on the menu and the client's dietary plans. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the 		

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			<p>home.</p> <p>The ARC will monitor as they complete their audits.</p> <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10th, 2013</p>		

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 3 of 4 sampled clients (#1, #2 and #3) and 4 additional clients (#5, #6, #7 and #8), the facility failed to implement the clients' training objectives during formal and informal training opportunities.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/19/13 between 3:45 PM and 6:15 PM. The following was observed: 3:45 PM - Upon entering the group home, the RC (Residential Coordinator) opened the front door with client #4 beside him and stated, "I want to tell you before you get started, [client #4] has Autism. You have to forgive him because he is a little out of sorts tonight." The RC stayed with client #4, taking client #4 by the hand and keeping him away from the kitchen area. Three staff were in the home with the RC. At 4:45 PM, the RC left the group home.</p> <p>Client #1 - At 3:45 PM client #1 walked</p>	W000249	<p>W 249 Program Implementation</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The RC will ensure that programming is in place for all clients addressing their identified need at all times. · Client's #1, #2, #3, #7 and #8 will be put on programming to address their leisure skills and food preparation needs. · Client #1, #2, #3, #7 and #8's ISP's will be updated to 	04/10/2013			

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	<p>the halls, stood in the dining room and kitchen without activity. At 4:45 PM, client #1 stood in the dining room, watching staff #2 and client #5 preparing the evening meal. At 4:50 PM client #1 sat at the dining room table and drank a soda she had brought home from the work shop and then got up to shower. After showering, client #1 was in her bedroom and/or dining room until time for the evening meal at 5:40 PM. Client #1 was not involved with the evening meal preparation. Staff did not offer client #1 a choice of activities.</p> <p>Client #2 - At 3:50 PM client #2 was sitting at the dining room table eating puffed corn. After finishing his snack, client #2 walked to the medication room to get his PM medications. Client #2 walked at a fast pace with a walker and his right shoe lace was untied and dangling between his feet. After getting his medication client #2 went to his room, walked the hallway to the dining room/kitchen, stood for a few minutes and returned to his room. At 4:35 PM client #2 laid down in his bed, not sleeping. At 5:42 PM staff #1 prompted client #2 to get out of bed and go to the dining room. Client #2 got up, walked to the dining room and sat down at the dining room table. The staff assisted client #2 to filling his plate with portions</p>		<p>reflect their leisure skill and food preparation needs.</p> <ul style="list-style-type: none"> · Client #7 will be placed on programming to understand the consequences of smoking. · Client #7's ISP will be updated to reflect the need to understand the consequences of smoking. · Programming will be put in place for Clients #1, #2, #3, and #4 to address their identified needs in regards to dining, personal hygiene, hair care, bathing, dressing, tooth brushing, and toileting. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. · Active treatment schedules will be developed for Client's #1 and #4. · The active treatment schedules for Clients #2, #3, #5, #6, #7 and #8 will be individualized. · Staff will be trained on the active treatment schedules for Client's #1-#8 at their next team meeting. <p>2. How will we identify other</p>				

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	<p>of tuna noodle casserole and broccoli. At 6 PM client #2 got up from the table and walked back to his room. Client #2 did not eat the broccoli, bread with margarine or pineapple. Client #2 bit his right wrist frequently throughout this observation, even while in his bedroom and lying in bed. Client #2's right wrist was red and scarred, approximately the size of 5 cm (centimeter) by 7 cm where the client bites himself. Staff did not prompt or redirect client #2 from biting his wrist. Staff did not offer client #2 a choice of leisure activities and/or training objectives. Staff did not prompt client #2 to tie his shoelace and/or assist client #2 to tie his shoelace.</p> <p>Client #3 - At 3:45 PM, client #3 was in her bedroom, rummaging through her closet. Client #3 wore a gait belt under her clothing, the end of the belt dangling in front of her. Client #3 walked from her bedroom to the living room to the kitchen and back again. Client #3 stood watching the meal preparation and then went to the living room to sit in the recliner with a box of popsicle sticks on her lap until time for the evening meal at 5:40 PM when she walked to the dining room and sat down at the end of the table by the window. Client #3 asked staff #2 if she was coming to sit with her and staff #2 stated, "In a minute, I have to make your</p>		<p>residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. · Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. · Staff will be trained on the active treatment schedules for Client's #1-#8 at their next team meeting. 		

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	<p>pineapple first." Staff #1 put a tablespoon of chocolate instant powder in client #3's milk and prompted her to mix it up. Client #3 had a divided dish, a toddler spoon and fork with rubber handles and 3 cups with straws. Staff #2 pureed client #3's food for her and brought it to the table in dishes and set it in front of client #3. At 5:45 PM, client #3 placed the food on her plate and immediately began eating at a fast pace, taking large bites. By 5:50 PM client #3 was finished with her food, asked for more and was given another serving of tuna noodle casserole, broccoli and pineapple. The toddler spoon did not prevent client #3 from taking large bites and the staff did not prompt client #3 to take smaller bites or to slow her pace of eating. Client #3 did not participate in the evening meal preparation. The staff did not offer client #3 a choice of leisure activities and/or training objectives.</p> <p>Client #7 - At 3:45 PM until 5:40 PM client #7 was observed in her bedroom lying in her bed. The staff did not offer client #7 a choice of leisure activities and/or training objectives during this observation.</p> <p>Client #8 - At 4 PM client #8 was curled up on the couch in a sitting position with her face in her arms, leaning on the back of the couch. The television was on but</p>		<p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. · Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. · Staff will be trained on the active treatment schedules for Client's #1-#8 at their next team meeting. <p>4. How will the corrective action be monitored to ensure the deficient practice will not</p>		

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	<p>client #8 was not interested or watching what was on. At 5:15 PM staff #1 went with client #8 to the bathroom for client #8 to shower. After showering, client #8 returned to the couch until time for the evening meal at 5:40 PM. The staff did not offer client #8 a choice of leisure activities and/or training objectives during this observation.</p> <p>Observations were conducted at the group home on 2/20/13 between 5:35 AM and 8:05 AM.</p> <p>5:35 AM - Two staff were in the home with 8 clients. Staff #5 was in the bathroom with client #6. The dining room table was set for the morning meal. Staff #4 indicated the staff set the table prior to the clients getting up. Client #8 sat curled up on the couch, Client #3 was in the recliner and client #2 was sitting at the dining room table. Client #1 was in her room getting dressed.</p> <p>5:40 AM - Client #2 got up from the table and went back to his bedroom to lie down.</p> <p>5:50 AM - Staff #4 woke client #7 and prompted her to go to the bathroom for her AM care. Staff #1 arrived and began the morning meal.</p> <p>6 AM - Client #1 came to the kitchen.</p>		<p>recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10th, 2013</p>				

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	<p>Staff #1 prompted client #1 to make the toast. Client #1 proceeded to toast the bread, buttering each slice and placing it on a platter. Clients #4 and #5 were still in bed.</p> <p>6:10 AM - Staff #5 wheeled client #6 to the dining room table.</p> <p>6:20 AM - Clients #4 and #5 were up, dressed and in the dining room. As soon as client #4 got to the table he started grabbing at the bowls of food and the plate of toast on the table. Staff #4 redirected client #4 several times to leave the food alone and to sit down at the table. Client #7 was still in the bathroom. Staff #4 stated, "She always takes a long time."</p> <p>6:25 AM - Clients #1, #2, #3, #4, #5, #6 and #8 were sitting at the dining room table. On the table were a large bowl of oatmeal, a large bowl of scrambled eggs and a platter of toast. Staff #4 assisted clients #3 and #4 in filling their plates while staff #1 assisted client #2 and staff #5 assisted client #6. Clients #3 and #4 began eating immediately, taking large bites and eating at a fast pace. Client #4 continued to grab at the food, bowls and glasses near him. Client #8 sat without food on her plate, picking her nose, until staff #4 could assist her with filling her</p>				

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	<p>plate. Staff #1 and #4 were constantly redirecting client #4 from grabbing items on the table and grabbing at other clients' food. Staff #4 began feeding client #8 while staff #1 assisted client #2 and staff #5 assisted client #6.</p> <p>6:35 AM - Client #4 stood up from the table and was redirected to sit back down. Client #7 came from her bedroom, wearing her coat to go outside to smoke a cigarette. Clients #4 and #5 ate all the food on their plate and wanted more. Client #5 asked for more eggs and was told no because not everyone had gotten their food yet. Staff #5 fed client #6 while staff #1 and #4 redirected client #4. Client #8 began eating her eggs with her hands and client #2 sat biting his wrist.</p> <p>6:40 AM - Client #4 got up from the table and grabbed the bowl of eggs. Staff #4 prompted client #4 to put the bowl down, sit down and to eat more oatmeal. After several prompts, client #4 put the bowl of eggs down and sat down. Client #7 returned from outside and sat down at the table. Client #4 reached across the table in front of client #7 and took the last 2 pieces of toast and stuffed them in his mouth.</p> <p>6:45 AM - Client #4 jumped up, grabbed the bowl of scrambled eggs and placed</p>				

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	<p>the ladle with scrambled eggs in his mouth. Staff #4 stood up and stated, "Now I have to make more eggs, [client #7] still hasn't ate." Staff #4 got up from the table to fix more eggs for client #7 and client #8 began eating her food with her hands again. After much prompting from staff #1 and staff #4, client #4 took the bowl of eggs to the kitchen counter and set them down. Staff #1 took client #4 by the arm and prompted him to go to the living room where client #4 stayed for only a few minutes and returned to the dining room.</p> <p>6:50 AM - Client #4 picked up a hand towel and flipped it at client #5, hitting him on the left shoulder. Client #2 got up from the table and went back to his room. Client #2 had not finished his meal. Staff #4 tried to redirect client #4 but was not able to. Client #4 then grabbed client #5 by his clothing on his left shoulder. Client #5 stood up and stepped toward client #4 when staff #4 and #1 intervened. Client #4 was escorted to the living room where he sat with staff #1 throughout the remainder of the observation. Client #5 asked for more eggs and was told there weren't any. Client #5 then stated, "Can I have some toast if I fix it myself?" Client #5 proceeded to make himself some toast.</p> <p>Interview with staff #4 on 2/20/13 at 7:10</p>			

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	<p>indicated clients #4 and #5 were not woken up until breakfast was made and on the table. Staff #4 stated "because they [clients #4 and #5] won't leave anything alone and will eat anything that is sitting out, so we just leave them in bed because there's just not enough of us to handle it." Staff #4 stated client #4's behavior in the AM observation happened "almost every day." Staff #4 indicated there was not enough staff to offer training in the mornings because of client #4's behaviors.</p> <p>Client #1's record was reviewed on 2/25/13 at 11:00 AM. Client #1's ISP (Individual Support Plan) dated 12/28/12 indicated client #1 was admitted to the group home on 11/30/12. Client #1's record did not indicate any formal or informal training objectives for client #1. Client #1's undated IPOP (Individual Plan of Protective Oversight) indicated client #1 required assistance with her personal hygiene, meal preparation, money, medications and doing laundry.</p> <p>Client #2's record was reviewed on 2/21/13 at 11:30 AM. Client #2's IPOP of 2/9/12 indicated client #2 will stand biting his arm if his environment is too loud or if there were too many people. "He needs supervision at all times." Client #2's Approach Plan of 3/2/10 (updated 2/14/12) indicated client #2 chewed on</p>						

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	<p>his wrist, hand and fingers. The plan indicated staff were to approach client #2 calmly and ask client #2 to stop his behavior while at the same time, the staff were to touch client #2's arm. The plan indicated staff were to continue until client #2 stopped the behavior.</p> <p>Client #2's ISP dated 2/14/12 indicated the following formal objectives: ___ To pick up his pill crusher during med pass with hand over hand assistance. ___ To demonstrate opening his mouth for the dentist. ___ To brush his teeth. ___ To use a communication book to communicate his wants and needs with hand over hand assistance. ___ To identify a nickel. ___ To wash his hands with hand over hand assistance.</p> <p>Client #2's ISP indicated client #2 could feed himself, but staff had to physically assist him in order for him to eat his meals with utensils; otherwise he will leave the table without eating. Staff have to physically assist client #2 with bathing, dressing and basic household chores. Client #2's IPOP of 2/9/12 indicated client #2 required assistance with meal preparation and household tasks. The IPOP indicated client #2 will move his body parts for bathing but doesn't assist</p>						

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	<p>staff during personal hygiene, bathing and dressing. The IPOP indicated client #2 wears a "depends (an adult brief)" and has no toileting skills and is to be taken to the bathroom every 2 hours during the night. The IPOP indicated client #2 will sit in his room alone, "but we are working on him to socialize more often." Client #2's IPOP indicated client #2 used a walker for ambulation and required close monitoring and physical assistance with all aspects of daily living.</p> <p>Client #3's record was reviewed on 2/21/13 at 2 PM. Client #3's ISP dated 10/16/12 indicated the following formal objectives:</p> <ul style="list-style-type: none"> __ To independently state/point to a nickel. __ To understand her rights and recognize abuse/report abuse. __ To be able to select her Advair (an inhaler) from the cart. __ To allow staff to assist her with the use of a gait belt if needed. __ To increase independence in using lock box code to access the sharps. __ To increase independence in using own key to access hazmat. __ To do standing balance exercises for 10 min. <p>Client #5's record was reviewed on 2/21/13 at 3:30 PM. Client #5's ISP of</p>						

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	<p>7/10/12 indicated the following formal objectives:</p> <ul style="list-style-type: none"> <input type="checkbox"/> To make his bed. <input type="checkbox"/> To wear and take care of his glasses. <input type="checkbox"/> To demonstrate appropriate table manners. <input type="checkbox"/> To put his clean clothes up. <input type="checkbox"/> To state the times he uses his Chlorhexdine mouth wash. <input type="checkbox"/> To independently monitor his daily living skills. <input type="checkbox"/> To identify the consequences of his actions. <input type="checkbox"/> To independently count his money. <input type="checkbox"/> To respect his peers and staff. <input type="checkbox"/> To brush his teeth. <p>Client #6's record was reviewed on 2/21/13 at 3 PM. Client #6's ISP of 5/31/12 indicated the following formal objectives:</p> <ul style="list-style-type: none"> <input type="checkbox"/> To count fifteen pennies with staff assistance. <input type="checkbox"/> To relate a story or an event with another person. <input type="checkbox"/> To complete his physical therapy exercises. <input type="checkbox"/> To wear his glasses for 15 minutes. <input type="checkbox"/> To identify 2 ways to deal with frustration. <input type="checkbox"/> To identify a \$1 bill. <input type="checkbox"/> To state what he takes for a headache. <input type="checkbox"/> To independently feed himself finger foods. 						

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	<p>Client #7's record was reviewed on 2/25/13 at 12:45 PM. Client #7's ISP of 4/30/12 indicated the following objectives:</p> <p><input type="checkbox"/> To give cashier money back when buying cigarettes.</p> <p><input type="checkbox"/> To sign the correct sign for cooking dinner.</p> <p><input type="checkbox"/> To identify the items in her personal first aid kit.</p> <p><input type="checkbox"/> To independently use her own key to access the hazmats/sharps.</p> <p>Client #7's physician's orders for 1/2013 indicated the client was to be allowed a 30 minute to 60 minute rest after coming home from work.</p> <p>Client #8's record was reviewed on 2/25/13 at 12:30 PM. Client #8's ISP of 2/14/12 indicated the following formal objectives:</p> <p><input type="checkbox"/> To display the correct sign for happy with the staff.</p> <p><input type="checkbox"/> To use a communication book to communicate her wants and needs.</p> <p><input type="checkbox"/> To make the sign to eat once a day.</p> <p><input type="checkbox"/> To wash her hands with hand over hand assistance.</p> <p><input type="checkbox"/> To hold a \$1 bill. Staff will tell client #8 this is a dollar and explain money in the most basic form.</p> <p><input type="checkbox"/> With hand over hand assistance, client #8 will gather the items needed for a</p>						

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	<p>medication pass.</p> <p>Client #8's Dining Plan of 11/8/10 indicated the staff needed to sit next to client #8 on her right side while she was eating a meal. "Staff assists her with scooping food up onto her utensils with hand over hand assistance. Once the food is on her utensil, she is able to take the food to her mouth." The plan indicated client #8 likes to eat with her hands, "unless staff is there to prompt her to stop and to assist her with using her utensils."</p> <p>Interview with the RC and the PS (Program Specialist) on 2/20/13 at 2:45 PM indicated clients were to be offered a choice of activities and/or training throughout the day. The PS indicated clients should not be sitting idle without activity for long periods and should be prompted to activity every 15 minutes.</p> <p>9-3-4(a)</p>				

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W000250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#4, #6, #7 and #8), the facility failed to develop an active treatment schedule for clients #1 and #4 after admission to the facility and failed to ensure client #2's, #3's #5's, #6's, #7's and #8's active treatment schedules were individualized.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 2/25/13 at 11:00 AM. Client 1#'s record indicated client #1 was admitted to the group home on 11/30/12. Client #1's record did not indicate an active treatment schedule had been developed for client #1 since her admission to the facility.</p> <p>Client #4's record was reviewed on 2/20/13 at 2 PM. Client #4's record indicated client #4 was admitted to the group home on 11/5/12. Client #4's record did not indicate an active treatment schedule had been developed for client #4 since his admission to the facility.</p> <p>Client #2's, #3's #5's, #6's, #7's and #8's</p>	W000250	<p>W 250 Program Implementation</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. · Active treatment schedules will be developed for Client's #1 and #4. · The active treatment schedules for Clients #2, #3, #5, #6, #7 and #8 will be individualized. · Staff will be trained on the active treatment schedules for Client's #1-#8 at their next team meeting. 	04/10/2013			

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	<p>Active Treatment Daily Schedules were reviewed on 2/25/13 at 1 PM. Client #2's, #3's #5's, #6's, #7's and #8's Active Treatment Daily Schedules were identical with fixed daily regimens of activities for the clients.</p> <p>12 AM - 6 AM sleep 6 AM - 7 AM wake, morning hygiene, get dressed, meds, straighten room and start breakfast 7 AM - 8 AM eat breakfast and go to day services 3 PM - 4 PM come home from day services, clean lunch boxes 4 PM - 5 PM Meds 5 PM - 6 PM chores and supper 6 PM - 7 PM leisure of choice 7 PM - 8 PM bath/shower 9 PM - 12 AM - sleep</p> <p>Interview with the PS (Program Specialist) on 2/25/13 at 2 PM indicated she was unable to find an active treatment schedule for clients #1 and #4. The PS indicated all clients were to have an active treatment schedule developed after admission to the group home. The PS indicated active treatment schedules were to be individualized for each client.</p> <p>9-3-4(a)</p>		<p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. · Staff will be trained on the active treatment schedules for Client's #1 -#8 at their next team meeting. · The ARC will review with the RC the importance of ensuring that the active treatment schedules are individualized. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p>		

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			<ul style="list-style-type: none"> · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · Staff will be retrained on the importance of ensuring active treatment at all times during their team meeting. · Staff will be trained on the active treatment schedules for Client's #1-#8 at their next team meeting. · The ARC will review with the RC the importance of ensuring that the active treatment schedules are individualized. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. 		

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			<p>5. What is the date by which the systemic changes will be completed? April 10 th , 2013</p>	

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W000259	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 4 sampled clients (#2) and 1 additional client (#8), the facility failed to ensure the IDT (Interdisciplinary Team) reviewed and/or updated the clients' CFAs (Comprehensive Functional Assessments) annually.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 2/21/13 at 11:30 AM. The client's record indicated an IPOP (Individual Plan of Protective Oversight/CFA) last completed on 2/9/12. The record did not indicate the IDT had reviewed and/or updated client #2's IPOP within 365 days from the date of the previous IPOP dated 2/9/12.</p> <p>Client #8's record was reviewed on 2/25/13 at 12:30 PM. The client's record indicated an IPOP last completed on 2/9/12. The record did not indicate the IDT had reviewed and/or updated client #8's IPOP within 365 days from the date of the previous IPOP dated 2/9/12.</p> <p>Interview with the PS (Program Specialist) on 2/25/13 at 2 PM indicated</p>	W000259	<p>W 259 Program Monitoring and Change</p> <p>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Client #2 and #8's IPOP assessments will be updated to reflect their changed needs over the past year. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The RC will monitor the residents programming and 	04/10/2013			

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	the IDT was to review and update the clients' IPOP's annually (every 365 days). 9-3-4(a)		<p>behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan.</p> <ul style="list-style-type: none"> The RC will ensure that each client's ISP and assessments are updated at least on an annual basis. The ARC will review with the RC the importance of ensuring that client's ISP's and assessments are updated at least on an annual basis. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. The RC will ensure that each client's ISP and assessments are updated at least on an annual basis. The ARC will review with the RC the importance of 		

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			<p>ensuring that client's ISP's and assessments are updated at least on an annual basis.</p> <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10 th , 2013</p>		

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W000260	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on interview and record review for 1 of 4 sampled clients (#2) and 1 additional client (#8), the RC (Residential Coordinator) failed to revise the client's ISPs (Individual Support Plans) within 365 days of the previous ISP.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 2/21/13 at 11:30 AM. Client #2 had an ISP dated 2/14/12. The client's record indicated the ISP had not been revised within 365 days of the completion of the previous ISP.</p> <p>Client #8's record was reviewed on 2/25/13 at 12:30 PM. Client #2 had an ISP dated 2/14/12. The client's record indicated the ISP had not been revised within 365 days of the completion of the previous ISP.</p> <p>Interview with the PS (Program Specialist) on 2/25/13 at 2 PM indicated the most current ISP for clients #2 and #8 were provided for review. The PS indicated ISP's were to be updated and revised annually (every 365 days) to</p>	W000260	<p>W 260 Program Monitoring and Change</p> <p>At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Client #2 and #8's ISP's have been updated. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their 	04/10/2013			

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	reflect the clients' program needs, objectives and changes. 9-3-4(a)		<p>programming, assessments, ISP and behavior plan.</p> <ul style="list-style-type: none"> · The RC will ensure that each client's ISP and assessments are updated at least on an annual basis. · The ARC will review with the RC the importance of ensuring that client's ISP's and assessments are updated at least on an annual basis. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · The RC will ensure that each client's ISP and assessments are updated at least on an annual basis. · The ARC will review with the RC the importance of ensuring that client's ISP's and assessments are updated at least on an annual basis. 		

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			<p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10th , 2013</p>		

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W000264	<p>483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, record review and interview for 4 of 4 sample clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the HRC (Human Rights Committee) reviewed and approved all of the restrictive practices within the home for each of the clients living in the group home.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/19/13 between 3:45 PM and 6:15 PM and on 2/20/13 between 5:35 AM and 8:05 AM. During both observations, the sharp knives, snack foods (cookies, pretzels, chips, graham crackers, cereal, cereal bars, etc.) and carbonated beverages were locked in a closet off by the rear exit door of the group home. The chemicals, cleaning supplies and laundry products were locked in a cupboard in the laundry/medication room. The keys to the</p>	W000264	<p>W 264 Program Monitoring and Change</p> <p>The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>1. What corrective action will be accomplished?</p> <p>All 8 residents will be assessed to determine their ability to have access to knives/sharps and cleaning supplies. Guardian approval will be requested if resident is not found to be able to safely handle knives/sharps and cleaning supplies. If it is found that</p>	04/10/2013			

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	<p>locked items were hanging on a key ring inside of the office. Clients #1, #2, #3, #4, #5, #6, #7 and #8 did not have access to the keys to the locked items. Alarms were on the front and back doors of the group home as well as on the window in client #4's and #5's bedroom. When the doors during both observations, no alarms were audible.</p> <p>Interview with staff #2 on 2/19/13 at 5 PM stated she did not know why the knives and cleaning supplies were locked, "They just have always been locked up." Staff #2 stated the snacks were locked because "I think it's because of [client #4]. He grabs food and stuffs it in his mouth if you don't watch him." When asked why there were alarms on the doors and client #4's and #5's windows, staff #2 stated, "Oh, I don't know. We don't use them. I think the night shift turns them on at night in case anyone would get up and try to leave the home." Staff #2 indicated no clients in the group home had a key to the locked items within the home and had to ask staff for access whenever they wanted any of the locked items.</p> <p>Interview with staff #4 on 2/20/13 at 7:10 AM indicated the knives, food and snacks were locked in the closet near the back door of the home. Staff #4 indicated the cleaning supplies were locked in a cabinet</p>		<p>knives/sharps and cleaning supplies should be locked, those residents that can safely use said items will be provided a key in order to access them independently.</p> <ul style="list-style-type: none"> · All food and snacks will be available to all residents at all times – no edible items will be locked at any time. · The alarms on the doors and windows have been determined that they not needed at this time. They have been removed from the house. · Staff training will occur so they are aware of any restrictions regarding knives/sharps and cleaning supplies relevant to each resident at their team meeting. · Clients #1-#8's IPOP assessments and behavior plans will be reviewed and updated to reflect the necessary changes regarding their needs for access to knives/sharps, cleaning supplies, and use of chimes on the doors. · Client #3's programming regarding access to sharps/knives and cleaning supplies will be updated to reflect her abilities in her new home. · Client's #1, #2, #4, #5, #6, #8 and #8 will be placed on programming to address their 				

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	<p>in the medication/laundry room. Staff #4 indicated the clients had to ask staff to get those items for them if they wanted them. Staff #4 indicated the door/window alarms had not been used for a long time. Staff #4 indicated the night shift did not turn the alarms on the door at night as indicated by staff #2. Staff #4 indicated she did not know why the knives were being locked nor did she know why the alarms were on the doors/windows.</p> <p>The facility's reportable records 2/1/12 through 2/19/13 were reviewed on 2/19/13 at 2 PM and again on 2/25/13 at 11:30 AM. The BDDS report of 7/19/12 indicated on 7/18/12 at 5 PM client #5 walked away from the group home to a local convenience store and returned carrying a fountain drink and a bag of chips. The facility's reportable records did not indicate any incidents in regards to sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products requiring the need to lock these items within the group home in regards to clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>Client #1's record was reviewed on 2/25/13 at 11:00 AM. Client #1's ISP (Individualized Support Plan) of 12/28/12 did not indicate a need for client #1 to be restricted from sharp objects, food, snacks, chemicals, cleaning supplies</p>		<p>needs regarding locked items in the home.</p> <ul style="list-style-type: none"> HRC approval will be obtained for all clients regarding the restrictions in the home. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the same deficient practice. All 8 residents will be assessed to determine their ability to have access to knives/sharps and cleaning supplies. Guardian approval will be requested if resident is not found to be able to safely handle knives/sharps and cleaning supplies. If it is found that knives/sharps and cleaning supplies should be locked, those residents that can safely use said items will be provided a key in order to access them independently. All food and snacks will be available to all residents at all times – no edible items will be locked at any time. The alarms on the doors and windows have been 				

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	<p>and/or laundry products. Client #1's record did not indicate a need for alarms to be on the front and back doors.</p> <p>Client #2's record was reviewed on 2/21/13 at 11:30 AM. Client #2's ISP of 2/14/12 and Approach Plan (BSP - Behavior Support Plan) of 3/2/10 did not indicate a need for client #2 to be restricted from sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products. Client #2's record did not indicate a need for alarms to be on the front and back doors.</p> <p>Client #3's record was reviewed on 2/21/13 at 2 PM. Client #3's ISP of 10/16/12 indicated "The sharps are locked in a lock box with a code and the hazmats are locked in the closets. In the past [client #3] has not been responsible with her key and she has given it to individuals in the home that are not appropriate with sharps. [Client #3] is now on a program so she may access the sharps with a code." Client #3's BSP of 10/16/12 did not indicate a need for client #3 to be restricted from sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products. Client #3's record did not indicate a need for alarms to be on the front and back doors.</p> <p>Client #4's record was reviewed on</p>		<p>determined that they not needed at this time. They have been removed from the house.</p> <ul style="list-style-type: none"> · Staff training will occur so they are aware of any restrictions regarding knives/sharps and cleaning supplies relevant to each resident at their team meeting. · HRC approval will be obtained for all clients regarding the restrictions in the home. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · All 8 residents will be assessed to determine their 		

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	<p>2/20/13 at 2 PM. Client #4's IPOP (Individual Plan of Protective Oversight) of 9/24/12 indicated client #4 "tends to overeat" and his parents locked the pantry and refrigerator doors when the client was living at home. The BSP indicated client #4 "will eat constantly if not controlled. He (client #4) will eat whatever he can get his hands on. He needs closely supervised and cannot be left attended but for short periods of time." Client #4's ISP of 12/4/12 and/or BSP of 12/24/12 did not indicate the food or snacks were to be locked within the group home. Client #4's record did not indicate a need for client #4 to be restricted from sharp objects, chemicals, cleaning supplies and/or laundry products. Client #4's record did not indicate a need for alarms to be on the front and back doors and or his bedroom window.</p> <p>Client #5's record was reviewed on 2/21/13 at 3:30 PM. Client #5's BSP of 7/30/12 indicated client #5 had a behavior of stealing food or eating out of the trash can. When client #5 was caught stealing food or eating out of the trash can, the staff were to redirect client #5 to his "free foods" in the cabinet in the kitchen. Client #5's ISP indicated client #5 "was not safe using hazardous materials in the home." The ISP indicated client #5 "has a history of walking off." Client #5's record did not</p>		<p>ability to have access to knives/sharps and cleaning supplies. Guardian approval will be requested if resident is not found to be able to safely handle knives/sharps and cleaning supplies. If it is found that knives/sharps and cleaning supplies should be locked, those residents that can safely use said items will be provided a key in order to access them independently.</p> <ul style="list-style-type: none"> · All food and snacks will be available to all residents at all times – no edible items will be locked at any time. · The alarms on the doors and windows have been determined that they not needed at this time. They have been removed from the house. · Staff training will occur so they are aware of any restrictions regarding knives/sharps and cleaning supplies relevant to each resident at their team meeting. · HRC approval will be obtained for all clients regarding the restrictions in the home. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p>				

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	<p>indicate a need for client #5 to be restricted from sharp objects. Client #5's record did not indicate snacks, food and cleaning supplies were to be locked to prevent client #5 access to these items. Client #5's record did not indicate the use of alarms on the front and back doors of the group home as well as on client #5's bedroom window.</p> <p>Client #6's record was reviewed on 2/21/13 at 3 PM. Client #6's ISP of 12/28/12 did not indicate a need for client #6 to be restricted from sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products. Client #6's record did not indicate a need for alarms to be on the front and back doors of the group home.</p> <p>Client #7's record was reviewed on 2/25/13 at 12:45 PM. Client #7's ISP of 4/30/12 did not indicate a need for client #7 to be restricted from sharp objects, food, snacks, chemicals, cleaning supplies and/or laundry products. Client #7's record did not indicate a need for alarms to be on the front and back doors.</p> <p>Client #8's record was reviewed on 2/25/13 at 12:30 PM. Client #8's ISP of 2/14/12 and BSP of 8/11/09 did not indicate a need for client #8 to be restricted from sharp objects, food,</p>		<ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed? April 10 th , 2013</p>		

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	<p>snacks, chemicals, cleaning supplies and/or laundry products. Client #8's IPOP of 2/9/12 indicated a behavior concern "That she [client #8] did not wander away from the group home" and needs to be monitored at all times. The IPOP indicated client #8 required a fenced in yard, but could sit outside unsupervised. Client #8's record did not indicate the use of alarms on the front and back doors of the group home.</p> <p>The facility's Human Rights Committee (HRC) notes for the previous 12 months were reviewed on 2/25/13 at 12:15 PM.</p> <p>__The HRC notes did not indicate the approval to lock the sharps and hazardous materials from clients #5, #6 and #7.</p> <p>__The HRC notes did not indicate the approval to use door alarms on the front and back doors for clients #1, #6 and #7.</p> <p>__The HRC notes did not indicate the approval to use window alarms on client #4's window.</p> <p>During interview with the RC (Residential Coordinator) and the PS (Program Specialist) on 2/20/13 at 2:45 PM, the RC stated the knives were locked up because "We have clients that cannot handle knives because of their intellect." The RC stated clients #3 and #8 "for example." The RC stated the group home was a "locked home because of the</p>						

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	<p>hazmat items (cleaning supplies)." The RC stated the cleaning supplies were locked because the potential for clients with "lower intellect" to ingest liquid chemicals was higher and it was safer to keep them locked. The RC and the PS indicated they were not aware the staff were locking food and/or snacks. The RC indicated the alarms were on the front and back doors and client #5's bedroom window because client #5 went AWOL in July of 2012. The PS indicated the alarms were placed on the front and back doors because client #8 has a history of wandering away from the group home. The PS stated "Not so much in the winter as in the summer."</p> <p>Interview with the PS on 2/25/13 at 2 PM indicated client #4's and #5's ISP and BSPs did not include locking food or snacks. The PS indicated client #5's ISP and/or BSP did not include the use of alarms on the doors and or windows in regard to his AWOL incident in 2012. The PS indicated the HRC had not reviewed and or approved the locking of snack/food within the group home. The PS stated the knives and the hazmat materials "have been locked in the home for years." The PS indicated the HRC was to review and renew all restrictions annually.</p>						

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	9-3-4(a)				

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W000290	<p>483.450(b)(5) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Standing or as needed programs to control inappropriate behavior are not permitted. Based on record review and interview, for 1 of 4 sample clients (#2) and 2 additional clients (#7 and #8), the facility failed to prohibit the use of standing as needed order for the use of physical restraint.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 2/21/13 at 11:30 AM. Client #2's 1/1/13 physician's orders indicated an order for "use of restraint approved for crisis." The physician's orders indicated the order for restraints had been in place since 8/23/2011. Client #2's record indicated an "Approach Plan" dated 3/2/10 that addressed client #2's SIB (self injurious behavior) of biting his wrist and fingers. The Approach Plan did not include the use of a physical restraint.</p> <p>Client #7's record was reviewed on 2/25/13 at 12:45 PM. Client #7's 1/1/13 physician's orders indicated an order for "use of restraint approved for crisis." The physician's orders indicated the order for restraints had been in place since 8/23/2011. Client #7's record indicated a BSP dated 8/11/09 that addressed agitation, physical aggression, property</p>	W000290	<p>W 290 Management of Inappropriate Client Behavior</p> <p>Standing or as needed programs to control inappropriate behavior are not permitted.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The standing order for restraints has been removed from Client #2, #7, and #8's Medication Administration Record. · Occazio's policy regarding Behavior Change Interventions in Crisis will be reviewed will all staff during their team meeting. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The RC will monitor the residents programming and 	04/10/2013			

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	<p>destruction and depression. Client #7's BSP (Behavior Support Plan) did not indicate the use of a physical restraint.</p> <p>Client #8's record was reviewed on 2/25/13 at 12:30 PM. Client #8's 1/1/13 physician's orders indicated an order for "use of restraint approved for crisis." The physician's orders indicated the order for restraints had been in place since 8/23/2011. Client #8's record did not indicate a BSP requiring the use of physical restraints.</p> <p>Interview with the PS (Program Specialist) on 2/25/13 at 2 PM indicated clients should not have a standing order for the use of a restraint. The PS indicated the order was put in place originally in case the staff would need to use the facility's Handle with Care restraint.</p> <p>9-3-5(a)</p>		<p>behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan.</p> <ul style="list-style-type: none"> The standing order for restraints has been removed from all of the Client's Medication Administration Records where restraint is not warranted in their behavior plan. Occazio's policy regarding Behavior Change Interventions in Crisis will be reviewed will all staff during their team meeting. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. The standing order for restraints has been removed from all of the Client's Medication Administration Records where restraint is not warranted in their behavior plan. 		

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			<ul style="list-style-type: none"> · Occazio's policy regarding Behavior Change Interventions in Crisis will be reviewed will all staff during their team meeting. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10 th , 2013</p>		

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W000371	<p>483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to develop medication objectives to provide medication training.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 2/25/13 at 11:00 AM. Client #1's record indicated client #1 was admitted to the group home on 11/30/12. Client #1's physician's orders of 12/10/12 indicated client #1 was to have Kariva 28 day tablet once a day (for birth control). Client #1's undated IPOP (Individual Plan of Protective Oversight) indicated client #1 required assistance with medication training. Client #1's ISP (Individual Support Plan) of 12/28/12 did not indicate any training objectives to assist client #1 with taking and/or identifying medications.</p> <p>Interview with the PS (Program Specialist) on 2/25/13 at 2 PM indicated client #1 was admitted to the group home on 11/30/12. The PS indicated since client</p>	W000371	<p>W 371 Drug Administration</p> <p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The RC will ensure that programming is in place for all clients addressing their identified need at all times. · Programming regarding medication training will be implemented for Client #1. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p>	04/10/2013	

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	#1's admission to the group home, the RC had not implemented any objectives for client #1. The PS indicated client #1 was not independent in taking medications and required staff assistance and supervision. 9-3-6(a)		<ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. · The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. · Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. 		

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			<ul style="list-style-type: none"> · The Area Residential Coordinator will ensure that the Residential Coordinator is monitoring treatment programs for all 8 clients in the home. · Regular monitoring, integration, and coordination of treatment programs will be completed for Clients #1-#8 by the Residential Coordinator. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10 th , 2013</p>		

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W000383	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview for 4 of 4 sample clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6,#7 and #8), the facility failed to ensure the clients' medications were locked except when being prepared for administration.</p> <p>Findings include:</p> <p>During observations at the group home on 2/20/13 between 5:35 AM and 8:05 AM, client #1's, #2's, #3's, #4's, #5's, #6's, #7's and #8's medications were stored in a locked medication cart and in locked cabinets in the medication/laundry room. The door to the medication room was not locked. At 6:05 AM staff #4 unlocked the medication cart to begin AM medications. Staff #4 gave client #3 her medication, locked the medication cart, left the keys lying on the cart and left the room. At 7:30 AM staff #4 returned to the medication room, picked up the keys, unlocked the cart and gave client #7 her AM medication. Staff #4 again locked the medication cart, laid the keys on the cart and left the room. At 7:45 AM staff #4 returned to the mediation room, picked up the keys, unlocked the medication cart, and gave clients #2, #3, #6 and #7 their AM medications. During this observation,</p>	W000383	<p>W 383 Drug Storage and Recordkeeping</p> <p>Only authorized persons may have access to the keys to the drug storage area.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The medication keys have been moved to a secure location. · All staff will review Occazio's medication administration policy and the Core A/B components that discuss the importance of keeping medications secured. · A medication practicum will be completed with Staff #4 by 4-10-13. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. 	04/10/2013			

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	<p>clients walked by the medication room, the door was open and the keys were laying out in full view of everyone that walked by.</p> <p>Interview with staff #4 on 2/20/13 at 7:50 AM stated "We just leave them (the medication keys) here (as she pointed to the top of the medication cart) or we just put them in this pocket (an open area on the side of the medication cart)." Staff #4 indicated the keys to the medication also hung just inside the office door and the office door was usually open.</p> <p>Interview with the facility nurse on 2/21/13 at 1:45 PM indicated medications were to be secured at all times and unlocked only when the staff were preparing the medications. The facility nurse indicated the staff were to carry the medication keys on their person at all times and were never to leave them laying anywhere.</p> <p>9-3-6(a)</p>		<ul style="list-style-type: none"> · The medication keys have been moved to a secure location. · All staff will review Occazio's medication administration policy and the Core A/B components that discuss the importance of keeping medications secured. · Random medication practicums will be completed with staff to ensure that they are following the proper medication administration passing guidelines. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The medication keys have been moved to a secure location. · All staff will review Occazio's medication administration policy and the Core A/B components that discuss the importance of keeping medications secured. · Random medication practicums will be completed with staff to ensure that they are following the proper medication administration passing guidelines. 		

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			<p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor on a regular basis when they are in the home. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10th, 2013</p>		

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W000426	<p>483.470(d)(3) CLIENT BATHROOMS</p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>Based on observation, record review and interview for 3 of 4 sampled clients (#2, #3 and #4) and 2 additional clients (#6 and #8), the facility failed to ensure water temperatures did not exceed 110 degrees.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/20/13 between 5:35 AM and 8 AM. At 7:15 AM client #5 was in the medication room washing his hands prior to taking his AM medications. While washing his hands, client #5 stated, "This water is really hot" and steam was seen rising from the sink. The water temperature was taken at 7:30 AM in the sink of the medication room and found to be 126 degrees Fahrenheit. The water temperature was taken in the sinks in the two bathrooms off of the medication room at 8 AM and was found to be 122 degrees Fahrenheit.</p> <p>Client #2's record was reviewed on 2/21/13 at 11:30 AM. The client's record did not indicate client #2 could adjust the</p>	W000426	<p>W 426 Client Bathrooms</p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate the water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · The water temperature in the home has been adjusted back to 110 degrees Fahrenheit. · Staff is to complete water temperature checks three times a week and document the findings on the water temperature check sheet in Therap. Temperatures above 110 degrees Fahrenheit are reported to the RC for the home. · Staff will be retrained on the importance of checking the water temperature and reporting temperature concerns to the RC during their team meeting. 	04/10/2013			

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	<p>water temperature within the group home.</p> <p>Client #3's record was reviewed on 2/21/13 at 2 PM. The client's record did not indicate client #3 could adjust the water temperature within the group home.</p> <p>Client #4's record was reviewed on 2/20/13 at 2 PM. The client's record did not indicate client #4 could adjust the water temperature within the group home.</p> <p>Client #6's record was reviewed on 2/21/13 at 3 PM. The client's record did not indicate client #6 could adjust the water temperature within the group home.</p> <p>Client #8's record was reviewed on 2/25/13 at 12:30 PM. The client's record did not indicate client #8 could adjust the water temperature within the group home.</p> <p>Review of the SCS (Safety Check Sheets) for October 2012 through February 2013 on 2/25/13 at 2 PM indicated water temperatures of:</p> <p>10/04/12 - 112 degrees Fahrenheit. 10/18/12 - 112 degrees Fahrenheit. 10/28/12 - 114 degrees Fahrenheit. 11/01/12 - 116 degrees Fahrenheit. 11/02/12 - 112 degrees Fahrenheit. 11/03/12 - 112 degrees Fahrenheit. 11/09/12 - 116 degrees Fahrenheit. 11/15/12 - 111 degrees Fahrenheit.</p>		<ul style="list-style-type: none"> · Water temperature assessments will be completed with Client #2, #3, #4, #6, and #8. · The IPOP assessments will be updated to reflect Client's #2, #3, #4, #6, and #8's abilities to regulate water temperatures. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Staff is to complete water temperature checks three times a week and document the findings on the water temperature check sheet in Therap. Temperatures above 110 degrees Fahrenheit are reported to the RC for the home. · Staff will be retrained on the importance of checking the water temperature and reporting temperature concerns to the RC during their team meeting. · The IPOP assessments and water temperature assessments will be reviewed and updated as the resident's needs change. 		

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	<p>11/16/12 - 118 degrees Fahrenheit. 11/17/12 - 118 degrees Fahrenheit. 11/18/12 - 116 degrees Fahrenheit. 11/19/12 - 112 degrees Fahrenheit. 11/24/12 - 114 degrees Fahrenheit. 11/29/12 - 118 degrees Fahrenheit.</p> <p>Interview staff #4 on 2/20/13 at 7:50 AM stated "Ever since they worked on the sprinkler system a couple of weeks ago, the temperature of the water has been a lot hotter." Staff #4 indicated clients #2, #3, #4, #6 and #8 required assistance with regulating the water temperatures in the group home.</p> <p>Interview with the PS (Program Specialist) on 2/25/13 at 1:30 PM indicated clients #2, #3, #4, #6 and #8 required assistance regulating the water temperature in the home. The PS indicated the water temperature was not to exceed 110 degrees Fahrenheit. The PS indicated the water temperatures within the group home were to be monitored on a regular basis. The PS indicated the only records she had for the monitoring of the water temperature were for October and November 2012. The PS indicated no other safety check sheets were available for review.</p> <p>9-3-7(a)</p>		<p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Staff is to complete water temperature checks three times a week and document the findings on the water temperature check sheet in Therap. Temperatures above 110 degrees Fahrenheit are reported to the RC for the home. · Staff will be retrained on the importance of checking the water temperature and reporting temperature concerns to the RC during their team meeting. · The IPOP assessments and water temperature assessments will be reviewed and updated as the resident's needs change. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor as they 				

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			<p>complete their audits.</p> <ul style="list-style-type: none"> · The ARC will monitor as they complete their audits. · The Maintenance Director will also monitor as he completes his checks. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10 th , 2013</p>		

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 2 of 4 sampled clients (#1 and #3) who wore eyeglasses, the facility failed to teach and encourage the clients to wear and take care of their eyeglasses.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/19/13 between 3:45 PM and 6:15 PM. During this observation clients #1 and #3 were not observed wearing any eyeglasses.</p> <p>During observations at the group home on 2/20/13 between 5:35 AM and 8:05 AM, client #1 was not observed wearing her eyeglasses until getting onto the facility van at 8 AM. At 8:05 AM staff #4 came out of the house with client #3's eyeglasses in her hand and stated, "I almost forgot to give [client #3] her eyeglasses."</p> <p>Interview with staff #4 on 2/20/13 at 8:05 AM indicated clients #1 and #3 wore eyeglasses and were to take their</p>	W000436	<p>W 436 Space and Equipment</p> <p>The facility must furnish, maintain in food repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Client's #1 and #3 will be placed on programming to encourage them to wear their eyeglasses and to take care of them. · Staff will be retrained during their team meeting on the importance of ensuring adaptive equipment is available, in good repair and to encourage the residents to utilize the equipment. 	04/10/2013			

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	<p>eyeglasses off in the afternoon after coming home from the day service programs and then every morning the staff would give the clients their eyeglasses back to them prior to leaving for the day service program. Staff #4 indicated clients #1 and #3 had a history of breaking their eyeglasses and not taking care of them properly.</p> <p>Client #1's record was reviewed on 2/25/13 at 11:00 AM. Client #1's 6/27/11 vision assessment indicated client #1 had prescribed eye eyeglasses. Client #1's 12/28/12 ISP (Individual Support Plan) did not indicate any objectives to assist the client to wear and/or take care of her eyeglasses.</p> <p>Client #3's record was reviewed on 2/21/13 at 2 PM. Client #3's 9/6/11 vision assessment indicated client #3 had prescribed eye eyeglasses. Client #3's 10/16/12 ISP did not indicate any objectives to assist the client to wear and/or take care of her eyeglasses.</p> <p>Interview with the RC (Residential Coordinator) and the PS (Program Specialist) on 2/20/13 at 2:45 PM indicated the RC did not know for sure if clients #1 and #3 had objectives in their ISP in regards to wearing and taking care of their eyeglasses.</p>		<p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Staff will be retrained during their team meeting on the importance of ensuring adaptive equipment is available, in good repair and to encourage the residents to utilize the equipment. · The residents IPOP assessments will be reviewed and updated as their needs change. · Programming will be implemented based on the residents assessments and as their needs change. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Staff will be retrained during their team meeting on the importance of ensuring adaptive equipment is available, in good repair and to encourage the residents to utilize the equipment. 				

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	<p>Interview with the PS (Program Specialist) on 2/25/13 at 2 PM indicated client #1 was admitted to the group home on 11/10/12 and the RC had not initiated any training objectives for client #1. The PS indicated clients that were not able to care for their eyeglasses or did not wear them as prescribed should have a training objective in place to teach them to wear and care for their eyeglasses.</p> <p>9-3-7(a)</p>		<ul style="list-style-type: none"> · The residents IPOP assessments will be reviewed and updated as their needs change. · Programming will be implemented based on the residents assessments and as their needs change. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor as they complete their audits. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed? April 10 th , 2013</p>		

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W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8) who resided in the group home, the facility failed to ensure an evacuation drill was conducted for each shift of personnel for the day shift (7 AM - 3 PM) for the first quarter (January, February and March) 2012 and/or 2013, for the evening shift (3 PM - 11 PM) for the fourth quarter (October, November and December) 2012 and for the night shift (11 PM - 7 AM) for the third quarter (July, August and September) 2012 and for the fourth quarter 2012.</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 2/21/13 at 11:40 AM. The review indicated the facility failed to conduct evacuation drills for clients #1, #2, #3, #4, #5, #6, #7 and #8 for the first quarter of 2012 and/or 2013 for the day shift, for the fourth quarter of 2012 for the evening shift and for the third and fourth quarters of 2012 for the night shift.</p> <p>Interview with the PS (Program Specialist) on 2/25/13 at 1:30 PM indicated the PS was unable to locate any</p>	W000440	<p>W 440 Evacuation Drills</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · A day shift (7am-3pm), an evening shift (3pm-11pm) and night shift (11pm-7am) drill will be run by 4-10-13. · The importance of ensuring that evacuation drills are ran at least quarterly for each shift of personnel will be reviewed with the staff and RC during their team meeting on 2-1-13. · A drill tracking sheet will be utilized by the RC and Site Manager to ensure that drills for each shift of personnel are being conducted. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p>	04/10/2013			

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	<p>further evacuation drills for clients #1, #2, #3, #4, #5, #6, #7 and #8 for the first shift for the first quarter of 2012 and/or 2013, for the evening shift for the fourth quarter of 2012 and for the night shift for the third and fourth quarters of 2012. The PS indicated evacuation drills were to be conducted quarterly for each shift of personnel.</p> <p>9-3-7(a)</p>		<ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · The importance of ensuring that evacuation drills are ran at least quarterly for each shift of personnel will be reviewed with the staff and RC during their team meeting. · A drill tracking sheet will be utilized by the RC and Site Manager to ensure that drills for each shift of personnel are being conducted. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · The importance of ensuring that evacuation drills are ran at least quarterly for each shift of personnel will be reviewed with the staff and RC during their team meeting. · A drill tracking sheet will be utilized by the RC and Site Manager to ensure that drills for each shift of personnel are being conducted. <p>4. How will the corrective action be monitored to ensure</p>		

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			<p>the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor as they complete their audits. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10th , 2013</p>		

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W000460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the staff followed the facility menu and provided client substitutions for food not eaten.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/19/13 between 3:45 PM and 6:15 PM. The evening meal consisted of tuna noodle casserole, cooked broccoli, bread with margarine and pineapple. At 5:58 PM client #8 got up from the table. Client #8 did not eat the broccoli and/or all of her serving of pineapple. Staff #2 stated, "I was going to make you a bologna sandwich." At 6 PM client #2 got up from the table. Client #2 did not eat the pineapple. Staff #3 stated, "It's not his favorite." Clients #1, #3, #4, #5, #6, #7 and #8 had a chocolate powder added to their milk. Staff #2 did not make a bologna sandwich for client #8. The staff did not offer clients #2 and #8 substitutions for the food they did not eat.</p> <p>Observations were conducted at the group</p>	W000460	<p>W 460 Food and Nutrition</p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially prescribed diets.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Regular meal observations will be completed by the RC and/or the Site Manager for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans. · Staff will be retrained on Client #1, #2, #3, #4, #5, #6, #7 and #8's dining plans, how to provide appropriate food substitutions and the importance of following the menu at their staff meeting. · Appropriate food substitutions will be provided to the day service provider for the clients who choose not to eat what they packed for lunch. 	04/10/2013			

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	<p>home on 2/20/13 between 5:35 AM and 8:05 AM. The morning meal consisted of scrambled eggs, oatmeal and toast with juice and milk. Clients #1, #2, #3, #4, #5, #6 and #8 sat down to eat at 6:25 AM. Client #7 had gone outside to smoke and did not sit down at the table to eat until 6:45 AM. Client #7 ate only a small portion of scrambled eggs and got up from the table. Client #7 did not eat any oatmeal or toast and did not drink any milk or juice. At 6:50 AM client #2 got up from the table. Client #2 ate only a few bites of his eggs. Client #2 did not eat any oatmeal or toast and did not drink his milk and/or juice. Clients #1, #3, #4, #5, #6 and #8 had a chocolate powder added to their milk. The staff did not offer the clients a substitution for food not eaten. At 7:55 AM staff #1 and #5 were in the kitchen preparing the clients' lunch boxes for the day program. Staff #5 indicated clients #1, #2, #3, #4, #5, #6, #7 and #8 did not assist this AM in preparing their lunch meals.</p> <p>The facility's menus were reviewed on 2/19/13 at 5 PM. The facility's Fall/Winter regular adult menu dated 10/7/09 indicated for the evening meal on 2/19/13 the clients were to have:</p> <p>__ 1 cup of macaroni and cheese with tuna __ 1 cup of cooked broccoli __ 1 slice of bread with 1 teaspoon of</p>		<p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Regular meal observations will be completed by the RC and/or the Site Manager for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans. · Staff will be retrained on Client #1, #2, #3, #4, #5, #6, #7 and #8's dining plans, how to provide appropriate food substitutions and the importance of following the menu at their staff meeting. · Appropriate food substitutions will be provided to the day service provider for the clients who choose not to eat what they packed for lunch. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p>		

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	<p>margarine</p> <p>__ 1/2 cup of sugar free or fat free pudding</p> <p>__ 1/2 cup of pineapples</p> <p>__ 1 cup of water</p> <p>__ 1 cup of skim or 1/2 % milk</p> <p>__ 8 to 12 ounces of sugar free punch</p> <p>The menu indicated the morning meal on 2/20/13 the clients were to have:</p> <p>__ 3/4 cup of apple juice</p> <p>__ 1 egg (any style)</p> <p>__ 3/4 cup of whole grain cereal or 1/2 cup of cereal of client's choice</p> <p>__ 2 slices of whole wheat toast with 1 teaspoon of margarine and 1 teaspoon of low sugar jelly</p> <p>__ 1 cup of water</p> <p>__ 1 cup of skim or 1/2 % milk</p> <p>Interview with staff #2 on 2/19/13 at 5:45 PM indicated all clients except client #2 added a chocolate instant powder to their milk at every meal. Staff #2 indicated client #2 didn't like it. Staff #2 indicated one of the clients had asked for chocolate milk in the past and it just became something all the clients wanted and started doing for each meal.</p> <p>Interview with staff #4 on 2/20/13 at 7:10 AM indicated the clients added (name of chocolate powder) to their milk at every meal. Staff #4 indicated clients #2, #8 and #6 would not eat if the staff did not feed</p>		<ul style="list-style-type: none"> · Regular meal observations will be completed by the RC and/or the Site Manager for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans. · Staff will be retrained on Client #1, #2, #3, #4, #5, #6, #7 and #8's dining plans, how to provide appropriate food substitutions and the importance of following the menu at their staff meeting. · Appropriate food substitutions will be provided to the day service provider for the clients who choose not to eat what they packed for lunch. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor as they complete their audits. · The ARC will monitor as they complete their audits. 		

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	<p>them. Staff #4 indicated staff were to offer clients a substitute for foods not eaten at a meal.</p> <p>Interview with client #5 at the Day Program on 2/20/13 at 11:30 AM indicated client #5 could pack his own lunch, but the staff had packed it for him and he did not get a choice in what was in his lunch box. Client #5 indicated the staff usually packs everyone's lunch boxes for the afternoon meals.</p> <p>Interview with the RC (Residential Coordinator) and the PS (Program Specialist) on 2/20/13 at 2:45 PM indicated if clients did not eat the provided food on the menu, the staff were to offer the clients a similar food substitute. The PS indicated the staff were not to be giving the clients a chocolate powder in the clients' milk unless it was directed by the dietician, approved and added to the facility menus. The PS indicated clients were to assist in packing their lunches for the day program and the staff were not to pack the lunches for the clients.</p> <p>9-3-8(a)</p>		<p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10 th , 2013</p>		

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W000484	<p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to provide complete table service for all clients.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/19/13 between 3:45 PM and 6:15 PM. At 5:30 PM staff #2 prompted client #5 to butter the bread for the evening meal. Client #5 placed butter on the bread, placed the buttered bread on a platter and placed the platter on the table. At 5 PM clients #1, #2, #3, #4, #5, #6, #7 and #8 sat down to eat their evening meal of tuna casserole, broccoli, sliced bread with margarine and pineapple. The table service did not include knives nor were the clients prompted to butter their own bread.</p> <p>Observations were conducted at the group home on 2/20/13 between 5:35 AM and 8:05 AM. Upon entering the group home at 5:35 AM, the table was set for the AM meal with plates, bowls and juice cups. The table service did not include knives.</p>	W000484	<p>W 484 Dining Areas and Services</p> <p>The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Regular meal observations will be completed by the RC and/or the Site Manager for the home to ensure that the table is set properly. · Staff will be trained on ensuring that the table is set properly including knives to be utilized during the meal. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the 	04/10/2013			

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	<p>At 5:55 AM staff #4 prompted client #1 to make the toast. Client #1 toasted bread, placed butter on the bread, placed the buttered bread on a platter and placed the platter on the table. Clients #1, #2, #3, #4, #5, #6, #7 and #8 ate their morning meal of scrambled eggs, oatmeal, toast with margarine and jelly. The clients were not prompted to butter their own bread and/or provided table knives to butter their bread themselves.</p> <p>Interview with staff #4 at 7 AM on 2/20/13 indicated table knives were not used at meal times and the sharp knives were locked in the closet. When asked why, staff #4 stated, "We just always have."</p> <p>Interview with the RC (Residential Coordinator) and the PS (Program Specialist) on 2/20/13 at 2:45 PM indicated table knives could and should be used when appropriate.</p> <p>9-3-8(a)</p>		<p>same deficient practice.</p> <ul style="list-style-type: none"> · Regular meal observations will be completed by the RC and/or the Site Manager for the home to ensure that the table is set properly. · Staff will be trained on ensuring that the table is set properly including knives to be utilized during the meal. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Regular meal observations will be completed by the RC and/or the Site Manager for the home to ensure that the table is set properly. · Staff will be trained on ensuring that the table is set properly including knives to be utilized during the meal. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. 		

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			<ul style="list-style-type: none"> · The RC will monitor as they complete their audits. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10 th , 2013</p>		

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W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure all clients were supervised and/or redirected to take appropriate bites, use utensils and/or eat in a manner consistent with their skills. The facility failed to ensure the clients participated in their meal preparation and packed their own lunch boxes.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/19/13 between 3:45 PM and 6:15 PM. The evening meal consisted of tuna noodle casserole, cooked broccoli, bread with margarine and pineapple. Clients #1, #2, #3, #6, #7 and #8 did not assist with the preparation of the evening meal. Staff #3 pureed client #3's food and set it on the table for client #3. As soon as client #3's food was on her plate, client #3 began taking large bites of food and eating at a fast pace. The staff did not supervise and/or redirect client #3 to take smaller bites and/or to slow her pace of eating. Client #2 had not finished eating his meal and got up from the table and</p>	W000488	<p>W 488 Dining Areas and Services</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Client's #1-#8 will be placed on programming for them to assist with packing their lunches for day program. · Client's #1-#8 will be placed on programming to participate in family style dining. · Staff will be retrained on the importance of ensuring family style dining and proper supervision of the client's needs during the meal. · Staff will be retrained on the client's dining plans and choking risk plans. · Client's #1-8 will be placed on programming to assist with the meal preparation. 	04/10/2013			

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	<p>returned to his bedroom.</p> <p>Observations were conducted at the group home on 2/20/13 between 5:35 AM and 8:05 AM. At 5:35 AM, the dining room table was set for the morning meal. Staff #4 indicated the staff had set the table prior to the clients getting up. At 5:50 AM staff #1 arrived and began the morning meal. The morning meal consisted of scrambled eggs, oatmeal and toast with juice and milk. Client #1 made the toast. Staff #1 pureed client #3's food and set it on the table. Clients #2, #3, #5, #6, #7 and #8 did not assist with the preparation of the morning meal. During the meal, client #3 was observed taking large bites and eating at a fast pace. The staff did not supervise and/or redirect client #3 to take smaller bites and/or to slow her pace of eating. When not supervised, client #8 ate her scrambled eggs with her fingers. Client #2 did not finish his breakfast and got up from the table and returned to his bedroom.</p> <p>Interview with staff #4 on 2/20/13 at 7:10 indicated clients #4 and #5 were not woken up until breakfast was made and on the table. Staff #4 stated "because they [clients #4 and #5] won't leave anything alone and will eat anything that is sitting out, so we just leave them in bed because there's just not enough of us to handle it."</p>		<p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Staff will be retrained on the importance of ensuring family style dining and proper supervision of the client's needs during the meal. · Staff will be retrained on the client's dining plans and choking risk plans. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Staff will be retrained on the importance of ensuring family style dining and proper 				

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	<p>Staff #4 indicated clients #1, #2, #3, #5, #6, #7 and #8 could not prepare a meal independently.</p> <p>Client #1's record was reviewed on 2/25/13 at 11:00 AM. Client #1's undated IPOP (Individual Plan of Protective Oversight) indicated client #1 required assistance with meal preparation.</p> <p>Client #2's record was reviewed on 2/21/13 at 11:30 AM. Client #2's ISP of 2/14/12 indicated client #2 could feed himself, but staff had to physically assist him in order for him to eat his meals with utensils; otherwise he would leave the table without eating.</p> <p>Client #3's record was reviewed on 2/21/13 at 2 PM. Client #3's IPOP of 9/17/12 indicated client #3 required verbal prompts to not overload her utensils. Client #3's dining plan of 10/2007 indicated client #3 used smaller size utensils and was at risk of choking.</p> <p>Client #8's record was reviewed on 2/25/13 at 12:30 PM. Client #8's Dining Plan of 11/8/10 indicated the staff needed to sit next to client #8 on her right side while she was eating a meal. "Staff assists her with scooping food up onto her utensils with hand over hand assistance. Once the food is on her utensil, she is able</p>		<p>supervision of the client's needs during the meal.</p> <ul style="list-style-type: none"> · Staff will be retrained on the client's dining plans and choking risk plans. · The RC will monitor the residents programming and behavior needs on a regular basis. As their needs change or new concerns are identified, changes will be reflected in their programming, assessments, ISP and behavior plan. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · The Site Manager will monitor on a daily basis when they are in the home. · The RC will monitor as they complete their audits. · The ARC will monitor as they complete their audits. <p>5. What is the date by which the systemic changes will be completed?</p> <p>April 10 th , 2013</p>				

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	<p>to take the food to her mouth." The plan indicated client #8 likes to eat with her hands, "unless staff is there to prompt her to stop and to assist her with using her utensils."</p> <p>Interview with the RC and the PS (Program Specialist) on 2/20/13 at 2:45 PM indicated the clients were to be involved with the preparation of the meals and the staff were to provide the clients supervision and assistance while eating. The RC indicated client #3 was to be prompted to take smaller bites and to slow her pace of eating. The RC indicated clients #1, #2, #3, #5, #6, #7 and #8 could not prepare a meal independently.</p> <p>9-3-8(a)</p>				