

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/06/2014
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374
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W000000	<p>This visit was for the post-certification revisit (PCR) survey to the predetermined full recertification and state licensure survey and to the investigation of complaint #IN00154234 completed on 9/22/14.</p> <p>Complaint #IN00154234: Not corrected.</p> <p>Dates of Survey: November 5 and 6, 2014.</p> <p>Facility Number: 000904 Provider Number: 15G390 AIMS Number: 100233320</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/21/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients</p>	W000104	<p>Correctiveactionforresident(s)foun dtohavebeenaffected All repairs have been corrected. GHM has witnessed the repairs have</p>	12/05/2014

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

TITLE

(X6) DATE

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

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	<p>(E, F and G), the governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of client to client abuse were thoroughly investigated for client A and to ensure the facility was maintained and in good repair for clients A, B, C, D, E, F and G.</p> <p>Findings include:</p> <p>1. Observations were conducted at the facility (client A's, B's, C's, D's, E's, F's and G's home) on 11/5/14 between 4 PM and 6 PM. The bathroom next to the staff office was observed to have:</p> <p>___ Black, broken and crumbling plaster with a large piece of plaster missing between the shower and sink along the bottom of the wall.</p> <p>___ The shower curtain rod was rusted and the curtain was stuck in an open position and difficult to move and/or slide into a closed position for showering.</p> <p>___ The metal strip along the front edge of the shower was black and rusted.</p> <p>Interview with the RM (Residential Manager) on 11/5/14 at 6 PM indicated the facility maintenance staff had been in the home and had repaired the bathroom after the recertification survey on 9/22/14. After going into the bathroom the RM indicated she was not aware the</p>		<p>been completed.</p> <p>Shower and water temperature haven been corrected. Bader Mechanical tested water for 3 weeks and it is under 109 degrees. GHM will continue to monitor water temperatures monthly by reviewing staff's documentation and through environmental quality checks completed by a manager each month.</p> <p>How facility will identify other residents potentially affected and what measures taken</p> <p>All residents could be affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure recurrence</p> <p>The GHM will submit all maintenance requests to the AWS/Benchmark maintenance department and will copy the RD. The maintenance department will document on each request the date they fulfilled the maintenance request and will turn a copy back in to the GHM.</p> <p>Monthly a member of the management team conduct an environmental quality check (CQA) and turn it into the RD for tracking and compliance. If any deficiencies are noted, the manager will notify the GHM to turn in a maintenance request. All managers will be retrained on this.</p> <p>How corrective actions will be monitored to ensure recurrence</p>		

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W000154	<p>repairs had not been done and indicated she would contact the maintenance staff. The RM indicated the clients' home was to be maintained at all times.</p> <p>During interview with the maintenance staff on 11/6/14 at 11 AM, the maintenance staff stated, "I fixed the veneer around the sink earlier but overlooked the other repairs on the request. I will have these repairs done today."</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure a thorough investigation was conducted for client A. Please see W154.</p> <p>This federal tag relates to complaint #IN00154234.</p> <p>This deficiency was cited on 9/22/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly</p>		<p>The GHM will submit all maintenance requests to the AWS/Benchmark maintenance department and will copy the RD. The maintenance department will document on each request the date they fulfilled the maintenance request and will turn a copy back in to the GHM.</p> <p>Monthly a member of the management team conduct an environmental quality check (CQA) and turn it into the RD for tracking and compliance. If any deficiencies are noted, the manager will notify the GHM to turn in a maintenance request. All managers will be retrained on this.</p>				

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	<p>investigated.</p> <p>Based on record review and interview for 1 of 4 allegations of client to client abuse, the facility failed to ensure a thorough investigation was conducted for client A.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 11/6/14 at 11 AM. The 9/26/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 9/26/14 at 3 PM while at the workshop "[Client A] reported to staff that she was shoved by [name of peer] and fell to the ground landing on her back."</p> <p>The Investigative Report - Summary dated 9/30/14 indicated the incident was not observed by staff. The Report indicated interviews with two workshop staff, client A and with client A's peer that client A alleged had shoved her and knocked her down. The Summary indicated no further client and/or staff interviews. The investigative paperwork indicated no staff statements and/or the documentation of the content of the interviews conducted.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional), the RM (Residential</p>	W000154	<p>Correctiveactionforresident(s)fou dthavebeenaffected Workshop is responsible forconducting investigations when incidents occur during day hours. The PC from the workshop will send thecompleted investigation to the Regional Director for tracking. The RD will then send a copy to the AssistantDirector of GH to place in the investigations binder. The RD will email the PCfrom workshop whenever an incident is reported that requires an investigationas a reminder to send the completed investigation to the RD upon completion. That email will be placed in the investigationsbinder until the RD has received the completed investigation.</p> <p>Howfacilitywillidentifyotherreside ntspotentiallyaffectedandwhatmea surestaken All residentsare affected and correctiveaction will address theneeds of all clients.</p> <p>Measuresorsystemicchangesfacility putinplacetoensurenorecurrence The RD will email the PCfrom workshop whenever an incident is reported that requires an investigationas a reminder to send the completed investigation to the RD uponcompletion. That email will be placed inthe investigations binder until the RD has received the completedinvestigation.</p>	12/05/2014

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W000210	<p>Manager) and the AD (Assistant Director) on 11/6/14 at 5 PM, the RM indicated all incidents that happen at the workshop are investigated by director of the workshop. The RM stated, "That's all they (the workshop) gave us." When asked if this is evidence of a thorough investigation, the AD stated, "No." The AD indicated the investigative paperwork was to include all documentation of staff statements and the content of the interviews. The AD stated all staff and clients in the area "should be interviewed" and documentation of the interviews and staff statements "should be" included in the investigative paperwork.</p> <p>This federal tag relates to complaint #IN00154234.</p> <p>This deficiency was cited on 9/22/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate</p>		<p>The PC will complete the investigation within 5 days and will turn it in to their director. The director will review and sign and send to the VP for review. The VP will then sign and send it to the corporate Director of Compliance for review. Once all signatures are obtained, a copy will be sent to the PC and the Regional Director. That signed copy will be placed in the investigations binder.</p> <p>How corrective actions will be monitored to ensure no recurrence The RD will email the PC from workshop whenever an incident is reported that requires an investigation as a reminder to send the completed investigation to the RD upon completion. That email will be placed in the investigations binder until the RD has received the completed investigation.</p> <p>The PC will complete the investigation within 5 days and will turn it in to their director. The director will review and sign and send to the VP for review. The VP will then sign and send it to the corporate Director of Compliance for review. Once all signatures are obtained, a copy will be sent to the PC and the Regional Director. That signed copy will be placed in the investigations binder.</p>		

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	<p>assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (A) and 1 additional client G, the facility failed:</p> <p>__ To ensure the IDT (Interdisciplinary Team) assessed/reassessed client A's repeated refusals to take her prescribed medications and/or to comply with medical requests.</p> <p>__ To ensure client G's Comprehensive Functional Assessments (CFAs) included an assessment of the client G's fine and gross motor skills and/or a PT/OT (Physical Therapy/Occupational Therapy) assessment and to ensure client G's dining needs were assessed.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 11/6/14 at 2 PM. Client A's Medication Refusal Reports (MRRs) indicated: On 11/11/13 client A refused her 4 PM meds: Divalproex Sodium 500 mg and Gabapentin 200 mg. The report indicated "Just refused meds and told staff 'No'."</p> <p>On 11/12/13 at 10:20 AM client A refused to go to her dental appointment.</p>	W000210	<p>Corrective action for resident(s) found to have beenaffected Staff have beenretrained that all med errors will be reported to nurse immediately. Anyclient who refuses 3 medications within a 24 hour period will be taken to ERfor evaluation. All clients have received needed referrals for PT/OT per IDT orphysician recommendations. These PT/OT referrals and assessments have beencompleted and are on file. Client B hasreceived doctors' order for wrist weights. Food choppers have been placed in thehome for cutting food. Dining plans have been revised to state "Clients will besupervised and within eyesight at all times while eating". Risk and dining plans have been updated andstaff have been trained.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken All residentsare affected and correctiveaction will address theneeds of all clients.</p> <p>Measures or systemic changes facility put in place toensure no recurrence A new LPN has beenhired and a new QIDP-d and a new Assistant Director positions have beencreated. These new staff will assist intracking all required documentation. The IDT met andimplemented for</p>	12/05/2014
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	<p>On 11/12/13 client A refused her 4 PM meds: Divalproex Sodium 500 mg and Gabapentin 200 mg. The report indicated "Client was very upset and refused meds."</p> <p>On 12/27/13 client A refused her 4 PM meds: Divalproex Sodium 500 mg and Gabapentin 200 mg. The report indicated "Staff asked her 3x (three times) over the period of 4 PM and 5 PM for meds and was cursed at. Staff notified nurse [client A] never wanted to take them." The nurse instructed the staff to "Just wait and see if she takes them and fill out a refusal."</p> <p>On 1/19/14 client A refused her 7 AM medications: Bupropion and Sertraline for depression, Calcium with Vitamin D, Divalproex Sodium, Gabapentin, Seroquel (an antipsychotic), Hydrochlorothiazide (a diuretic), a Multi Vitamin and Zovia (for menses regulation). The report indicated "Staff knocked on [client A's] door, she (client A) refused meds. Staff waited 20 minutes. She (client A) refused again. Staff waited another 20 minutes and she (client A) told</p>		<p>any client refusing medications 3 times within 24 hours to besent to ER for evaluation. The IDT feltthat chronically refusing medications is a behavioral concern and being sent tothe ER will be a deterrent for that concern. The physician is notified every time a medication is refused. The physician was consulted about the newprotocol of sending a client to the ER after 3 medication refusals within 24hours and was in agreement for that course of action as a behavioraldeterrent.</p> <p>How corrective actions will be monitored to ensure norecurrence The QIPD-d willcomplete monthly file audits and turn then into the Q, the AD, and the RD. The Q and the AD will ensure any missingdocumentation is completed and filed within 10 days. The Q and AD will fill out the action planand return it to the RD once completed.</p>		

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	<p>staff to 'leave me alone'."</p> <p>On 2/5/14 client A refused her 7 AM medications: Bupropion, Sertraline, Calcium with Vitamin D, Divalproex Sodium, Gabapentin, Hydrochlorothiazide, Seroquel, Multi Vitamin, Zovia and Prevident 5000 Sensitive tooth paste. The report indicated "Ask (sic) 3x's (three times) at different times to take her meds and she (client A) wouldn't even talk to staff. She (client A) shook her head no and that was it."</p> <p>On 2/12/14 client A refused all of her 7 AM medications: Bupropion, Sertraline, Calcium with Vitamin D, Divalproex Sodium, Gabapentin, Hydrochlorothiazide, Seroquel, Multi Vitamin and Zovia. The report indicated "Staff asked her to come take her meds then she slapped them and cussed them out."</p> <p>On 6/9/14 client A refused to take her 4 PM Divalproex Sodium 500 mg tab and two Gabapentin 100 mg caps. The report indicated "She just keeps saying will not take drs (doctors) orders."</p>						

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	<p>On 6/12/14 client A refused her 8 PM Crest Pro Health mouth wash.</p> <p>On 6/13/14 client A refused her 8 PM Crest Pro Health mouth wash.</p> <p>On 6/29/14 client A refused her 8 AM medications of Bupropion and Sertraline for depression, Calcium, Divalproex Sodium, Gabapentin, Hydrochlorothiazide, Seroquel, Multi Vitamin and Zovia. The report indicated "Kept saying no, refusing to get out of bed, saying 'Shut up'."</p> <p>On 6/30/14 fax "Please be advised [client A] refused all morning meds on 6/30/14."</p> <p>On 8/16/14 client A refused her 4 PM meds: Divalproex Sodium 500 mg and Gabapentin 200 mg. The report indicated "I (the staff) asked her to please take her meds 5x she kept telling me (the staff) NO!"</p> <p>On 9/10/14 client A refused all of her 8 AM medications of Bupropion and Sertraline for depression, Calcium, Divalproex Sodium, Gabapentin, Hydrochlorothiazide, Seroquel, Multi Vitamin and</p>						

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	<p>Zovia.</p> <p>Client A's Monthly Health Reviews for 2014/2013 indicated: On 12/9/13 refused to see optometrist. On 8/1/14 client A refused AM meds and labs ordered by her PCP. On 8/10/14 client A refused 7 AM meds. On 8/14/14 client A refused her 8 PM mouthwash. 10/30/14 client A refused to have her blood drawn for lab work.</p> <p>Client A's updated 10/28/14 BSP (Behavior Support Plan) indicated client A had a targeted behavior of "Refusals: Refusing to complete chores, refusing available work, not following directions given by parents or supervisors." Client A's BSP did not include refusals of medications, labs and/or refusals to comply with medical requests.</p> <p>Client A's ISP of 10/1/14 and client A's Updated Risk Summary dated 9/17/14 did not include refusals of medications, treatments and/or refusals of medical requests and what the staff were to do when the client refused.</p> <p>Client A's record indicated no IDT (Interdisciplinary Team) meetings in regard to client A's refusals of medications and medical requests.</p>			
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	<p>Interview with staff #2 on 11/5/14 at 6 PM indicated client A continues to refuse her medications. Staff #2 indicated there was no specific plan in regard to client A's refusals of medications. Staff #2 stated, "We just ask her a couple of times to take it (medications) and if she doesn't we can't force her."</p> <p>During interview with the facility's LPN and the QIDP (Qualified Intellectual Disabilities Professional) on 11/6/14 at 4 PM, the QIDP indicated client A's ISP/BSP did not address client A's refusals of medication and/or medical requests. The LPN and the QIDP indicated no IDT (Interdisciplinary Team) meetings to assess and/or reassess client A in regard to client A's refusals of medications and medical requests. The QIDP and the LPN indicated no changes and/or assessments were made by the IDT in regard to client A's plan of care since the recertification survey on 9/22/14.</p> <p>2. Observations were conducted at the group home on 11/5/14 between 4 PM and 6 PM. During this observation period, the following was observed: Client G was short in stature, ambulated with a slow unsteady gait and would stand for long periods in</p>			
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	<p>the same place, wringing her hands and watching the activities in the room.</p> <p>Client G was served a hamburger, broccoli, tater tots and pineapple for her evening meal.</p> <p>Client G used a clothing protector and a divided plate while eating her evening meal.</p> <p>The staff cut client G's food for her with a pair of scissors.</p> <p>Client G had hand tremors while eating.</p> <p>Client G did not use wrist weights while eating her evening meal.</p> <p>Client G's record was reviewed on 11/6/14 at 3 PM. Client G's CFA (Comprehensive Functional Assessment) dated 2014 failed to include an assessment of client G's fine and gross motor skills. Client G's record indicated no assessment from PT/OT.</p> <p>Client G's dining plan dated 9/18/14 indicated client G "May use wrist weights as needed to help with shaking while eating." Client G's record indicated no assessment of client G's dining needs and/or adaptive equipment needed while dining.</p> <p>During interview with staff #1 and #2 on 11/5/14 at 5:50 PM, staff #1 stated, "A few days ago someone left wrist weights</p>			

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	<p>in the staff office on the desk with a note attached to them that said they were to be used for [client G] while eating." Staff #1 and #2 indicated they did not know how they were supposed to use the wrist weights and staff #1 stated, "They look really awkward and I don't see how anyone could eat with them on."</p> <p>During interview with the RM (Residential Manager) on 11/5/14 at 5:45 PM the RM indicated client G was not able to independently cut her own food. When asked if client G had ever been assessed for the use of a rocker knife the RM indicated she did not know what a rocker knife was. The RM stated, "To my knowledge" client G had not had an assessment of her dining needs.</p> <p>During interview with the QIDP on 11/5/14 at 6:15 PM, the QIDP indicated the wrist weights that were provided for client G were exercise weights and she wasn't sure how client G would wear and/or use the weights while eating. The QIDP indicated she was not aware the LPN had purchased the wrist weights and had provided them to the staff to use while client G was dining.</p> <p>During interview with the QIDP, the facility's LPN and the AD (Assistant Director) on 11/6/14 at 4 PM, the LPN</p>			

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W000227	<p>indicated she had asked client G's physician for an order for client G to have a PT/OT assessment and client G's physician indicated a PT/OT assessment was not necessary. The LPN indicated she then purchased a set of exercise wrist weights and took them to the facility for the staff to use while client G was eating. The QIDP indicated the facility's assessment form that was currently being used to complete the comprehensive assessments did not include an assessment of fine and gross motor skills. The AD indicated she had contacted client G's physician and a PT/OT assessment was ordered and client G would be assessed/reassessed for her ambulatory and dining needs.</p> <p>This federal tag relates to complaint #IN00154234.</p> <p>This deficiency was cited on 9/22/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the</p>						

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	<p>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 2 of 4 sampled clients (B and D) and 3 additional clients (E, F and G), the clients' Individual Support Plans (ISPs) failed to address the clients' identified training needs in regards to the use of a knife to cut their food.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/5/14 between 4 PM and 6 PM. During this observation period, the following was observed: Clients B, D, E, F and G were served their evening meal of a hamburger, bread, broccoli, tater tots and pineapple for their evening meal.</p> <p>Client B's and D's hamburger was ground in a food processor by the staff.</p> <p>Once the food was on the clients' plates the staff cut client B's, D's, E's, F's and G's food into small pieces with a pair of scissors.</p> <p>Client B's record was reviewed on 11/6/14 at 1:30 PM. Client B's ISP dated 10/1/14 indicated no objectives to assist client B with the use of a knife to cut her food.</p>	W000227	<p>Corrective action for resident(s) found to have beenaffected It will be placed in therevised ISP that client will use a chopper and rolling cutter to cut their ownfood. The chopper and the cutter hasbeen trained on by the Dietician. Theseitems will be secured in the lock box that will be kept in the kitchen. A picture board will be available to clientsto point to the picture if they want a particular item.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken All residentsare affected and correctiveaction will address theneeds of all clients.</p> <p>Measures or systemic changes facility put in place toensure no recurrence A chopper andplastic pizza cutter have been purchased and the staff have been trained.</p> <p>How corrective actions will be monitored to ensure norecurrence A member ofmanagement will be conduct observations in the home at least weekly during mealtimes to ensure clients are given active treatment and encouraged to cut theirrown food. The dietician visits at leastquarterly to ensure compliance.</p>	12/05/2014

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	<p>Client D's record was reviewed on 11/6/14 at 2:30 PM. Client D's ISP dated 10/1/14 indicated no objectives to assist client D with the use of a knife to cut her food.</p> <p>Client E's record was reviewed on 11/6/14 at 3:30 PM. Client E's ISP dated 10/1/14 indicated no objectives to assist client E with the use of a knife to cut her food.</p> <p>Client F's record was reviewed on 11/6/14 at 3:30 PM. Client F's ISP dated 10/1/14 indicated no objectives to assist client F with the use of a knife to cut her food.</p> <p>Client G's record was reviewed on 11/6/14 at 3 PM. Client G's ISP dated 10/1/14 indicated no objectives to assist client G with the use of a knife to cut her food.</p> <p>During interview with the RM (Residential Manager) on 11/5/14 at 5:45 PM, the RM indicated clients B, D, E, F and G were not able to independently cut their own food and stated it was "just easier" for the staff to use scissiors to cut their food for them.</p> <p>During interview with staff #1 and #2 on</p>			

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W000240	<p>11/5/14 at 5:50 PM, staff #1 and #2 indicated clients B, D, E, F and G were unable to use a knife independently to cut their food and staff #2 stated "We just use the scissors and cut their food up for them."</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 11/5/14 at 6:15 PM, the QIDP indicated clients B, D, E, F and G were not able to use a knife independently and their ISPs did not include objectives to assist the clients with the use of a knife to cut their food.</p> <p>9-3-4(a)</p> <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 3 sampled clients (A and C), __ Client A's ISP/BSP (Individual Support Plan/Behavior Support Plan) failed to address what the staff were to do when client A refused medications and/or refused to comply with medical requests. __ Client C's ISP/BSP failed to address how the staff were to supervise/monitor</p>	W000240	<p>Corrective action for resident(s) found to have beenaffected The risk plan for client A have been updated on what to do if client refuses medications. Client C's risk plan has been updated to state that staff will use arm and arm assistance while loading and unloading van, on uneven ground and while showering. The LPN has contacted the PT to inquire about additional adaptive equipment since client C</p>	12/05/2014

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	<p>and assist client C throughout the day to prevent further injury from falls and how the staff were to supervise and monitor client C due to seizure activity.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 11/6/14 at 2 PM. Client A's Medication Refusal Reports (MRRs) indicated: On 9/13/13 at 4 PM client A refused her 4 PM meds (medications): Divalproex Sodium 500 mg (milligram) for mood stabilization, Gabapentin 200 mg for Schizoaffective Disorder and Fexofenadine HCL 180 mg for allergies. The report indicated client A was upset about not getting to have orange juice and went to her room and wrote. "She refused multiple times for multiple staff."</p> <p>On 9/30/13 client A refused her 4 PM meds: Divalproex Sodium 500 mg and Gabapentin 200 mg. The report indicated "Asked 4 times and other staff tried to talk to her also but she would not take them."</p> <p>On 11/11/13 client A refused her 4 PM meds: Divalproex Sodium 500</p>		<p>refuses wear a helmet or leg braces.</p> <p>How facility will identify other residents potentially affected and what measures taken All residents are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure recurrence Risk plans have been updated. An AD has been hired to ensure compliance in risk plans, BSPs, ISPs, and PCPs and these will be reviewed and discussed quarterly.</p> <p>How corrective actions will be monitored to ensure recurrence The quarterly meeting checklist will be filled out and turned into the RD within 24 hours after each meeting. This will ensure all plans are being reviewed at each quarterly meeting and updated as necessary.</p>		

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	<p>mg and Gabapentin 200 mg. The report indicated "Just refused meds and told staff 'No'."</p> <p>On 11/12/13 at 10:20 AM client A refused to go to her dental appointment.</p> <p>On 11/12/13 client A refused her 4 PM meds: Divalproex Sodium 500 mg and Gabapentin 200 mg. The report indicated "Client was very upset and refused meds."</p> <p>On 12/27/13 client A refused her 4 PM meds: Divalproex Sodium 500 mg and Gabapentin 200 mg. The report indicated "Staff asked her 3x (three times) over the period of 4 PM and 5 PM for meds and was cursed at. Staff notified nurse [client A] never wanted to take them." The nurse instructed the staff to "Just wait and see if she takes them and fill out a refusal."</p> <p>On 1/19/14 client A refused her 7 AM medications: Bupropion and Sertraline for depression, Calcium with Vitamin D, Divalproex Sodium, Gabapentin, Seroquel (an antipsychotic), Hydrochlorothiazide (a diuretic), a Multi Vitamin and Zovia (for</p>			

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	<p>menses regulation). The report indicated "Staff knocked on [client A's] door, she (client A) refused meds. Staff waited 20 minutes. She (client A) refused again. Staff waited another 20 minutes and she (client A) told staff to 'leave me alone'."</p> <p>On 2/5/14 client A refused her 7 AM medications: Bupropion, Sertraline, Calcium with Vitamin D, Divalproex Sodium, Gabapentin, Hydrochlorothiazide, Seroquel, Multi Vitamin, Zovia and Prevident 5000 Sensitive tooth paste. The report indicated "Ask (sic) 3x's (three times) at different times to take her meds and she (client A) wouldn't even talk to staff. She (client A) shook her head no and that was it."</p> <p>On 2/12/14 client A refused all of her 7 AM medications: Bupropion, Sertraline, Calcium with Vitamin D, Divalproex Sodium, Gabapentin, Hydrochlorothiazide, Seroquel, Multi Vitamin and Zovia. The report indicated "Staff asked her to come take her meds then she slapped them and cussed them out."</p>			

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	<p>On 6/9/14 client A refused to take her 4 PM Divalproex Sodium 500 mg tab and two Gabapentin 100 mg caps. The report indicated "She just keeps saying will not take drs (doctors) orders."</p> <p>On 6/12/14 client A refused her 8 PM Crest Pro Health mouth wash.</p> <p>On 6/13/14 client A refused her 8 PM Crest Pro Health mouth wash.</p> <p>On 6/29/14 client A refused her 8 AM medications of Bupropion and Sertraline for depression, Calcium, Divalproex Sodium, Gabapentin, Hydrochlorothiazide, Seroquel, Multi Vitamin and Zovia. The report indicated "Kept saying no, refusing to get out of bed, saying 'Shut up'."</p> <p>On 6/30/14 fax "Please be advised [client A] refused all morning meds on 6/29/14."</p> <p>On 8/16/14 client A refused her 4 PM meds: Divalproex Sodium 500 mg and Gabapentin 200 mg. The report indicated "I (the staff) asked her to please take her meds 5x (five times) she kept telling me (the staff) NO!"</p>						

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	<p>On 9/10/14 client A refused all of her 8 AM medications of Bupropion and Sertraline for depression, Calcium, Divalproex Sodium, Gabapentin, Hydrochlorothiazide, Seroquel, Multi Vitamin and Zovia.</p> <p>Client A's Monthly Health Reviews for 2014/2013 indicated: On 12/9/13 refused to see optometrist. On 8/1/14 client A refused AM meds and labs ordered by her PCP. On 8/10/14 client A refused 7 AM meds. On 8/14/14 client A refused her 8 PM mouthwash. 10/30/14 client A refused to have her blood drawn for lab work.</p> <p>Client A's updated 10/28/14 BSP indicated client A had a targeted behavior of "Refusals: Refusing to complete chores, refusing available work, not following directions given by parents or supervisors." Client A's BSP did not include refusals of medications, labs and/or refusals to comply with medical requests.</p> <p>Client A's ISP of 10/1/14 and client A's Updated Risk Summary dated 9/17/14 did not include refusals of medications, treatments and/or refusals of medical</p>			

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	<p>requests and what the staff were to do when the client refused.</p> <p>Interview with staff #2 on 11/5/14 at 6 PM indicated client A continues to refuse her medications. Staff #2 indicated there was no specific plan in regard to client A's refusals of medications. Staff #2 stated, "We just ask her a couple of times to take it (medications) and if she doesn't we can't force her."</p> <p>During interview with the facility's LPN and the QIDP (Qualified Intellectual Disabilities Professional) on 11/6/14 at 4 PM, the QIDP indicated client A's ISP/BSP did not address client A's refusals of medication and/or medical requests. When asked what the staff were to do wen client A refuses the LPN indicated client A's physician would be notified via a fax and the staff were to encourage the client to comply. The QIDP indicated no IDT (Interdisciplinary Team) meetings in regard to client A's refusals of medications and medical requests and no changes were made in client A's plan of care since the recertification survey on 9/22/14.</p> <p>2. Observations were conducted at the workshop on 11/6/14 between 11:30 AM and 11:45 AM. During this observation period client C wore a brace on her left</p>			

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	<p>lower leg and walked with a forward lean and an unsteady gait.</p> <p>Client C's record was reviewed on 11/6/14 at 1 PM. Client C's record indicated diagnoses of, but not limited to, Seizure Disorder and Cerebral Palsy (a disorder of posture, muscle tone and movement resulting from brain damage).</p> <p>Client C's Seizure Reports indicated: On 5/3/14 at 4:34 PM client C was helping to set the table and "got stiff and began to pee her pants." On 5/29/14 at 6 PM client C "yelped, peed on the floor after grabbing her crotch and said she was okay." On 6/2/14 at 5:10 PM client C "Yelped, grabbed her crotch, pee'd (sic) and took off for the bathroom." On 6/9/14 at 4:30 PM client C "Yelped, shook, pee'd (sic) herself and took off for the bathroom holding her crotch." On 6/15/14 at 5:47 PM client C "Was at the dinner table eating her dinner and talking to staff. Client (C) let out a yelp or cry, then her whole body stiffened, eyes got big and she was holding her private area, because she started peeing." On 6/16/14 at 7:51 PM client C "Yelped, grabbed crotch and wet on the couch and immediately got up to</p>			

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	<p>go change her clothes."</p> <p>On 6/17/14 at 6:17 PM client C "Yelped, shook, pee'd (sic) on the floor and started saying she's sorry."</p> <p>On 6/22/14 at 5:25 PM client C "Yelled out, whole body stiffened and she grabbed her private area because she wet herself."</p> <p>On 6/28/14 at 4:10 PM client C "yelled, her body stiffened at first then started shaking. Client was also holding her private area but didn't pee."</p> <p>On 7/1/14 at 5:30 PM client C "started shaking and her head was shaking and [client C] kept saying I'm sorry and her body shook and was shaking."</p> <p>On 7/6/14 5:31 PM client C was eating her dinner and "grown (sic) and chew her food. Kept eaten her dinner (sic)."</p> <p>On 8/16/14 at 6:50 PM client C was sitting in a chair and "said a few words, wet herself and shook."</p> <p>On 9/29/14 at 8 PM client C had a seizure lasting 5 seconds. The report indicated client C "Yelped, grabbed herself and pee'd on herself."</p> <p>Client C's Post Fall Assessment forms indicated</p> <p>On 11/8/13 at 11:55 AM while at the DP</p>						

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	<p>client C was walking up the sidewalk incline to the DP and she tripped on her feet and fell. The assessment indicated actions to prevent future falls "Direct client to point toes forward and plant feet before attempting to walk."</p> <p>On 11/17/13 at 7:50 AM client C was "walking to the bathroom to get some water to take her pills when she leaned into a chair and fell on her butt." The assessment indicated actions to prevent future falls "Try to make sure she is walking okay to the whatever it is she's going and maybe keep an eye on her more when walking around without her shoes."</p> <p>On 6/2/14 at 8:20 AM client C rode to the DP (Day Program) on the house bus, exited the bus and was walking up a slight incline to enter the DP and fell.</p> <p>On 7/5/14 at 12:50 PM client C was going down some steps and was holding onto the railing. "After taking a step and having both feet on a step she lost her balance a feel but still had her right hand on the railing (sic)." The Assessment indicated client C was wearing a brace on her left ankle and indicated immediate actions to</p>			

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	<p>prevent future falls "Walk in front of client and have someone walk behind."</p> <p>On 7/13/14 at 5:45 PM client C was at the group home in the living room and was arguing with a peer. When the peer went to hit client C, client C took a step back and lost her balance, fell and knocked over a lamp.</p> <p>On 8/18/14 at 1:30 PM client C was walking to the break room at the DP and fell.</p> <p>Client C's nursing notes indicated 5/3/14 "Received report of seizure in which client had seizure activity while assisting with prepping meal. Client had urinary incontinence but was able to change her clothes with assist of staff. No injury to report."</p> <p>5/20/14 "Received report of injury form from 5/16 (5/16/14) in which it is reported that client fell out of her seat in the van when coming home from group home outing. Per report no treatment was needed."</p> <p>5/24/14 "Received report of seizure. Per report client was having dinner with roommates. She was joking around with peer and then grabbed herself and was incont</p>			

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	<p>(incontinent) of urine. Per report, client stated she wanted to go home but did was oriented to self and did no show signs of confusion (sic)."</p> <p>5/28/14 client C's doctor "is aware that client did not have her Divalproex 25 mg tab at 1 PM on this day."</p> <p>6/2/14 "Received post fall assessment form in which it is reported that client fell walking up a slight incline into the main center building. No reports of injury noted."</p> <p>6/3/14 Reviewed report of seizure on 6/2/14 in which it is reported that client had 5 seconds of seizure activity during evening meal. Client ran to bathroom when activity ceased, no reports of injury noted."</p> <p>6/10/14 Reviewed report of seizure dated 6/9/14 in which it is reported that client had 10 seconds of seizure activity with incontinence. Client has no reports of injury with this incident."</p> <p>6/14/14 "Received report of seizure activity from 6/15/14. Client noted to have 15-20 seconds of activity. Client had episodes of incontinence during activity."</p> <p>7/1/14 "Report of seizure form received. Approx (approximately) 30</p>			

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	<p>second duration. No injury reported. Client (C) seen by [name of neurologist] on this date. New orders obtained to begin increase of Onfi to 20 mg (milligrams) BID (twice a day)."</p> <p>7/2/14 "Received report of fall with no injury." "Received report of injury in which it is stated that client got out of her chair, hit her left leg and fell on buttocks. Client required no medical intervention related to this incident and has had no complaints of pain or other."</p> <p>7/5/14 "Received report of fall with no injury."</p> <p>7/9/14 "Received report of seizure form for seizure lasting 20 seconds with no injury to report."</p> <p>7/14/14 "Reviewed report of injury for this date in which it is stated that client landed on her bottom while attempting to get off of the van after declining assistance from staff. Client denies injury. No medical intervention was required related to this incident."</p> <p>7/20/14 "Received report of seizure for this date. Seizure lasted approx 1 minute per this report. Client was not injured and returned to her usual level of daily activities shortly after seizure ended."</p>			

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	<p>7/21/14 "Received report of fall on 7/13/14 in which it is reported that client fell and knocked over a lamp. Per staff she has a red area on her back."</p> <p>8/4/14 "Client (C) sent to [name of hospital] ER (Emergency Room) on this date in the early morning for fall in which she stuck (sic) her head and was bleeding. Client was treated in the ER where head lac (laceration) was sutured. She remained at home and was observed by staff per protocol with neuro checks."</p> <p>8/7/14 "Reviewed report of seizure dated 8/6/14. No injury to report."</p> <p>8/7/14 "Received to (sic) report of seizure on this date each lasting approx (approximately) 30 seconds. No injury to report."</p> <p>8/8/14 client C was seen in the ER to have sutures removed.</p> <p>8/13/14 client C's doctor signed order for client to have a PT (Physical Therapy) evaluation.</p> <p>8/12/14 "Received three reports of seizure on this client (C) for separate occasions on this date. Clients (sic) seizure each lasted less then (sic) one minute, no injuries have been reported."</p> <p>8/14/14 client C scheduled for PT evaluation and treatment.</p>			

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	<p>8/16/14 client C had a seizure lasting 15 seconds.</p> <p>8/19/14 "Rec'd (Received) a (sic) injury report stating that [client C] was walking in the break room at the workshop and lost her balance and fell landing on her right hip. Staff assisted her to here (sic) feet and she was assessed for injury. None noted."</p> <p>8/19/14 at 6:10 PM client C had a 30 second seizure. "Started to shake and was incontinent. No injury."</p> <p>8/19/14 at 7:45 PM client C had a seizure while sitting in a chair that lasted one minute. "Hand shaking and was incontinent. No injury."</p> <p>8/22/14 at 5:40 PM client C had a 30 second seizure while sitting at the dinner table. No injury.</p> <p>8/22/14 at 7:30 PM client C had a seizure while sitting on the couch. Client C was shaking all over and was incontinent of urine. No injury.</p> <p>8/23/14 at 6 PM client C had a 30 second seizure. No injury.</p> <p>8/24/14 at 6:27 PM client C had a 30 second seizure while getting off the facility van at church. "Body stiffened, got goose bumps and saying 'No' during seizure. Also incontinent of urine. No injury."</p> <p>10/22/14 "Staff reported got out of shower. Peed on the floor and had</p>						

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	<p>goose bumps."</p> <p>10/29/14 Staff noted seizure stating she looked up, face was red, body stiffened and urinated on self...."</p> <p>Client C's PT evaluation dated 8/26/14 indicated the report indicated client C was a middle aged female with CP who had recently had an increased incidence of falls as well as reports of declining posture which affected client C's balance and safety. The evaluation indicated client C wore a left AFO (ankle-foot-orthotic) and had an internal rotation of her left lower leg starting at the hip and had decreased strength "through left LE and flexion contracture (a shortening of muscle tissue and tendons, which forces a joint into a flexed position) of left UE (upper extremity)." The evaluation indicated client C had a severe forward lean with an "increased thoracic kyphosis (an excess curvature in the upper back causing a hump).... This patient would benefit from PT to address above issues to decreased likelihood of falls."</p> <p>__The PT evaluation did not indicate level of staff supervision and assistance client C required throughout the day when in and out of the home, when at work, when going up and down steps and/or getting on and off the facility van. The PT evaluation indicated no</p>			

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	<p>recommendations to address how the facility staff were to assist and monitor client C throughout the day to prevent further injury from falls.</p> <p>Client C's 11/5/14 Medical Appointment form indicated client C was seen by PT and "was provided balance training, strengthening of trunk and lower extremities, stair training and postural strengthening.</p> <p>Client C's Risk Summary dated 10/1/14 indicated client C had a history of falls and seizures. The summary indicated for falls: Pt (patient) requires guard assist if walking on uneven ground (grass). Independent on level ground. Staff are to prompt [client C] when walking to point toe forward. Staff are to check brace daily to be sure it is on properly. Staff will assist [client C] in doing home exercise program 5 days a week scheduled while at the center Monday thru Friday."</p> <p>The Risk Summary indicated for seizures the staff were to stay with client C, keep her safe, loosen her clothing if too tight, remove any hard objects and padding/pillow under her head, turn her</p>			

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	<p>to her side and not to put anything in her mouth.</p> <p>Client C's Risk Summary/Plan failed to indicate how the staff were to supervise, monitor and assist client C throughout the day while ambulating to prevent further injury from falls. The Risk Summary failed to indicate how the staff were to supervise and monitor client C throughout the day due to seizures including while in her bedroom and bathroom at home and at work.</p> <p>The facility's LPN and QIDP were interviewed on 11/6/14 at 4 PM. The LPN indicated the PT evaluation did not specify the level of supervision and/or assistance client C required while going up and down steps and/or while getting on and/or off the facility van.</p> <p>When asked how the staff were to supervise, monitor and assist client C throughout the day to ensure client C's safety in regard to falls and seizures, the LPN stated, "They're (the staff) to follow her (client C's) Risk Plans."</p> <p>The LPN indicated client C's Risk summary for falls and seizures did not indicate client C's level of</p>			

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W000249	<p>supervision and assistance throughout the day while at home, while at work, while showering and going to the bathroom, while going up and down stairs and/or while getting on and off the facility van. The QIDP stated, "I'm sure they (the staff) help her on and off the van."</p> <p>The LPN and the QIDP indicated no changes in client C's care and/or Risk Summary in regard to client C's history of increased falls, injury with falls and increased seizures since the recertification survey of 9/22/14.</p> <p>This deficiency was cited on 9/22/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and</p>	W000249	Corrective action for resident(s) found to have beenaffected	12/05/2014			

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	<p>record review for 1 of 4 sample clients (D) and 3 additional clients (E, F and G), the facility failed to ensure the staff implemented the clients' dining plans.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/5/14 between 4 PM and 6 PM. During this observation period:</p> <p>__The staff prepared hamburgers, buns, tater tots, broccoli and pineapple for the evening meal.</p> <p>__At 5 PM while clients A, B, D, E and G were sitting at the dining room table, staff #1 and #3 began placing the food on the table and serving the clients by passing the bowls of food between the staff and placing food on the clients' plates.</p> <p>__Clients D, E and G began eating as soon as food was placed on their plates, not waiting on the staff to finish serving the other clients and/or to cut up other clients' food.</p> <p>__At 5:10 PM staff #2 prompted client F to wash her hands and come to the dining room table. Staff #2 prepared client F's plate with a hamburger, a bun, tater tots and pineapple.</p> <p>__At 5:13 PM staff #2 sat down between clients E and F. Staff #2 prompted client E to slow her pace of eating.</p>		<p>The AD has placed arestriction in the BSP that if there are acute behavioral issues during mealtimes, clients can eat separately and not be required to participate in familystyle dining. Dining plans have been revised and now state that clients will bein eyesight of staff at all times while eating. Staff have been trained on the revised plans.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken All residents areaffected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place toensure no recurrence Staff were retrainedon family style dining by the LPN and the dietician. A chopper and a plastic pizza cutter have been purchased to facilitate clients cutting theirfood independently. Dining plans havebeen updated to reflect that clients should be within eyesight of staff at alltimes while eating. Also the BSP hasbeen updated to state that a client who is having acute behavioral issuesduring meal times will not be required to participate in family style diningand will be allowed to eat separately.</p> <p>How corrective actions will be monitored to ensure norecurrence A member ofmanagement is in the home at least weekly to observe</p>				

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	<p>__ Staff #1 and #3 stood near the table and continued assisting clients with food and cutting client B's, D's, E's, F's and G's food into small pieces with a pair of scissors</p> <p>__ At 5:20 PM staff #3 sat down between clients B and D and said to client D, "You need to take a drink before you take another bite." Client D had finished her tater tots and most of her ground up meat. At the same time staff #1 sat down beside client G and began prompting client G to slow her pace of food and to take a drink.</p> <p>__ At 5:23 PM clients B and D had eaten the main portion of their meal and were eating their pineapple.</p> <p>__ At 5:28 PM clients B and D were finished eating their meal and got up from the table.</p> <p>During this observation period:</p> <p>__ Clients D, F and G were not provided 1:1 (one staff to one client) supervision while eating their evening meal.</p> <p>__ The staff failed to prompt client D to slow her pace of eating, to take small sips/bites, to place her utensil down between bites and/or to take a drink between bites.</p> <p>__ The staff failed to prompt client E to alternate her consistencies, to use extra swallows and/or to put her spoon down between bites.</p> <p>__ Client F was given a hamburger, a bun,</p>		during meal time. This will facilitate on the spot training and active treatment. The dietician visits at least quarterly to ensure compliance.				

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	<p>tater tots and pineapple all at one time.</p> <p>__The staff failed to prompt Client F to put down her utensil between bites of food and to take a drink of liquid between bites.</p> <p>__The staff failed to prompt client G to alternate food/liquids with each bite.</p> <p>Client D's record was reviewed on 11/6/14 at 2:30 PM. Client D's revised dining plan dated 10/1/14 indicated client D was at risk for choking and aspiration. Client D's dining plan indicated (not all inclusive): "EATING/DRINKING STRATEGIES: 1:1 supervision is required. Small sips/bites. Must be alert and sitting upright (90 degrees if possible)." Client D's 10/1/14 ISP indicated client D had an objective to eat at safer pace by placing her utensils down between bites and taking a drink between bites.</p> <p>Client E's record was reviewed on 11/6/14 at 3:30 PM. Client E's revised dining plan dated 10/1/14 indicated client E was at risk for choking and aspiration. Client E's dining plan indicated (not all inclusive): "EATING/DRINKING STRATEGIES: Supervision required for eating and drinking. Prompt to take small bites/sips, slowing rate, alternating consistencies and to use extra swallows.... Specific skills to</p>			

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	<p>maintain/acquire: Place spon (sic) down between bites to slow eating pace."</p> <p>Client F's record was reviewed on 11/6/14 at 3:30 PM. Client F's dining plan indicated client F was to have 1:1 staff supervision while eating and staff were to prompt client F to slow her pace of eating. The plan indicated client F was to be given only 1 food item at a time on her plate. Client F's 10/1/13 ISP indicated client F had an objective to place her utensil down between bites of food and take a drink of liquid.</p> <p>Client G's record was reviewed on 11/6/14 at 3 PM. Client G's revised dining plan dated 10/1/14 indicated client G was at "moderate" risk for choking and at risk for aspiration. Client G's dining plan indicated (not all inclusive): "FOOD TEXTURE: Regular. It is appropriate for staff to cut food into 1/4" (inch) to 1/2" pieces due to her tendency to grab foods and put them into her mouth. She does not always chew her food well.</p> <p>EATING/DRINKING STRATEGIES: She is to have 1:1 supervision during meal times. Staff need to encourage her to alternate food/liquid. Food should be cut into 1/4" to 1/2" pieces to prevent choking."</p> <p>The QIDP (Qualified Intellectual</p>			

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W000263	<p>Disabilities Professional), the RM (Residential Manager) and the AD (Assistant Director) were interviewed on 11/6/14 at 4 PM.</p> <p>__The RM indicated the staff were to follow the clients' dining plans whenever the clients were eating their snacks and/or their meals.</p> <p>__The AD indicated 1:1 staff supervision indicated one staff was to be supervising one client at a time while the client that required 1:1 supervision was eating. The AD indicated the staff providing the 1:1 supervision was not to get up from the table, be serving other clients and/or cutting up food for another client and leaving the client that was to have 1:1 supervision unsupervised while eating. The AD indicated the 1:1 staff was to be focused on one client and nothing else.</p> <p>__The QIDP indicated the staff were to follow the clients' ISPs and dining plans at every meal.</p> <p>This deficiency was cited on 9/22/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE</p>						

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	<p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review for 2 of 3 sampled clients (A and C) with restrictive programs, the facility failed to obtain written informed consent from the clients and/or the clients' legal representatives for the clients' restrictive programs including the use of behavior modification medication and the locking of the sharps within the home.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 11/6/14 at 2 PM.</p> <p>__ Client A's revised 10/28/14 BSP (Behavior Support Plan) indicated client A was taking Wellbutrin SR 200 mg (milligrams) qd (every day) for depression, Depakote 500 mg bid (twice a day) for mood stabilization, Seroquel 300 mg qd for impulse control and depression, Neurontin 200 mg bid for Schizoaffective disorder (a mental condition that causes both a loss of contact with reality and mood problems) and Sertraline (an antidepressant) 50 mg qd.</p> <p>__ Client A's BSP Addendum dated 10/28/14 indicated "[Client A] has had a history of self injurious behaviors and</p>	W000263	<p>Correctiveactionforresident(s)foundedtohavebeenaffected The new AD is updating allBSPs. BSPs are being sent by trackableFed-Ex to guardians to ensure copies of the BSP and restrictive measures aredelivered. They will be asked to signand return a copy for Benchmark records.</p> <p>Howfacilitywillidentifyotherresidentspotentiallyaffectedandwhatmeasuresstaken All residentsreceiving psychotropicmedications are affectedand corrective action willaddress the needsof all clients.</p> <p>Measuresorsystemicchangesfacility putinplacetoensurenorecurrence The AD is updatingall BSPs and will obtain guardian and/or client signatures. The AD is sending the documentation toguardians via trackable Fed Ex to ensure delivery.</p> <p>Howcorrectiveactionswillbemonitoredtoensurenorecurrence The quarterlymeeting checklist will be filled out and turned into the RD within 24 hoursafter each meeting. This will ensure allplans are being reviewed at each quarterly meeting and updated asnecessary. This will also ensure teammembers are looking at the plans periodically to</p>	12/05/2014

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	<p>injuries related to these attempts. In order to keep [client A] and her housemates safe restrictive measures have needed to be placed within the home. Restrictions: [Client A] will not be permitted to enter the garage if not accompanied by staff. The garage will be kept locked at all times and the sharps (the knife, scissors, and pizza cutter) will be held in there as well as other sharp utensils as determined by the IDT (Interdisciplinary Team). This restriction is in place to maintain control over sharps in order to keep [client A] and her housemates safe. Review: [Client A's] IDT will review these restrictions at least on a quarterly basis. If the team decides at any time to reduce restrictions, it can be implemented immediately. A team member will simply need to cross out the restriction in the book, date the change, and sign/initial. All new restrictions need HRC approval."</p> <p>__Client A's record indicated client A was represented by a legal guardian. Client A's record indicated the facility had not obtained written informed consent from client A's legal representative for the restrictive BSP that included the use of Wellbutrin, Depakote, Seroquel, Neurontin and Sertraline and the locking of the sharps in the home in regard to client A.</p> <p>Client C's record was reviewed on</p>		ensure all are signed and upto date.		

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	<p>11/6/14 at 1 PM. Client C's 9/16/14 BSP indicated client C was taking Buspirone 10 mg qd for anxiety and Risperidone 2.5 mg for mood disorder. Client C's record indicated client C was represented by a legal representative. Client C's record indicated the facility had not obtained written informed consent from client C and/or client C's legal representative for the restrictive BSP that included the use of Buspirone and Risperidone.</p> <p>Interview with staff #2 on 11/5/14 at 6 PM indicated the sharps were locked within the home and away from the client A because client A had threatened harm with a knife on more than one occasion.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 11/6/14 at 4 PM, the QIDP indicated she was unable to locate client A's and C's written informed consents for their restrictive BSPs including the use of behavior modification medications and the locking of the sharps for client A. The QIDP indicated she received telephone approval from client A's representative to lock the knives but she had not been able to obtain written informed consent from client A's and/or client C's legal representatives.</p>						

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W000323	<p>This deficiency was cited on 9/22/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 4 of 4 sampled clients (A, B, C and D), the facility failed to ensure the clients' hearing was evaluated annually.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 11/6/14 at 2 PM. Client A's record indicated no hearing evaluation. Client A's record indicated client A's hearing was not evaluated annually.</p> <p>Client B's record was reviewed on 11/6/14 at 1:30 PM. Client B's record indicated no hearing evaluation. Client B's record indicated client B's hearing was not evaluated annually.</p>	W000323	<p>Correctiveactionforresident(s)foun dtohavebeenaffected All annual physicals andannual vision screenings have been completed. Annual hearing evaluations and annual dental appointments have beenscheduled.</p> <p>Howfacilitywillidentifyotherreside ntspotentiallyaffectedandwhatmea surestaken All residentscould be affected andcorrective action planwill be put inplace to protect allconsumers.</p> <p>Measuresorsystemicchangesfacility putinplacetoensurenorecurrence A new LPN has beenrecruited and hired who is knowledgeable of GH regulations. Also the LPN will place a spreadsheet on theR drive of the Benchmark computer system that all</p>	12/05/2014	

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	<p>Client C's record was reviewed on 11/6/14 at 1 PM. Client C's record indicated no hearing evaluation. Client C's record indicated client C's hearing was not evaluated annually.</p> <p>Client D's record was reviewed on 11/6/14 at 2:30 PM. Client D's record indicated no hearing evaluation. Client D's record indicated client D's hearing was not evaluated annually.</p> <p>During interview with the facility's LPN on 11/6/14 at 4 PM, the LPN indicated: ___ Clients A, B, C and D had not had annual hearing evaluations and the clients' PCP (Primary Care Physicians) did not conduct hearing evaluations when their physicals were conducted. ___ She was presently getting clients A, B, C and D scheduled for hearing tests. ___ Client D was to have a hearing test and was found to have bilateral ear wax build up. ___ Client D's wax build up in her ears had to be addressed first before a hearing evaluation could be conducted.</p> <p>This deficiency was cited on 9/22/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>		<p>management team has access to that will include the current dates of all necessary client appointments.</p> <p>How corrective actions will be monitored to ensure no recurrence The quarterly meeting checklist will be filled out and turned into the RD within 24 hours after each meeting. This will ensure all appointment dates are being reviewed at each quarterly meeting. Also the LPN will place a spreadsheet on the R drive of the Benchmark computer system that all management team has access to that will include the current dates of all necessary client appointments.</p>	

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (A, B, C and D) and 1 additional client (G), the facility nursing services failed to:</p> <p>__ Develop and implement a specific plan of care in regard to client C's frequent falls and seizures that included how the staff were to monitor and assist client C throughout the day while inside the home, in her bedroom and bathroom, while outside of the home and while on the facility van. The facility nursing services failed to ensure client C's PT (Physical Therapy) assessment addressed all of client C's mobility needs in regard to client C's fine and gross motor skills, going up and down steps and getting on and off the facility van.</p> <p>__ Develop and implement a specific plan of care to address client A's refusals of medications and medical requests.</p> <p>__ Ensure annual hearing evaluations for clients A, B,C and D.</p> <p>__ Ensure all drugs were administered in compliance with the each clients' physicians' orders for clients C and G.</p>	W000331	<p>Correctiveactionforresident(s)foun dtohavebeenaffected</p> <p>Staff have received training on recognizing types of seizures and what to look for, proper medicationadministration, reporting medication errors, and reporting medicationrefusals. Also a new medication refusalprotocol has been added to the risk plan and BSP. This will include the client being sent tothe ER for 3 medication refusals within 24 hours.</p> <p>A new AD has been hired tomonitor behavioral incidents and medication refusals.</p> <p>Howfacilitywillidentifyotherreside ntpotentiallyaffectedandwhatmea surestaken</p> <p>All residentsare affected and correctiveaction will address theneeds of all clients.</p> <p>Measuresorsystemicchangesfacility putinplacetoensurenorecurrence</p> <p>A new LPN has beenhired and an new AD position has been created. These positions will monitor medication errors and medication</p>	12/05/2014

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	<p>Findings include:</p> <p>1. Observations were conducted at the workshop on 11/6/14 between 11:30 AM and 11:45 AM. During this observation period client C wore a brace on her left lower leg and walked with a forward lean and an unsteady gait.</p> <p>Client C's record was reviewed on 11/6/14 at 1 PM. Client C's record indicated diagnoses of, but not limited to, Seizure Disorder and Cerebral Palsy (a disorder of posture, muscle tone and movement resulting from brain damage).</p> <p>Client C's Seizure Reports indicated: On 5/3/14 at 4:34 PM client C was helping to set the table and "got stiff and began to pee her pants." On 5/29/14 at 6 PM client C "yelped, peed on the floor after grabbing her crotch and said she was okay." On 6/2/14 at 5:10 PM client C "Yelped, grabbed her crotch, pee'd (sic) and took off for the bathroom." On 6/9/14 at 4:30 PM client C "Yelped, shook, pee'd (sic) herself and took off for the bathroom holding her crotch." On 6/15/14 at 5:47 PM client C "Was at the dinner table eating her dinner and talking to staff. Client (C) let</p>		<p>refusals and promote prompt responses to such.</p> <p>The IDT met and implemented for any client refusing medications 3 times within 24 hours to be sent to ER for evaluation. The IDT felt that chronically refusing medications is a behavioral concern and being sent to the ER will be a deterrent for that concern. The physician is notified every time a medication is refused. The physician was consulted about the new protocol of sending a client to the ER after 3 medication refusals within 24 hours and was in agreement for that course of action as a behavioral deterrent.</p> <p>How corrective actions will be monitored to ensure no recurrence The AD will track and report behavioral incidents including medication refusals. These will be discussed with the IDT. A new medication refusal protocol has been added to the risk plans and the BSP.</p>	

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	<p>out a yelp or cry, then her whole body stiffened, eyes got big and she was holding her private area, because she started peeing."</p> <p>On 6/16/14 at 7:51 PM client C "Yelped, grabbed crotch and wet on the couch and immediately got up to go change her clothes."</p> <p>On 6/17/14 at 6:17 PM client C "Yelped, shook, pee'd (sic) on the floor and started saying she's sorry."</p> <p>On 6/22/14 at 5:25 PM client C "Yelled out, whole body stiffened and she grabbed her private area because she wet herself."</p> <p>On 6/28/14 at 4:10 PM client C "yelled, her body stiffened at first then started shaking. Client was also holding her private area but didn't pee."</p> <p>On 7/1/14 at 5:30 PM client C "started shaking and her head was shaking and [client C] kept saying I'm sorry and her body shook and was shaking."</p> <p>On 7/6/14 5:31 PM client C was eating her dinner and "grown (sic) and chew her food. Kept eaten her dinner (sic)."</p> <p>On 8/16/14 at 6:50 PM client C was sitting in a chair and "said a few words, wet herself and shook."</p> <p>On 9/29/14 at 8 PM client C had a seizure lasting 5 seconds. The</p>			

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	<p>report indicated client C "Yelped, grabbed herself and peed on herself."</p> <p>Client C's Post Fall Assessment forms indicated</p> <p>On 11/8/13 at 11:55 AM while at the DP (Day Program) client C was walking up the sidewalk incline to the DP and she tripped on her feet and fell. The assessment indicated actions to prevent future falls "Direct client to point toes forward and plant feet before attempting to walk."</p> <p>On 11/17/13 at 7:50 AM client C was "walking to the bathroom to get some water to take her pills when she leaned into a chair and fell on her butt." The assessment indicated actions to prevent future falls "Try to make sure she is walking okay to the whatever it is she's going and maybe keep an eye on her more when walking around without her shoes."</p> <p>On 6/2/14 at 8:20 AM client C rode to the DP (Day Program) on the house bus, exited the bus and was walking up a slight incline to enter the DP and fell.</p> <p>On 7/5/14 at 12:50 PM client C was going down some steps and was holding onto the railing. "After</p>			

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	<p>taking a step and having both feet on a step she lost her balance a feel but still had her right hand on the railing (sic)." The Assessment indicated client C was wearing a brace on her left ankle and indicated immediate actions to prevent future falls "Walk in front of client and have someone walk behind."</p> <p>On 7/13/14 at 5:45 PM client C was at the group home in the living room and was arguing with a peer. When the peer went to hit client C, client C took a step back and lost her balance, fell and knocked over a lamp.</p> <p>On 8/18/14 at 1:30 PM client C was walking to the break room at the DP and fell.</p> <p>Client C's nursing notes indicated 5/3/14 "Received report of seizure in which client had seizure activity while assisting with prepping meal. Client had urinary incontinence but was able to change her clothes with assist of staff. No injury to report."</p> <p>5/20/14 "Received report of injury form from 5/16 (5/16/14) in which it is reported that client fell out of her seat in the van when coming home from group home outing.</p>			

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	<p>Per report no treatment was needed."</p> <p>5/24/14 "Received report of seizure. Per report client was having dinner with roommates. She was joking around with peer and then grabbed herself and was incont (incontinent) of urine. Per report, client stated she wanted to go home but did was oriented to self and did no show signs of confusion (sic)."</p> <p>5/28/14 client C's doctor "is aware that client did not have her Divalproex 25 mg tab at 1 PM on this day."</p> <p>6/2/14 "Received post fall assessment form in which it is reported that client fell walking up a slight incline into the main center building. No reports of injury noted."</p> <p>6/3/14 "Reviewed report of seizure on 6/2/14 in which it is reported that client had 5 seconds of seizure activity during evening meal. Client ran to bathroom when activity ceased, no reports of injury noted."</p> <p>6/10/14 "Reviewed report of seizure dated 6/9/14 in which it is reported that client had 10 seconds of seizure activity with incontinence. Client has no reports of injury with this</p>						

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	<p>incident."</p> <p>6/14/14 "Received report of seizure activity from 6/15/14. Client noted to have 15-20 seconds of activity. Client had episodes of incontinence during activity."</p> <p>7/1/14 "Report of seizure form received. Approx (approximately) 30 second duration. No injury reported. Client (C) seen by [name of neurologist] on this date. New orders obtained to begin increase of Onfi to 20 mg (milligrams) BID (twice a day)."</p> <p>7/2/14 "Received report of fall with no injury." "Received report of injury in which it is stated that client got out of her chair, hit her left leg and fell on buttocks. Client required no medical intervention related to this incident and has had no complaints of pain or other."</p> <p>7/5/14 "Received report of fall with no injury."</p> <p>7/9/14 "Received report of seizure form for seizure lasting 20 seconds with no injury to report."</p> <p>7/14/14 "Reviewed report of injury for this date in which it is stated that client landed on her bottom while attempting to get off of the van after declining assistance from staff. Client denies injury. No</p>			

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	<p>medical intervention was required related to this incident."</p> <p>7/20/14 "Received report of seizure for this date. Seizure lasted approx 1 minute per this report. Client was not injured and returned to her usual level of daily activities shortly after seizure ended."</p> <p>7/21/14 "Received report of fall on 7/13/14 in which it is reported that client fell and knocked over a lamp. Per staff she has a red area on her back."</p> <p>8/4/14 "Client (C) sent to [name of hospital] ER (Emergency Room) on this date in the early morning for fall in which she stuck (sic) her head and was bleeding. Client was treated in the ER where head lac (laceration) was sutured. She remained at home and was observed by staff per protocol with neuro checks."</p> <p>8/7/14 "Reviewed report of seizure dated 8/6/14. No injury to report."</p> <p>8/7/14 "Received to (sic) report of seizure on this date each lasting approx (approximately) 30 seconds. No injury to report."</p> <p>8/8/14 client C was seen in the ER to have sutures removed.</p> <p>8/13/14 client C's doctor signed order for client to have a PT (Physical Therapy) evaluation.</p>			

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	<p>8/12/14 "Received three reports of seizure on this client (C) for separate occasions on this date. Clients (sic) seizure each lasted less then (sic) one minute, no injuries have been reported."</p> <p>8/14/14 client C scheduled for PT evaluation and treatment.</p> <p>8/16/14 client C had a seizure lasting 15 seconds.</p> <p>8/19/14 "Rec'd (Received) a (sic) injury report stating that [client C] was walking in the break room at the workshop and lost her balance and fell landing on her right hip. Staff assisted her to here (sic) feet and she was assessed for injury. None noted."</p> <p>8/19/14 at 6:10 PM client C had a 30 second seizure. "Started to shake and was incontinent. No injury."</p> <p>8/19/14 at 7:45 PM client C had a seizure while sitting in a chair that lasted one minute. "Hand shaking and was incontinent. No injury."</p> <p>8/22/14 at 5:40 PM client C had a 30 second seizure while sitting at the dinner table. No injury.</p> <p>8/22/14 at 7:30 PM client C had a seizure while sitting on the couch. Client C was shaking all over and was incontinent of urine. No injury.</p> <p>8/23/14 at 6 PM client C had a 30 second seizure. No injury.</p>						

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	<p>8/24/14 at 6:27 PM client C had a 30 second seizure while getting off the facility van at church. "Body stiffened, got goose bumps and saying 'No' during seizure. Also incontinent of urine. No injury."</p> <p>10/22/14 "Staff reported got out of shower. Peed on the floor and had goose bumps."</p> <p>10/29/14 Staff noted seizure stating she looked up, face was red, body stiffened and urinated on self...."</p> <p>Client C's PT evaluation dated 8/26/14 indicated the report indicated client C was a middle aged female with CP who had recently had an increased incidence of falls as well as reports of declining posture which affected client C's balance and safety. The evaluation indicated client C wore a left AFO (ankle-foot-orthotic) and had an internal rotation of her left lower leg starting at the hip and had decreased strength "through left LE and flexion contracture (a shortening of muscle tissue and tendons, which forces a joint into a flexed position) of left UE (upper extremity)." The evaluation indicated client C had a severe forward lean with an "increased thoracic kyphosis (an excess curvature in the upper back causing a hump).... This patient would benefit from PT to address above issues</p>						

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	<p>to decreased likelihood of falls." ___The PT evaluation did not indicate level of staff supervision and assistance client C required throughout the day when in and out of the home, when at work, when going up and down steps and/or getting on and off the facility van. The PT evaluation indicated no recommendations to address how the facility staff were to assist and monitor client C throughout the day to prevent further injury from falls.</p> <p>Client C's 11/5/14 Medical Appointment form indicated client C was seen by PT and "was provided balance training, strengthening of trunk and lower extremities, stair training and postural strengthening."</p> <p>Client C's Risk Summary dated 10/1/14 indicated client C was at risk for falls and had a history of falls. The Summary indicated "[Client C] has a history of falls. [Client C] was evaluated to [name of hospital] physical therapy. Most recent PT evaluation was completed 4/15/13 and re-eval 8/1/13 resulting in discharge from PT 8/19/13.</p> <p>Pt (patient) requires guard assist if walking on uneven ground (grass). Independent on level ground. Staff are to prompt [client C] when</p>			

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	<p>walking to point toe forward. Staff are to check brace daily to be sure it is on properly. Staff will assist [client C] in doing home exercise program 5 days a week scheduled while at the center Monday thru Friday."</p> <p>Client C's record indicated no IDT (Interdisciplinary Team) meetings in regard to client C's increased number of seizures and falls. Client C's ISP/Risk Summary failed to indicate how the staff were to supervise, monitor and assist client C throughout the day while ambulating to prevent further injury from falls and/or seizures.</p> <p>The facility's LPN and QIDP (Qualified Intellectual Disabilities Professional) were interviewed on 11/6/14 at 4 PM. The LPN indicated client C was going to PT and had recently seen her neurologist and medication changes were made.</p> <p>The LPN indicated the PT evaluation did not specify the level of supervision and/or assistance client C required while going up and down steps and/or while getting on and/or off the facility van.</p> <p>When asked how the staff were to supervise, monitor and assist</p>			

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	<p>client C throughout the day to ensure client C's safety in regard to falls and seizures, the LPN stated, "They're (the staff) to follow her (client C's) Risk Plans."</p> <p>The LPN indicated client C's Risk summary for falls and seizures did not indicate client C's level of supervision and assistance throughout the day while at home, while at work, while showering and going to the bathroom, while going up and down stairs and/or while getting on and off the facility van. The QIDP stated, "I'm sure they (the staff) help her on and off the van."</p> <p>The LPN and the QIDP indicated no changes in client C's care and/or Risk Summary in regard to client C's history of increased falls, injury with falls and increased seizures since the recertification survey of 9/22/14.</p> <p>2. Client A's record was reviewed on 11/6/14 at 2 PM.</p> <p>Client A's Medication Refusal Reports (MRRs) indicated: On 11/11/13 client A refused her 4 PM meds: Divalproex Sodium 500 mg and Gabapentin 200 mg. The</p>			

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	<p>report indicated "Just refused meds and told staff 'No'."</p> <p>On 11/12/13 at 10:20 AM client A refused to go to her dental appointment.</p> <p>On 11/12/13 client A refused her 4 PM meds: Divalproex Sodium 500 mg and Gabapentin 200 mg. The report indicated "Client was very upset and refused meds."</p> <p>On 12/27/13 client A refused her 4 PM meds: Divalproex Sodium 500 mg and Gabapentin 200 mg. The report indicated "Staff asked her 3x (three times) over the period of 4 PM and 5 PM for meds and was cursed at. Staff notified nurse [client A] never wanted to take them." The nurse instructed the staff to "Just wait and see if she takes them and fill out a refusal."</p> <p>On 1/19/14 client A refused her 7 AM medications: Bupropion and Sertraline for depression, Calcium with Vitamin D, Divalproex Sodium, Gabapentin, Seroquel (an antipsychotic), Hydrochlorothiazide (a diuretic), a Multi Vitamin and Zovia (for menses regulation). The report</p>						

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	<p>indicated "Staff knocked on [client A's] door, she (client A) refused meds. Staff waited 20 minutes. She (client A) refused again. Staff waited another 20 minutes and she (client A) told staff to 'leave me alone'."</p> <p>On 2/5/14 client A refused her 7 AM medications: Bupropion, Sertraline, Calcium with Vitamin D, Divalproex Sodium, Gabapentin, Hydrochlorothiazide, Seroquel, Multi Vitamin, Zovia and Prevident 5000 Sensitive tooth paste. The report indicated "Ask (sic) 3x's (three times) at different times to take her meds and she (client A) wouldn't even talk to staff. She (client A) shook her head no and that was it."</p> <p>On 2/12/14 client A refused all of her 7 AM medications: Bupropion, Sertraline, Calcium with Vitamin D, Divalproex Sodium, Gabapentin, Hydrochlorothiazide, Seroquel, Multi Vitamin and Zovia. The report indicated "Staff asked her to come take her meds then she slapped them and cussed them out."</p> <p>On 6/9/14 client A refused to take her 4</p>			

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	<p>PM Divalproex Sodium 500 mg tab and two Gabapentin 100 mg caps. The report indicated "She just keeps saying will not take drs (doctors) orders."</p> <p>On 6/12/14 client A refused her 8 PM Crest Pro Health mouth wash.</p> <p>On 6/13/14 client A refused her 8 PM Crest Pro Health mouth wash.</p> <p>On 6/29/14 client A refused her 8 AM medications of Bupropion and Sertraline for depression, Calcium, Divalproex Sodium, Gabapentin, Hydrochlorothiazide, Seroquel, Multi Vitamin and Zovia. The report indicated "Kept saying no, refusing to get out of bed, saying 'Shut up'."</p> <p>On 6/30/14 fax "Please be advised [client A] refused all morning meds on 9/29/14."</p> <p>On 8/16/14 client A refused her 4 PM meds: Divalproex Sodium 500 mg and Gabapentin 200 mg. The report indicated "I (the staff) asked her to please take her meds 5x she kept telling me (the staff) NO!"</p>			

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	<p>On 9/10/14 client A refused all of her 8 AM medications of Bupropion and Sertraline for depression, Calcium, Divalproex Sodium, Gabapentin, Hydrochlorothiazide, Seroquel, Multi Vitamin and Zovia.</p> <p>Client A's Monthly Health Reviews for 2014/2013 indicated: On 12/9/13 refused to see optometrist. On 8/1/14 client A refused AM meds and labs ordered by her PCP. On 8/10/14 client A refused 7 AM meds. On 8/14/14 client A refused her 8 PM mouthwash. 10/30/14 client A refused to have her blood drawn for lab work.</p> <p>Client A's updated 10/28/14 BSP (Behavior Support Plan) indicated client A had a targeted behavior of "Refusals: Refusing to complete chores, refusing available work, not following directions given by parents or supervisors." Client A's BSP did not include refusals of medications, labs and/or refusal to comply with medical requests. Client A's ISP of 10/1/14 and client A's Updated Risk Summary dated 9/17/14 did not include refusals of medications, treatments and/or refusals of medical requests and what the staff were to do when the client refused. Client A's record</p>				

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	<p>indicated no IDT (Interdisciplinary Team) meetings in regard to client A's refusals of medications and medical requests. Client A's record indicated nursing failed to address client A's refusals of medication and medical requests.</p> <p>Interview with staff #2 on 11/5/14 at 6 PM indicated client A continues to refuse her medications. Staff #2 indicated there was no specific plan in regard to client A's refusals of medications. Staff #2 stated, "We just ask her a couple of times to take it (medications) and if she doesn't we can't force her."</p> <p>During interview with the facility's LPN and the QIDP (Qualified Intellectual Disabilities Professional) on 11/6/14 at 4 PM, the QIDP indicated client A's ISP/BSP did not address client A's refusals of medication and/or medical requests. The LPN and the QIDP indicated no IDT (Interdisciplinary Team) meetings in regard to client A's refusals of medications and medical requests. The QIDP and the LPN indicated no changes were made in client A's plan of care since the recertification survey on 9/22/14.</p> <p>3. Client A's record was reviewed on 11/6/14 at 2 PM. Client A's record</p>						

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	<p>indicated no hearing evaluation. Client A's record indicated client A's hearing was not evaluated annually.</p> <p>Client B's record was reviewed on 11/6/14 at 1:30 PM. Client B's record indicated no hearing evaluation. Client B's record indicated client B's hearing was not evaluated annually.</p> <p>Client C's record was reviewed on 11/6/14 at 1 PM. Client C's record indicated no hearing evaluation. Client C's record indicated client C's hearing was not evaluated annually.</p> <p>Client D's record was reviewed on 11/6/14 at 2:30 PM. Client D's record indicated no hearing evaluation. Client D's record indicated client D's hearing was not evaluated annually.</p> <p>During interview with the facility's LPN on 11/6/14 at 4 PM, the LPN indicated: ___ Clients A, B, C and D had not had annual hearing evaluations and the clients' PCP (Primary Care Physicians) did not conduct hearing evaluations when their physicals were conducted. ___ She was presently getting clients A, B, C and D scheduled for hearing tests. ___ Client D was to have a hearing test and was found to have bilateral ear wax build up.</p>			

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	<p>__ Client D's wax build up in her ears had to be addressed first before a hearing evaluation could be conducted.</p> <p>4. The facility's reportable records were reviewed on 11/6/14 at 11 AM.</p> <p>The 10/20/14 BDDS (Bureau of Developmental Disabilities Services) report indicated client G was not given her 8 PM dose of Phenobarbital (for seizures) 64.8 mg (milligrams).</p> <p>The 10/22/14 BDDS report indicated "On 10/22/14 it was found that [client C] had not been administered her 500 mg Divalproex (for seizures) at 7 AM for the last fifteen days."</p> <p>The investigative report dated 10/28/14 indicated: __ A physician's order dated 4/23/14 from client C's NP (Nurse Practitioner) for Divalproex 250 mg tid (three times a day). __ A physician's order dated 9/23/14 from client C's neurologist for Divalproex ER (Extended Release) 500 mg a day. __ Client C did not receive Divalproex 500 mg at 7 AM from 10/1/14 through 10/22/14. __ The facility nurse notified client C's neurologist of the missed doses of Divalproex and was told client C was to</p>			

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	<p>receive Divalproex ER 500 mg a day only and the previous orders for Divalproex from the NP should have been discontinued.</p> <p>Review of client C's MAR (Medication Administration Record) for October 2014 on 11/6/14 at 2 PM indicated: ___ Client C received Divalproex 750 mg at 7 AM and 250 mg at 1 PM and 8 PM on October 1, 2, 3, 4, 6, 7, 8, 9, 10, 14, 23, 24, 25 and 26, 2014. ___ Client C received Divalproex 750 mg at 7 AM 10/26/14 and began Divalproex ER 500 mg once a day on 10/28/14.</p> <p>The facility's LPN was interviewed on 11/6/14 at 4:30 PM. The LPN: ___ Indicated client C saw her NP on 9/23/14 and was given an order for Divalproex 250 mg three times a day. ___ Indicated client C saw a neurologist on 9/23/14 and was given an order for Divalproex ER (Extended Release) 500 mg daily. ___ Indicated when client C received the new order on 9/23/14, the pharmacy placed both medications on client C's October MAR in error but did not send the 500 mg ER tablet to the facility. ___ Indicated the staff were notifying the TL of the missing medication and the TL failed to then notify nursing. ___ Indicated the staff are to notify nursing</p>			

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W000368	<p>whenever a medication was missing and/or not given as scheduled. __ Indicated all clients were to receive their medications as ordered by their physician.</p> <p>This federal tag relates to complaint #IN00154234.</p> <p>This deficiency was cited on 9/22/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 1 of 4 sampled clients (C) and 1 additional client (G), the facility nurse failed to ensure all drugs were administered in compliance with the clients' physician's orders.</p> <p>Findings include:</p> <p>The facility's reportable records were reviewed on 11/6/14 at 11 AM.</p>	W000368	<p>Corrective action for resident(s) found to have been affected Supervisor was retrained by the GHM on medication reordering, what to instruct staff to write on the back of the MAR, and other supervisor duties pertaining to medications. Staff have been instructed to contact the LPN for medication errors. All staff were retrained in medication administration and reporting medication errors. The LPN retrained the supervisor, the GHM, and the med floater on how to conduct a proper medication audit so</p>	12/05/2014

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	<p>The 10/20/14 BDDS (Bureau of Developmental Disabilities Services) report indicated client G was not given her 8 PM dose of Phenobarbital (for seizures) 64.8 mg (milligrams).</p> <p>The 10/22/14 BDDS report indicated "On 10/22/14 it was found that [client C] had not been administered her 500 mg Divalproex (for seizures) at 7 AM for the last fifteen days."</p> <p>The investigative report dated 10/28/14 indicated: ___ A physician's order dated 4/23/14 from client C's NP (Nurse Practitioner) for Divalproex 250 mg tid (three times a day). ___ A physician's order dated 9/23/14 from client C's neurologist for Divalproex ER (Extended Release) 500 mg a day. ___ Client C did not receive Divalproex 500 mg at 7 AM from 10/1/14 through 10/22/14. ___ The facility nurse notified client C's neurologist of the missed doses of Divalproex and was told client C was to receive Divalproex ER 500 mg a day only and the previous orders for Divalproex from the NP should have been discontinued.</p> <p>Review of client C's MAR (Medication Administration Record) for October 2014</p>		<p>med errors could be found more quickly. The LPN was trained to conduct a random medication audit in the home monthly to ensure there are no missing medications or medication errors. The GH supervisor will conduct a medication audit once per week on Thursday or Friday to ensure all medications are present for the weekend and to ensure there have been no medication errors during the week. The medication floater will conduct a medication audit once per week on Monday or Tuesday to ensure all medications were passed appropriately over the weekend and to ensure there were no medication errors.</p> <p>How facility will identify other residents potentially affected and what measures taken All residents are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence Medication audits will be conducted twice per week to ensure all medications are present and being passed correctly.</p> <p>How corrective actions will be monitored to ensure no recurrence The LPN will conduct medication passes with the supervisors observing to see how to properly pass medications. Then the LPN will conduct a medication observation with the supervisors observing. This will ensure the supervisors conduct medication observations the way the</p>				

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	<p>on 11/6/14 at 2 PM indicated: ___ Client C received Divalproex 750 mg at 7 AM and 250 mg at 1 PM and 8 PM on October 1, 2, 3, 4, 6, 7, 8, 9, 10, 14, 23, 24, 25 and 26, 2014. ___ Client C received Divalproex 750 mg at 7 AM 10/26/14 and began Divalproex ER 500 mg once a day on 10/28/14.</p> <p>The facility's LPN was interviewed on 11/6/14 at 4:30 PM. The LPN: ___ Indicated client C saw her NP on 9/23/14 and was given an order for Divalproex 250 mg three times a day. ___ Indicated client C saw a neurologist on 9/23/14 and was given an order for Divalproex ER (Extended Release) 500 mg daily. ___ Indicated when client C received the new order on 9/23/14, the pharmacy placed both medications on client C's October MAR in error but did not send the 500 mg ER tablet to the facility. ___ Indicated the staff were notifying the TL of the missing medication and the TL failed to then notify nursing. ___ Indicated the staff are to notify nursing whenever a medication was missing and/or not given as scheduled. ___ Indicated all clients were to receive their medications as ordered by their physician.</p> <p>This deficiency was cited on 9/22/14. The</p>		<p>LPN would conduct amedication observation. The supervisor will conduct a medication observation with each staff monthly to ensure compliance with medication passing. The LPN will conduct a medication observation with each manager monthly to ensure they are compliant with passing medications. A member of GH management is in the house at least weekly until 7pm to observe medication pass. Also a member of management does a random visit at least daily to ensure compliance.</p>				

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W000426	<p>facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p> <p>483.470(d)(3) CLIENT BATHROOMS 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 and interview for 1 of 3 sampled clients (B) and 3 additional clients (D, E and F), the facility failed to ensure the water temperatures within the facility did not exceed 110 degrees Fahrenheit.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 11/5/14 between 4 PM and 6:30 PM. At 6 PM the water temperature was tested in the north hall bathroom sink immediately after client D had showered and exited the bathroom. The water temperature was found to be 119 degrees Fahrenheit.</p> <p>On 11/6/14 at 11 AM this surveyor entered the facility with the facility</p>	W000426	<p>Corrective action for resident(s) found to have been affected Shower and water temperature have been corrected. Bader Mechanical tested water for 3 weeks and it is under 109 degrees. GHM will continue to monitor water temperatures monthly by reviewing staff's documentation and through environmental quality checks completed by a manager each month.</p> <p>How facility will identify other residents potentially affected and what measures taken All residents could be affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence The GHM will submit all maintenance requests to the AWS/Benchmark maintenance</p>	12/05/2014	

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	<p>maintenance staff. Both this surveyor and the facility maintenance staff tested the temperature of the water in the south hall bathroom sink. This surveyor and the facility maintenance staff obtained readings of 118 degrees to 120 degrees Fahrenheit.</p> <p>Review of the facility Water Temperature Log from 10/8/14 to 11/5/14 on 11/6/14 at 3 PM indicated temperatures from 110 degrees to 122 degrees Fahrenheit were recorded daily from October 8 through November 5, 2014.</p> <p>During interview with the RM (Residential Manager) on 11/5/14 at 6:30 PM, the RM indicated clients B, D, E and F were unable to regulate water temperatures independently and required staff assistance. The RM indicated the facility staff began testing the water temperatures throughout the home nightly on 10/8/14. The RM indicated she was not aware of any current issues with the water temperatures being too high.</p> <p>During interview with the facility maintenance staff on 11/6/14 at 11:10 AM, the maintenance staff indicated the facility had a local company repair the water heater in September and stated the facility was having the same local company come back "today and take a</p>		<p>department and will copy the RD. The maintenance department will document on each request the date they fulfilled the maintenance request and will turn a copy back in to the GHM. Monthly a member of the management team conduct an environmental quality check (CQA) and turn it into the RD for tracking and compliance. If any deficiencies are noted, the manager will notify the GHM to turn in a maintenance request. All managers will be retrained on this. This will include a check of the water temperature.</p> <p>How corrective actions will be monitored to ensure no recurrence Monthly a member of the management team conduct an environmental quality check (CQA) and turn it into the RD for tracking and compliance. If any deficiencies are noted, the manager will notify the GHM to turn in a maintenance request. All managers will be retrained on this. This will include a check of the water temperature.</p>	

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	<p>look at it again."</p> <p>Telephone interview with the RM on 11/7/14 at 5:30 PM indicated the night shift staff were told to notify the RM when the water temperature results were over 110. The RM indicated the staff had not notified her and she had not monitored the temperature log. The RM stated, "They (the facility staff) thought I (the RM) was going to be in the home every day and would be checking the log but I didn't." The RM indicated she was not aware there was an issue with the water temperatures being above 110 degrees Fahrenheit until this surveyor had asked to see the temperature logs. The RM indicated after reviewing the water temperature logs on 11/5/14, she retrained with the TL (Team Lead) on 11/6/14 to notify the RM immediately via phone or text when a temperature above 110 degrees Fahrenheit was obtained when testing the water temperature. The RM stated the facility had an outside company come to the facility and look at the water heater "again to hopefully fix the problem this time."</p> <p>This deficiency was cited on 9/22/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-7(a)</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 3 of 4 sampled clients (A, B and D) and 3 additional clients (E, F and G), the facility failed to ensure the staff provided the clients with a knife to cut their food with.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/5/14 between 4 PM and 6 PM. During this observation period clients A, B, D, E, F and G were served hamburgers, buns, tater tots, broccoli and pineapple for their evening meal. The clients were not provided a table knife and/or did the staff use a table knife to cut the clients' food. The staff cut client A's, B's, D's, E's and F's food with a pair of kitchen scissors.</p> <p>Client G's dining plan dated 9/18/14 was reviewed on 11/6/14 at 2 PM and indicated client G "May use wrist weights as needed to help with shaking while</p>	W000484	<p>Corrective action for resident(s) found to have beenaffected It has been placed in therevised ISP that client will use a chopper and or rolling cutter to cut their own food. The chopper and the cutter has been trainedon by the Dietician. These items will besecured in the lock box that will be kept in the kitchen. A picture book will be available to clientsto point to the picture if they want a particular item.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken All residentsare affected and correctiveaction will address theneeds of all clients.</p> <p>Measures or systemic changes facility put in place toensure no recurrence A chopper andplastic pizza cutter have been purchased and the staff have been trained.</p> <p>How corrective actions will be monitored to ensure norecurrence A member ofmanagement will be conduct observations in the home at</p>	12/05/2014

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W000488	<p>eating." Client G's record indicated no assessment of client G's dining needs and/or adaptive equipment needed while dining.</p> <p>During interview with the RM (Residential Manager) on 11/5/14 at 5:45 PM the RM indicated clients B, D, E, F and G were not able to independently cut their own food. When asked why the clients were not provided a knife and/or a rocker knife to cut their food, the RM indicated she did not know what a rocker knife was and stated, "It's just easier if the staff used a pair of scissors to cut up their (the clients) food."</p> <p>9-3-8(a)</p> <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 and interview for 3 of 4 sampled clients (A, B and D) and 3 additional clients (E, F and G), the facility failed to ensure the staff provided training in meal preparation and family style dining when formal.</p> <p>Findings include:</p>	W000488	<p>least weekly during mealtimes to ensure clients are given active treatment and encouraged to cut their own food. The dietician visits at least quarterly to ensure compliance.</p> <p>Corrective action for resident(s) found to have been affected It will be placed in therevised ISP that client will use a chopper and rolling cutter to cut their own food and to participate in family style dining. The chopper and the cutter have been trained on by the Dietician. These items will be secured in the lock box that will be</p>	12/05/2014

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	<p>Observations were conducted at the group home on 11/5/14 between 4 PM and 6 PM. During this observation period:</p> <p>__Staff #1 prepared hamburgers, buns, tater tots, broccoli and pineapple for the evening meal with minimal assistance from clients A, B, D, E, F and G.</p> <p>__Staff #1 placed the tater tots on a cooking sheet and then placed the cookie sheet into the oven.</p> <p>__Staff #1 prepared the hamburgers and broccoli.</p> <p>__Staff #1 placed a hamburger in a mini food processor and chopped it up for clients B and D.</p> <p>__Clients C and G were prompted to place their drinking cups at the place setting at the table. Staff #1 and #3 finished preparing the table for the evening meal.</p> <p>__At 5 PM while clients A, B, D, E and G were sitting at the dining room table, staff #1 and #3 began placing the food on the table and serving the clients by passing the bowls of food between the staff and placing food on the clients' plates.</p> <p>__Minimal to no hand over hand assistance was provided the clients while serving themselves.</p> <p>__Staff #1, #2 and #3 cut client B's, D's, E's, F's and G's food into small pieces</p>		<p>kept in the kitchen during non meal times. A picture book will be available to clientsto point to the picture if they want a particular item.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken All residentsare affected and correctiveaction will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place toensure no recurrence A chopper andplastic pizza cutter have been purchased and the staff have been trained. Staff have been retrained by the LPN and thedietician on family style dining.</p> <p>How corrective actions will be monitored to ensure norecurrence A member ofmanagement will be conduct observations in the home at least weekly during mealtimes to ensure clients are given active treatment, family style dining andencouraged to cut their own food. Thedietician visits at least quarterly to ensure compliance. Also a member ofmanagement does a random visit at least daily to ensure compliance, is in thehome until at least 7 pm at least once weekly, and conducts a random pop invisit during the hours of 1am-4am at least monthly. .</p>		

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	<p>with a pair of kitchen scissors.</p> <p>___The clients were not provided a knife to cut their own food and/or provided training to use a knife to cut their food.</p> <p>During this observation period the staff failed to provide the clients with formal and informal training in meal preparation and/or family style dining, serving themselves and/or cutting their food with a knife when opportunity existed.</p> <p>During interview with the RM (Residential Manager) on 11/5/14 at 5:45 PM, the RM stated the clients "should be" doing as much as possible for themselves and the staff were to act as role models during every meal and providing the clients hand over hand assistance when needed.</p> <p>During interview with staff #2 on 11/5/14 at 6 PM, staff #2 indicated clients B, D, E, F and G were unable to prepare a meal independently and required hand over hand assistance while preparing a meal and/or serving themselves.</p> <p>During interview with the RM and QIDP (Qualified Intellectual Disabilities Professionals) on 11/6/14 at 4 PM, the QIDP indicated the staff were to provide the clients with training in meal preparation and family style dining at</p>			
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W009999	<p>every available opportunity.</p> <p>This deficiency was cited on 9/22/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-8(a)</p>	W009999	no deficiency noted	12/05/2014	