

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/16/2014
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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989
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W000000	<p>This visit was for an extended recertification and state licensure survey.</p> <p>Dates of Survey: 5/7, 5/8, 5/9, 5/12, 5/13, 5/15, and 5/16/14.</p> <p>Facility Number: 000833 Provider Number: 15G314 AIM Number: 100243960</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/28/14 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. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the governing body failed to exercise operating direction over the facility to complete maintenance and repairs at the group home including client #7's damaged and missing closet doors and 2</p>	W000104	<p>W104 GoverningBody This item outlines that the agency failed to exercise operating direction over the facility to complete maintenance and repairs to the group home. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> On 5/16/2014, all lights were replaced in the indicated 	06/15/2014

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>of 2 burned out lower level bathroom lights for clients #1, #2, #3, #4, #5, #6, and #7.</p> <p>Findings include:</p> <p>On 5/7/14 from 4:30pm until 7:35pm, and on 5/8/14 from 6:00am until 8:20am, observations were conducted at the group home. During both observation periods clients #1, #2, #3, #4, #5, #6, and #7 had access to the lower level bathroom and two of two bathroom lights were burned out and not functioning. On 5/8/14 from 7:00am until 8:00am, clients #5 and #6 used the facility lower level bathroom and did not have light. At 7:00am, client #6 shaved his face in the lower level family room and indicated the bathroom was dark.</p> <p>During both observation periods client #7's bedroom closet had one of two closet doors missing and the remaining closet door was not hinged into place to open and close. On 5/7/14 at 5:40pm, client #7 indicated one of two closet doors was missing and the remaining closet door did not function and stated his closet doors had been that way for "about a year."</p> <p>On 5/07/14 at 7:00pm, GHS (Group Home Staff) #2 indicated no pending maintenance lists were available for</p>		<p>bathroom.</p> <ul style="list-style-type: none"> ·On 5/19/2014, the closet doors were replaced. ·The group home staff is monitoring the home at each shift and is checking all lights as well as fixtures to assure that all items are in working and good condition. ·The group home manager is checking the home while she is at the home. The manager is doing at least a weekly check of light fixtures and assuring all items are in working condition. The manager will complete an official report and will submit this to the QDDP weekly for 2 months. The manager and the QDDP will determine a different frequency if necessary after that timeframe lapses. ·The QDDP, LPN and/or COO will check the home to assure that all lights and fixtures are in working condition. These visits will be unannounced. ·Carey Services has a process of submitting Maintenance Requests to the Maintenance Department to address areas of concern. Maintenance will assist in addressing items that are repairable. ·For items that are not repairable, the manager and the QDDP will complete the purchasing process to assure that consumers have working fixtures in the home. 				

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W000112	<p>review.</p> <p>On 5/8/14 at 9:15am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated no maintenance requests were available for review for the burned out lights and for client #7's closet doors. The QIDP indicated clients should be able to visually see inside the lower level bathroom and client #7 should have functional closet doors.</p> <p>9-3-1(a)</p> <p>483.410(c)(2) CLIENT RECORDS</p> <p>The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</p> <p>Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the facility failed to keep each client's personal information confidential by posting client #7's skin assessment schedule and clients #1, #2, #3, #4, #5, #6, and #7's client names, family members names, addresses, and contact telephone numbers.</p> <p>Findings include:</p>	W000112	<p>W112 ClientRecords</p> <p>This item outlines that the agency failed to keep each client's personal information confidential. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·All applicable items were removed on 5/16/2014. ·All other homes were evaluated to comply as well. ·Training with DSPs will occur no later than 6/15/2014 on this topic. ·The monitoring agent will be ongoing checks by the manager, 	06/15/2014			

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	<p>On 5/7/14 from 4:30pm until 7:35pm, and on 5/8/14 from 6:00am until 8:20am, observations were conducted at the group home. During both observation periods clients #1, #2, #3, #4, #5, #6, and #7 had access to the group home office. Posted at eye level on the bulletin board were client #7's skin assessment schedule along with sheets of paper indicating client #1, #2, #3, #4, #5, #6, and #7's names, family members full names, addresses, and contact telephone numbers. On 5/8/14 at 6:00am, GHS (Group Home Staff) #1 indicated the bulletin board could be read standing in the kitchen area of the group home. At 6:00am GHS #1 indicated the following client information could be read from the kitchen area:</p> <p>-Client #7's full name on a sheet of paper which indicated "Daily to do list...Skin Assessment."</p> <p>-Client #4's "Mom is at Aunt [name of Aunt and the telephone number]" with times to call mother and client #4's "Grandma's" telephone number.</p> <p>-Client #1's "Family Members: Parents: [name of Dad, Mom, and Step Dad with addresses]. Siblings [Name of client #1's Brothers, Sisters and locations], Hopefully this will alleviate some of the confusion [client #1] is trying to achieve</p>		<p>QDDP and the LPN. The manager is responsible for each visit made to this site to assure compliance. The manager will complete a weekly check that she will submit to the QDDP for 2 months. The frequency of this check will be evaluated after that time lapses.</p> <p>-The QDDP and/or the LPN will complete checks at least once per month to assure maintained compliance.</p>		

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	<p>regarding who is friend and who is family,"</p> <p>-"Additional Phone Numbers: [Client #4's initials]. [Client #4's Mother and Sister names, addresses, and telephone numbers]. [Client #3's initials], [Client #3's Sister, Advocate, and Father's names, addresses, and telephone numbers]. [Client #5's initials], [Client #5's Power of Attorney, address, and telephone number]. [Client #6's initials], [Client #6's Mother and Step Father, Brother, Sister, and Grandparents names, addresses, email addresses, and telephone numbers]. [Client #7's initials], [Client #7's Sister's name, address, and telephone number]."</p> <p>-"Consumer Laundry Schedule" with clients #1, #2, #3, #4, #5, #6, and #7's full names listed.</p> <p>On 5/8/14 at 9:15am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client names, family members names, addresses, and telephone numbers should not be posted in the group home. The QIDP indicated the group home failed to keep client personal information confidential.</p> <p>9-3-1(a)</p>			
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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview, and record review, the facility failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7). The facility failed to implement their policy and procedures to protect the clients and to prevent abuse, neglect, and/or mistreatment from staff for staff sleeping while on duty; and failed to ensure clients' rights were protected to have access to locked utensils and to have personal privacy.</p> <p>Findings include:</p> <p>Please refer to W149. The facility neglected for 4 of 4 allegations of staff to client abuse/neglect (for clients #1, #2, #3, #4, #5, #6, and #7), to implement its Abuse/Neglect/Mistreatment policy to immediately report allegations of abuse, neglect, and/or mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law and neglected to take sufficient corrective action after continued allegations of staff to client abuse, neglect, and/or mistreatment for clients #1 and #3 and for an allegation of</p>	W000122	<p>W122 Client Protections This item outlines that the agency failed to implement their policy and procedures to protect the clients and to prevent ANE. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·Training will all staff will occur no later than 6/15/2014 on the policy and procedures and will include and emphasize timeliness of reporting, reporting protocol and secondary notification measures. ·As of 5/16/2014all clients were trained on where the key is located regarding locked utensils. All ISPs and Goals will comply with assessments completed by the QDDP no later than 6/15/2014. ·QDDP is assessing other homes to assure this deficiency is not repeated in another home. This evaluation will be completed no later than 6/15/2014 with a plan to address any other home that is noted to have the same deficiency. ·No later than6/15/2014 all staff will receive training on how to teach the clients about personal privacy and the importance of such. Additionally, training will occur on advocacy to assure that personal privacy is respected. ·The manager will monitor all actions at the home. The QDDP, 	06/15/2014			

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	<p>neglect of staff sleeping on duty for clients #1, #2, #3, #4, #5, #6, and #7.</p> <p>Please refer to W153. The facility failed for 2 of 4 allegations of staff to client abuse, neglect, and/or mistreatment (for clients #1, #2, #3, #4, #5, #6, and #7), to immediately report allegations of abuse, neglect, and/or mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law.</p> <p>Please refer to W157. The facility failed for 4 of 4 allegations of staff to client abuse/neglect (for clients #1, #2, #3, #4, #5, #6, and #7), to initiate sufficient corrective action to immediately report allegations to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law and failed to take sufficient corrective action after continued allegations of staff to client abuse, neglect, and/or mistreatment for clients #1 and #3 and for an allegation of neglect for staff sleeping on duty for clients #1, #2, #3, #4, #5, #6, and #7.</p> <p>Please refer to W125. The facility failed to develop criteria for 2 of 4 sampled clients (clients #1 and #3) to access sharps and utensils. The facility failed to ensure unimpeded access to sharps for 2</p>		<p>LPN and/or COO will engage in unannounced visits to the home to monitor staff interaction with clients, assure privacy is respected and that no ANE is present.</p> <p>·TheResidential Manager will visit the house at least 2 times weekly for the next 2months (through August 31) unannounced. The Director of Group Homes willvisit the house at least 1 time monthly for 2 months (through August 31).</p> <p>·Allconsumers at this home were assessed to be able to use a key to lock and unlockutensils.</p>		

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W000125	<p>of 4 sampled clients (clients #2 and #4) and three additional clients (clients #5, #6, and #6) who did not require restricted access to sharps and utensils.</p> <p>Please refer to W130. The facility failed for 3 of 7 clients (clients #4, #6, and #7), to encourage and teach personal privacy when opportunities existed.</p> <p>9-3-2(a)</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review, and interview, the facility failed to develop criteria for 2 of 4 sampled clients (clients #1 and #3) to access sharps and utensils. The facility failed to ensure unimpeded access to sharps for 2 of 4 sampled clients (clients #2 and #4) and three additional clients (clients #5, #6, and #7) who did not require restricted access to sharps and utensils.</p> <p>Findings include:</p>	W000125	<p>W125 Protection of Clients This item outlines that the agency failed to develop criteria for select clients to access sharp utensils. The plan of correction for this tag is as follows: ·As of 5/16/2014 all clients were trained on where the key is located regarding locked utensils. All ISPs and Goals will comply with assessments completed by the QDDP no later than 6/15/2014. ·QDDP is assessing other homes to assure this deficiency is not repeated in another home.</p>	06/15/2014			

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	<p>On 5/7/14 from 4:30pm until 7:35pm, and on 5/8/14 from 6:00am until 8:20am, observations were conducted at the group home. During both observation periods clients #1, #2, #3, #4, #5, #6, and #7 were not prompted or encouraged to access locked sharp utensils when opportunities existed to cut meat, cut vegetables, and prepare menu items. During both observation periods Group Home Staff (GHS) #1, GHS #2, and GHS #3 opened a locked tote inside the medication room to access a knife to cut food items, staff cleaned the knife, returned the knife to the locked tote, and no client was given access to locked sharp objects.</p> <p>On 5/7/14 at 7:30pm, GHS #3 stated clients #1 and #3 "needed" locked sharp objects in the group home. GHS #3 stated "No clients" had access to locked sharps because of client #1 and #3's identified safety need for the sharp objects to have been locked.</p> <p>On 5/8/14 at 9:15am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the practice of locked sharp objects was not addressed in the clients' plans. The QIDP indicated clients #1 and #3 had a history of misusing sharp objects and for their safety the group home had locked the</p>		<p>This evaluation will be completed no later than 6/15/2014 with a plan to address any other home that is noted to have the same deficiency.</p> <ul style="list-style-type: none"> ·The manager will monitor all actions at the home. The QDDP, LPN and/or COO will engage in unannounced visits to the home to monitor and assure compliance. ·All consumers at this home were assessed by QDDP before 06/15/2014 to be able to use a key to lock and unlock utensils. ·Anytime that the Residential Manager, LPN or the Director of Group Homes visits the home monitoring for client protections will be completed in addition to unannounced visits. <p>Unannounced visits; the Residential Manager will visit the house at least 2 times weekly for the next 2 months unannounced (through August 31). The Director of Group Homes will visit the house at least 1 time monthly for 2 months (through August 31).</p>		

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	<p>sharp objects. The QIDP indicated clients #2, #4, #5, #6, and #7 did not have an identified safety need for the locked sharp objects and that sharps were restricted for the clients who lived in the group home. The QIDP indicated the practice of locked sharp objects was not addressed in clients #2, #4, #5, #6, and #7's plans. The QIDP indicated clients #2, #4, #5, #6, and #7 would need to gain access to the sharps via staff.</p> <p>Client #1's record was reviewed on 5/12/14 at 1:10pm. Client #1's 1/2/14 ISP (Individual Support Plan), 1/2014 BSP (Behavior Support Plan), and 1/2/14 Comprehensive Functional Assessment (CFA) did not have an identified need to lock sharp objects.</p> <p>Client #2's record was reviewed on 5/8/14 at 11:00am and on 5/12/14 at 11:00am. Client #2's 1/2/14 ISP, 1/2014 BSP, and 1/2/14 CFA did not have an identified need to lock sharp objects.</p> <p>Client #3's record was reviewed on 5/12/14 at 3:15pm. Client #3's 3/27/14 ISP, 2/2014 BSP, and 3/21/14 CFA did not have an identified need to lock sharp objects.</p> <p>Client #4's record was reviewed on 5/8/14 at 10:26am and on 5/12/14 at</p>			

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W000130	<p>9:00am. Client #4's 3/27/14 ISP, 7/2012 BSP, and 5/8/14 CFA did not have an identified need to lock sharp objects.</p> <p>9-3-2(a)</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview, for 1 of 7 clients (client #7), the facility failed to encourage and teach personal privacy when opportunities existed.</p> <p>Findings include:</p> <p>On 5/8/14 at 6:35am, client #7 was requested to come to the medication room by GHS (Group Home Staff) #1. The medication room door was open to the kitchen with clients #3 and #4 standing in the kitchen watching client #7 inside the medication room. At 6:35am, client #7 independently performed glucometer testing of his blood sugar, drew his insulin into a syringe, shared personal information with GHS #1 verbally, and client #7 pulled his shirt up while pulling his pants downward to expose his lower abdomen to inject his insulin in full view of clients #3 and #4.</p>	W000130	<p>W130 Protection of Clients This item outlines that the facility failed to encourage and teach personal privacy when opportunities existed. The plan of correction for this tag is as follows: ·No later than 6/15/2014all staff will receive training on how to teach the clients about personal privacy and the importance of such. Additionally, training will occur on advocacy to assure that personal privacy is respected. ·The manager will monitor all actions at the home. The QDDP, LPN and/or COO will engage in unannounced visits to the home to monitor staff interaction with clients and assure privacy is respected. ·Anytimethat the Residential Manager, LPN or the Director of Group Homes visits thehome monitoring for client protections will be completed in addition tounannounced visits. Unannounced visits; the</p>	06/15/2014

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W000149	<p>No privacy was taught or encouraged by GHS #1.</p> <p>On 5/8/14 at 9:15am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated clients should have been redirected during formal and informal opportunities to teach and encourage personal privacy during the clients' morning routines.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview, and record review, for 4 of 4 allegations of staff to client abuse/neglect (for clients #1, #2, #3, #4, #5, #6, and #7), the facility neglected to implement its Abuse/Neglect/Mistreatment policy to immediately report allegations of abuse, neglect, and/or mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with state law and neglected to take sufficient corrective action after continued allegations of staff to client abuse, neglect, and/or mistreatment for clients #1 and #3 and for an allegation of</p>	W000149	<p>Residential Manager will visit the house at least 2 times weekly for the next 2 months unannounced (through August 31). The Director of Group Homes will visit the house at least 1 time monthly for 2 months (through August 31).</p> <p>W149 staff Treatment of Clients this item outlines that the facility failed to implement its ANE policy. The plan of correction for this tag is as follows: <ul style="list-style-type: none"> · Training with all staff will occur no later than 6/15/2014 on the ANE policies, procedures, regulations and will include and emphasize timeliness of reporting, reporting protocol and secondary notification measures. · Training will emphasize a secondary level of notification to indicate that once an employee reports ANE allegation, he/she must notify the QDDP/COO to assure that the allegation is followed up on immediately. </p>	06/15/2014	

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	<p>neglect for staff sleeping on duty for clients #1, #2, #3, #4, #5, #6, and #7.</p> <p>Findings include:</p> <p>1. On 5/7/14 at 12:15pm, the facility's BDDS reports from 10/2013 through 5/7/14 were reviewed and indicated the following staff to client allegations of abuse, neglect, and/or mistreatment:</p> <p>For client #1.</p> <p>-A 1/2/14 BDDS report for an incident on 1/2/14 at 11:20am, indicated "During an ISP (Individual Support Plan) meeting for [client #1], her mother informed...the [QIDP-Qualified Mental Retardation Professional] that [client #1] reported to her mother on Christmas day 12/25/13 that [Discharged Staff #10] had told [client #1] that she needed to be transferred out of the house before [Discharged Staff #10] hurt [client #1]." The report indicated Discharged Staff #10 "had told [client #1] that she [Discharged Staff #10] was going to hurt [client #1] and put her in the hospital because [client #1] was getting on [Discharged Staff #10's] nerves." The report indicated Discharged Staff #10 was suspended pending an investigation.</p> <p>An attached undated investigation indicated the following:</p>		<ul style="list-style-type: none"> ·The manager will monitor all actions at the home at each time in the home and report minimally to the QDDP weekly. The QDDP, LPN and/or COO will engage in unannounced visits to the home to monitor staff interaction with clients and assure privacy is respected. ·The reporting tool was previously addressed and has been implemented in Complaint Survey (Survey Event ID C06L11) and approved POC stated: ·The Carey Services Investigation Report (of a critical event used for ANE and other serious incidents) did not address the cause of injuries, did not address corrective action to take place and lacked clarity on what recommendation was being made i.e. no steps of caution were listed to what staff were to take to prevent future occurrences. The Investigation Report has been revised. Training to occur on this new form by the QDDP to the home no later than 1/26/2014. ·The summary of critical information now includes cues to the writer: <ul style="list-style-type: none"> ·Provide detailed description of any injuries with detail such as size and color. ·Attach Assessment from Nurse regarding all incidents involving allegations of physical abuse, injuries of known or unknown origin, or when other medically related concerns are 				

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	-Discharged staff #11's witness statement indicated Discharged staff #11 "reported that [Discharged Staff #10] cursed at [client #3] in the past...reports that she had discussed this matter and this previous matter with [the former Residential Manager] on two different occasions during a face to face conversation...[Discharged Staff #10] telling [client #3] to go to her f--ing bedroom and an incident whereby [Discharged Staff #11] witnessed [Discharged Staff #10] grabbed and pulled [client #3] out of the med (medication room) and locked the door disallowing [client #3] in the med room. The second occurrence whereby [Discharged Staff #11] reports discussing inappropriate actions with [the Residential Manager] regarding an allegation...where [Discharged Staff #11] heard [Discharged Staff #10] tell [client #3] you are why we can't keep staff at the home." Discharged Staff #11's witness statement "confirms that she heard [Discharged Staff #10] tell [client #1] that she would have to transfer to another home as [Discharged Staff #10] can't stand [client #1]...And confirms that she heard [Discharged Staff #10] threaten [client #1] to put [client #1] in the hospital if she had to continue to work with [client #1]."		present. ·Clearly Define the Cause of the incident. ·The summary of final findings and recommendations section now includes cues to the writer: ·Specify Corrective Action to be taken to prevent recurrence of this type of incident in the future. ·Detail any recommendations such as what should occur, when, by whom, etc. ·Investigator is responsible to assure that the responsible person to carry out recommendations is aware of these instructions. ·The document now has a second signature line. The first is where the investigator signs/dates the document. The second line is dedicated Signature of Person Responsible for Corrective Action & to Carry Out Recommendations. This will assure a complete hand-off of information and expectations to occur. <u>Note that the timeframes evaluated for the Complaint Survey and for the Annual Survey overlap.</u> ·Anytimethat the Residential Manager, LPN or the Director of Group Homes visits thehome monitoring for client protections will be completed in addition tounannounced visits. Unannounced visits; the Residential Manager willvisit the house at least 2 times weekly for		

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	<p>-Discharged Staff #10's witness statement indicated "That [client #1] may have overheard [Discharged Staff #10] talking to her co worker [Group Home Staff #5]. On 12/21/13 at approximately 11:00am, [Discharged Staff #10] reports that she was talking with [GHS #5] and stated that [Discharged Staff #10] was so stressed that she may need to have herself admitted to [name] a local community mental health center...She reported that [client #1] was nearby outside of the door and [Discharged Staff #10] was not aware of [client #1's] location...."</p> <p>-"Summary of Critical Information...Allegation from consumer via consumer's mother is confirmed by discharged staff #11 and nearly verbatim. Group Home manager had items brought to her attention that were not reported appropriately. The allegation of abuse is substantiated as evidenced by corroborating statements of verbal abuse from [Discharged Staff #10] toward [client #1]...Recommendation termination of [Discharged Staff #10]. Group Home manager failed to act appropriately when concerns were brought to her attention in a manner that aligns with policies, procedures, and State regulations...."</p> <p>On 5/12/14 at 12:30pm, Discharged Staff</p>		<p>the next 2 months unannounced (through August 31). The Director of Group Homes will visit the house at least 1time monthly for 2 months (through August 31).</p>	

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	<p>#10's "Timecard Report" for the period from 12/3/13 through 1/3/14 was reviewed and indicated Discharged Staff #10 worked at the group home on 12/20, 12/21, 12/22, 12/24, 12/25, 12/26, 12/27, 12/28, 12/30/13, and 1/1/2014. The investigation failed to identify that Discharged Staff #10 continued to work at the group home after the incident occurred and was not suspended until after client #1's mother reported the incident to the Agency.</p> <p>For client #3: -A 12/10/13 BDDS report, for an allegation on 12/9/13 at 9:00am, indicated client #3 had reported to day service staff that staff #3 had pushed her at the group home on 12/9/13. The report indicated an investigation would be completed with the assistance of the Cooperation Compliance Office (CCO) (Quality Assurance), and staff #3 was suspended pending the completion of the investigation.</p> <p>An attached investigative report dated 12/10/13 and completed by CCO and the RD/QDDP indicated client #3 had reported to unidentified day service staff that she had been pushed by staff #3. Client #3 was brought to the RD/QDDP and "reported the same as well as showed a scratch on her shoulder and a small</p>						

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	<p>bruise on her inner right arm." The investigation indicated client #3 and staff #3 fell on ice after client #3 swung a lunchbox at staff #3 as she was assisting her into the house after client #3 attempted to leave the home. The investigative report did not include documentation of her injuries on an injury/skin assessment report or nursing evaluation. Summary of the investigation indicated the allegation was not substantiated, and "since this allegation may represent a developing pattern of alleging abuse when she is having an aggressive behavior, it is recommended that a psycho/social (psychological evaluation) follow (sic) be conducted with [client #3's] behavior specialist to see if her Behavior Support Plan needs modification. In the interim it is recommended that all staff be advised to use extreme caution in any physical interaction with [client #3] during a behavior." The summary of the investigation did not address the cause of client #3's injuries.</p> <p>-A 11/13/13 BDDS report for an incident on 11/12/13 at 5:00pm, indicated client #3 came to day services and said Discharged staff #10 caused her unknown bruise. The 11/12/13 BDDS report indicated client #3 "came to workshop and showed her workshop supervisor a</p>			

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	<p>large bruise-approximately 2 inches in diameter on her left upper, inside of arm, close to armpit. When asked what happened, [client #3] said 'didn't get her shores (sic) done.' She then grabbed her arm where the bruise was and said 'staff.' When asked what the staff's name was she signed a 'B.'" Corrective action indicated the incident was "immediately reported to the Residential Director [name], so that she could begin an investigation into [client #3's] allegation." A follow up report dated 11/15/13 indicated the allegation was unsubstantiated. "[Client #3] had several small 1 to 2 cm (centimeter) bruises on both upper arms. According to an accident report on 11/11/13 [client #3] was observed by group home staff pinching and punching her upper arms...evening 11/11/13. During the investigation [client #3] did confirm she had pinched her upper arms."</p> <p>2. For clients #1, #2, #3, #4, #5, #6, and #7: -A 12/27/13 BDDS report for an allegation of neglect on 12/23/13 at 11:00pm, indicated "on Dec. (December) 23rd staff arrived at the group home and found [Discharged Staff #11] asleep on the couch." The report indicated the plan to resolve was to suspend Discharged Staff #11 pending an investigation.</p>						

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	<p>-A 12/27/13 "Investigation" indicated "Alleged or suspected abuse, neglect, or exploitation of consumer...[Name of QIDP] received an email that was sent on 12/26/13 at 4:49pm by [Group Home Staff (GHS) #6] but was not read till approximately 11:00am while on vacation (by the QIDP)." The investigation indicated the QIDP notified the Residential Manager to suspend Discharged Staff #11 pending an investigation and to send in a BDDS report. The investigation indicated the following information:</p> <p>-GHS #6's witness statement indicated "I walked in to work at 10:50pm on December 23, 2013, the overhead (garage) door in the garage was wide open. (I) shut the door and clocked in, went to the med room and the door was locked. (I) walked to the living room and found [Discharged Staff #11] sleeping. I yelled at her 3 times before she woke up. She gave me the med keys, clocked out, and left."</p> <p>-GHS #2's witness statement indicated "On Monday the 23rd [Discharged Staff #11] was sleeping at work. She had mentioned being tired and was sitting with some of the clients in the living room watching TV. I had been cleaning up the kitchen area and I noticed that I had not seen her in some time. I found</p>			

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	<p>her asleep in the living room. This was probably around 9pm I tried waking her by calling her name but she did not move. I waited a short period of time before trying again. This time she woke up and I went about making sure everybody took their bath/shower and went to bed. I found [Discharged Staff #11] asleep again in the living room. I am pretty sure it was around 9:30pm at this point in time. I tried to wake her but she did not stir. I really did not want to get her in trouble so I decided that I would wait and see if she would wake up before I left. So at 10pm, when I was scheduled to leave I tried waking her. She appeared to wake didn't seem wholly so. So, started my car to let it warm up and came back in and managed to wake her...I gave her the keys to the med cart and left."</p> <p>-Discharged Staff #11's witness statement indicated she fell "asleep" around 8:00pm. GHS #2 "had woke her up at approximately 9:00pm when he was leaving but that she fell back to sleep and that [GHS #6] woke her up when he came in around 11:00pm."</p> <p>-"Summary of Critical Information" indicated GHS #6 reported Discharged Staff #11 "was found sleeping when he arrived at the Upland Group Home on 12/23/13...Neglect is substantiated due to [Discharged Staff #11] being asleep on the job being the only staff person in the</p>						

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	<p>house on 12/23/13 from 10:00pm until 11:00pm. It is recommended that [Discharged Staff #11's] employment be terminated."</p> <p>On 5/12/14 at 12:30pm, Discharged Staff #11's "Timecard Report" for the period from 12/3/13 through 1/3/14 was reviewed and indicated Discharged Staff #11 worked at the group home on 12/21, 12/23, 12/24, and 12/25/13. Discharged Staff #11's timecard report indicated she continued to work at the group home until the allegation was reported to the Agency and not immediately following the incident.</p> <p>On 05/8/14 at 9:15am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the allegations of abuse, neglect, and/or mistreatment were not reported immediately to the administrator or in accordance with State Law. The QIDP indicated suspected abuse, neglect, and/or mistreatment allegations should be reported immediately by the facility staff and were not. The QIDP indicated the facility staff who witnessed the events and failed to report the allegation exposed the client to the potential of further abuse, neglect, and/or mistreatment. The QIDP indicated the facility followed the BDDS</p>			

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	<p>reporting guidelines for abuse, neglect, and/or mistreatment.</p> <p>On 5/16/14 at 10:25am, an interview with the QIDP was conducted. The QIDP indicated there was no additional corrective action, no staff training available for review, no monitoring to ensure compliance, and no documented indication of what steps staff were to take to prevent future occurrence. The QIDP indicated she did not visit the group home until after the 1/3/14 allegation was made by client #1's mother.</p> <p>On 5/7/14 at 12:15pm, a review of the facility's records indicated the facility's 6/15/11 "Abuse, Neglect, and Exploitation" policy which indicated, "It is the policy of Carey Services to respect the rights of consumers served and protect them from possible abusive treatment, negligence, or exploitation on the part of staff, volunteers, or other consumers. Abusive treatment and/or negligence of responsibilities with respect to the welfare and safety of consumers are incompatible with the purpose of the agency....Definition: Neglect: includes, but is not limited to, failure to provide appropriate supervision, care, training, a safe/clean/sanitary environment, food, medical care, medical supplies and</p>			

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	<p>equipment (as indicated in the ISP (Individual Support Plan))."</p> <p>On 5/7/14 at 12:15pm, a review of the facility's 10/22/12 "PROCEDURES FOR REPORTING ABUSE AND NEGLECT AND OTHER REPORTABLE OR UNUSUAL INCIDENTS. As required by law, it is the responsibility of each person to report suspected instances of abuse, neglect, and exploitation...responsibilities in reporting such incidents to authorities as well as to agency administrators immediately upon learning of the suspected abuse/neglect/exploitation. Agency staff and volunteers must immediately report incidents to the President/CEO, Human Resources Manager, or designee, who will assign responsibility for investigation and follow-up. The Corporate Compliance Officer will be notified of the allegation and may or may not be asked to assist with the investigation. A. <u>REPORTABLE INCIDENTS</u>: Carey Services shall meet all the conditions specified in any applicable article of 460 IAC. Carey Services shall report the following circumstances to DDRS/BDDS/DA (Department of Aging) no later than 24 hours after the occurrence of the reportable incident...The following incidents are considered reportable to the</p>			

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W000153	<p>appropriate entity as outlined in section B: 1. Any alleged, suspected, or actual abuse, neglect or exploitation of a consumer...."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review for 2 of 4 allegations of staff to client abuse, neglect, and/or mistreatment (for clients #1, #2, #3, #4, #5, #6, and #7), the facility failed to immediately report allegations of abuse, neglect, and/or mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law. Findings include: 1. On 5/7/14 at 12:15pm, the facility's BDDS reports from 10/2013 through 5/7/14 were reviewed and indicated the following staff to client allegations of abuse, neglect, and/or mistreatment:</p>	W000153	<p>W153 staff Treatment of Clients this item outlines that the facility failed to immediately report allegations of ANE. The plan of correction for this tag is as follows: ·Training with all staff will occur no later than 6/15/2014 on the ANE policies, procedures, regulations and will include and emphasize timeliness of reporting, reporting protocol and secondary notification measures. ·Training will emphasize a secondary level of notification to indicate that once an employee reports ANE allegation, he/she must notify the QDDP/COO to assure that the allegation is followed up on immediately. ·The manager will monitor all actions at the home each time in the home and report minimally to</p>	06/15/2014			

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	<p>For client #1.</p> <p>-A 1/2/14 BDDS report for an incident on 1/2/14 at 11:20am, indicated "During an ISP (Individual Support Plan) meeting for [client #1], her mother informed...the [QIDP-Qualified Mental Retardation Professional] that [client #1] reported to her mother on Christmas day 12/25/13 that [Discharged Staff #10] had told [client #1] that she needed to be transferred out of the house before [Discharged Staff #10] hurt [client #1]."</p> <p>The report indicated Discharged Staff #10 "had told [client #1] that she [Discharged Staff #10] was going to hurt [client #1] and put her in the hospital because [client #1] was getting on [Discharged Staff #10's] nerves." The report indicated Discharged Staff #10 was suspended pending an investigation.</p> <p>An attached undated investigation indicated the following:</p> <p>-Discharged staff #11's witness statement indicated Discharged staff #11 "reported that [Discharged Staff #10] cursed at [client #3] in the past...reports that she had discussed this matter and this previous matter with [the former Residential Manager] on two different occasions during a face to face conversation...[Discharged Staff #10] telling [client #3] to go to her f---ing</p>		<p>the QDDP weekly. The QDDP, LPN and/or COO will engage in unannounced visits to the home to monitor staff interaction with clients and assure privacy is respected.</p> <p>Anytimethat the Residential Manager, LPN or the Director of Group Homes visits thehome monitoring for client protections will be completed in addition tounannounced visits. Unannounced visits; the Residential Manager willvisit the house at least 2 times weekly for the next 2 months unannounced (throughAugust 31). The Director of Group Homes will visit the house at least 1time monthly for 2 months (through August 31).</p>	

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	<p>bedroom and an incident whereby [Discharged Staff #11] witnessed [Discharged Staff #10] grabbed and pulled [client #3] out of the med (medication room) and locked the door disallowing [client #3] in the med room. The second occurrence whereby [Discharged Staff #11] reports discussing inappropriate actions with [the Residential Manager] regarding an allegation...where [Discharged Staff #11] heard [Discharged Staff #10] tell [client #3] you are why we can't keep staff at the home." Discharged Staff #11's witness statement "confirms that she heard [Discharged Staff #10] tell [client #1] that she would have to transfer to another home as [Discharged Staff #10] can't stand [client #1]...And confirms that she heard [Discharged Staff #10] threaten [client #1] to put [client #1] in the hospital if she had to continue to work with [client #1]."</p> <p>-"Summary of Critical Information...Allegation from consumer via consumer's mother is confirmed by discharged staff #11 and nearly verbatim. Group Home manager had items brought to her attention that were not reported appropriately. The allegation of abuse is substantiated as evidenced by corroborating statements of verbal abuse from [Discharged Staff #10] toward</p>				

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	<p>[client #1]...Recommendation termination of [Discharged Staff #10]. Group Home manager failed to act appropriately when concerns were brought to her attention in a manner that aligns with policies, procedures, and State regulations...."</p> <p>2. For clients #1, #2, #3, #4, #5, #6, and #7:</p> <p>-A 12/27/13 BDDS report for an allegation of neglect on 12/23/13 at 11:00pm, indicated "on Dec. (December) 23rd staff arrived at the group home and found [Discharged Staff #11] asleep on the couch." The report indicated the plan to resolve was to suspend Discharged Staff #11 pending an investigation.</p> <p>-A 12/27/13 "Investigation" indicated "Alleged or suspected abuse, neglect, or exploitation of consumer...[Name of QIDP] received an email that was sent on 12/26/13 at 4:49pm by [Group Home Staff (GHS) #6] but was not read till approximately 11:00am while on vacation (by the QIDP)." The investigation indicated the QIDP notified the Residential Manager to suspend Discharged Staff #11 pending an investigation and to send in a BDDS report. The investigation indicated the following information:</p> <p>-GHS #6's witness statement indicated "I</p>			
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	<p>walked in to work at 10:50pm on December 23, 2013, the overhead (garage) door in the garage was wide open. (I) shut the door and clocked in, went to the med room and the door was locked. (I) walked to the living room and found [Discharged Staff #11] sleeping. I yelled at her 3 times before she woke up. She gave me the med keys, clocked out, and left."</p> <p>-GHS #2's witness statement indicated "On Monday the 23rd [Discharged Staff #11] was sleeping at work. She had mentioned being tired and was sitting with some of the clients in the living room watching TV. I had been cleaning up the kitchen area and I noticed that I had not seen her in some time. I found her asleep in the living room. This was probably around 9pm I tried waking her by calling her name but she did not move. I waited a short period of time before trying again. This time she woke up and I went about making sure everybody took their bath/shower and went to bed. I found [Discharged Staff #11] asleep again in the living room. I am pretty sure it was around 9:30pm at this point in time. I tried to wake her but she did not stir. I really did not want to get her in trouble so I decided that I would wait and see if she would wake up before I left. So at 10pm, when I was scheduled to leave I tried waking her. She appeared to</p>				

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	<p>wake didn't seem wholly so. So, started my car to let it warm up and came back in and managed to wake her...I gave her the keys to the med cart and left."</p> <p>-Discharged Staff #11's witness statement indicated she fell "asleep" around 8:00pm. GHS #2 "had woke her up at approximately 9:00pm when he was leaving but that she fell back to sleep and that [GHS #6] woke her up when he came in around 11:00pm."</p> <p>-"Summary of Critical Information" indicated GHS #6 reported Discharged Staff #11 "was found sleeping when he arrived at the Upland Group Home on 12/23/13...Neglect is substantiated due to [Discharged Staff #11] being asleep on the job being the only staff person in the house on 12/23/13 from 10:00pm until 11:00pm. It is recommended that [Discharged Staff #11's] employment be terminated."</p> <p>On 05/8/14 at 9:15am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the allegations of abuse, neglect, and/or mistreatment were not reported immediately to the administrator or in accordance with State Law. The QIDP indicated suspected abuse, neglect, and/or mistreatment allegations should be reported immediately by the facility staff.</p>						

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W000157	<p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview, and record review, for 2 of 4 allegations of staff to client abuse/neglect (for clients #1, #2, #3, #4, #5, #6, and #7), the facility failed to initiate sufficient corrective action to immediately report allegations of abuse, neglect, and/or mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law and failed to take sufficient corrective action after continued allegations of staff to client abuse, neglect, and/or mistreatment for clients #1 and #3 and for an allegation of neglect for staff sleeping on duty for clients #1, #2, #3, #4, #5, #6, and #7.</p> <p>Findings include:</p> <p>1. On 5/7/14 at 12:15pm, the facility's BDDS reports from 10/2013 through 5/7/14 were reviewed and indicated the following staff to client allegations of abuse, neglect, and/or mistreatment:</p> <p>For client #1. -A 1/2/14 BDDS report for an incident on</p>	W000157	<p>W157 staff Treatment of Clients this item outlines that the facility failed to initiate sufficient corrective action to immediately report ANE. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·Training with all staff will occur no later than 6/15/2014 on the ANE policies, procedures, regulations and will include and emphasize timeliness of reporting, reporting protocol and secondary notification measures. ·Training will emphasize a secondary level of notification to indicate that once an employee reports ANE allegation, he/she must notify the QDDP/COO to assure that the allegation is followed up on immediately. ·The manager will monitor all actions at the home each time in the home and report minimally to the QDDP weekly. The QDDP, LPN and/or COO will engage in unannounced visits to the home to monitor staff interaction with clients and assure privacy is respected. ·Inaddition to the staff immediately notifying the Administrator with all ANE, thestaff will be trained before 	06/15/2014			

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	<p>1/2/14 at 11:20am, indicated "During an ISP (Individual Support Plan) meeting for [client #1], her mother informed...the [QIDP-Qualified Mental Retardation Professional] that [client #1] reported to her mother on Christmas day 12/25/13 that [Discharged Staff #10] had told [client #1] that she needed to be transferred out of the house before [Discharged Staff #10] hurt [client #1]." The report indicated Discharged Staff #10 "had told [client #1] that she [Discharged Staff #10] was going to hurt [client #1] and put her in the hospital because [client #1] was getting on [Discharged Staff #10's] nerves." The report indicated Discharged Staff #10 was suspended pending an investigation. There was no additional corrective action, no monitoring to ensure compliance, and no documented indication of what steps staff were to take to prevent future occurrence.</p> <p>An attached undated investigation indicated the following: -Discharged staff #11's witness statement indicated Discharged staff #11 "reported that [Discharged Staff #10] cursed at [client #3] in the past...reports that she had discussed this matter and this previous matter with [the former Residential Manager] on two different occasions during a face to face</p>		<p>6/15/2014 to follow up with the QDDP, Corporate Compliance Officer and/or Chief Operations Officer to ensure that the allegation is followed up on immediately.</p> <ul style="list-style-type: none"> · Any staff that is reported for allegation of ANE will be immediately suspended pending outcome of the investigation. · Any and all recommended training from the outcome of the investigation will be completed within 7 days from the completion of the investigation and prior to the suspended staff returning to work. 		

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	<p>conversation...[Discharged Staff #10] telling [client #3] to go to her f---ing bedroom and an incident whereby [Discharged Staff #11] witnessed [Discharged Staff #10] grabbed and pulled [client #3] out of the med (medication room) and locked the door disallowing [client #3] in the med room. The second occurrence whereby [Discharged Staff #11] reports discussing inappropriate actions with [the Residential Manager] regarding an allegation...where [Discharged Staff #11] heard [Discharged Staff #10] tell [client #3] you are why we can't keep staff at the home." Discharged Staff #11's witness statement "confirms that she heard [Discharged Staff #10] tell [client #1] that she would have to transfer to another home as [Discharged Staff #10] can't stand [client #1]...And confirms that she heard [Discharged Staff #10] threaten [client #1] to put [client #1] in the hospital if she had to continue to work with [client #1]." There was no additional corrective action, no monitoring to ensure compliance, and no documented indication of what steps staff were to take to prevent future occurrence.</p> <p>-Discharged Staff #10's witness statement indicated "That [client #1] may have overheard [Discharged Staff #10] talking to her co worker [Group Home Staff #5].</p>			

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	<p>On 12/21/13 at approximately 11:00am, [Discharged Staff #10] reports that she was talking with [GHS #5] and stated that [Discharged Staff #10] was so stressed that she may need to have herself admitted to [name], a local community mental health center...She reported that [client #1] was nearby outside of the door and [Discharged Staff #10] was not aware of [client #1's] location...."</p> <p>-"Summary of Critical Information...Allegation from consumer via consumer's mother is confirmed by discharged staff #11 and nearly verbatim. Group Home manager had items brought to her attention that were not reported appropriately. The allegation of abuse is substantiated as evidenced by corroborating statements of verbal abuse from [Discharged Staff #10] toward [client #1]...Recommendation termination of [Discharged Staff #10]. Group Home manager failed to act appropriately when concerns were brought to her attention in a manner that aligns with policies, procedures, and State regulations...."</p> <p>On 5/12/14 at 12:30pm, Discharged Staff #10's "Timecard Report" for the period from 12/3/13 through 1/3/14 was reviewed and indicated Discharged Staff #10 worked at the group home on 12/20,</p>				

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	<p>12/21, 12/22, 12/24, 12/25, 12/26, 12/27, 12/28, 12/30/13, and 1/1/2014.</p> <p>Discharged Staff #10's timecard report indicated she continued to work at the group home after the incident and before the allegation was reported to the agency.</p> <p>For client #3: -A 12/10/13 BDDS report, for an allegation on 12/9/13 at 9:00am, indicated indicated client #3 had reported to day service staff that staff #3 had pushed her at the group home on 12/9/13. The report indicated an investigation would be completed with the assistance of the Cooperation Compliance Office (CCO) (Quality Assurance), and staff #3 was suspended pending the completion of the investigation. There was no additional corrective action, no monitoring to ensure compliance, and no documented indication of what steps staff were to take to prevent future occurrence.</p> <p>An attached investigative report dated 12/10/13 and completed by CCO and the RD/QDDP indicated client #3 had reported to unidentified day service staff that she had been pushed by staff #3. Client #3 was brought to the RD/QDDP and "reported the same as well as showed a scratch on her shoulder and a small bruise on her inner right arm." The investigation indicated client #3 and staff</p>						

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	<p>#3 fell on ice after client #3 swung a lunchbox at staff #3 as she was assisting her into the house after client #3 attempted to leave the home. The investigative report did not include documentation of her injuries on an injury/skin assessment report or nursing evaluation. Summary of the investigation indicated the allegation was not substantiated, and "since this allegation may represent a developing pattern of alleging abuse when she is having an aggressive behavior, it is recommended that a psycho/social (psychological evaluation) follow (sic) be conducted with [client #3's] behavior specialist to see if her Behavior Support Plan needs modification. In the interim it is recommended that all staff be advised to use extreme caution in any physical interaction with [client #3] during a behavior." The summary of the investigation did not address the cause of client #3's injuries. There was no additional corrective action or indication of what steps of caution staff were to take to prevent future occurrence of client #3's behavior.</p> <p>-A 11/13/13 BDDS report for an incident on 11/12/13 at 5:00pm, indicated client #3 came to day services and said Discharged staff #10 caused her unknown bruise. The 11/12/13 BDDS report</p>						

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	<p>indicated client #3 "came to workshop and showed her workshop supervisor a large bruise-approximately 2 inches in diameter on her left upper, inside of arm, close to armpit. When asked what happened, [client #3] said 'didn't get her shores (sic) done.' She then grabbed her arm where the bruise was and said 'staff.' When asked what the staff's name was she signed a 'B'." Corrective action indicated the incident was "immediately reported to the Residential Director [name], so that she could begin an investigation into [client #3's] allegation." A follow up report dated 11/15/13 indicated the allegation was unsubstantiated. "[Client #3] had several small 1 to 2 cm (centimeter) bruises on both upper arms. According to an accident report on 11/11/13 [client #3] was observed by group home staff pinching and punching her upper arms...evening 11/11/13. During the investigation [client #3] did confirm she had pinched her upper arms." There was no evidence of corrective action taken to prevent future occurrence of client #3's self injurious behavior in the follow up report.</p> <p>For clients #1, #2, #3, #4, #5, #6, and #7: -A 12/27/13 BDDS report for an allegation of neglect on 12/23/13 at 11:00pm, indicated "on Dec. (December)</p>			
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	<p>23rd staff arrived at the group home and found [Discharged Staff #11] asleep on the couch." The report indicated the plan to resolve was to suspend Discharged Staff #11 pending an investigation. There was no additional corrective action, no monitoring to ensure compliance, and no documented indication of what steps staff were to take to prevent future occurrence.</p> <p>-A 12/27/13 "Investigation" indicated "Alleged or suspected abuse, neglect, or exploitation of consumer...[Name of QIDP] received an email that was sent on 12/26/13 at 4:49pm by [Group Home Staff (GHS) #6] but was not read till approximately 11:00am while on vacation (by the QIDP)." The investigation indicated the QIDP notified the Residential Manager to suspend Discharged Staff #11 pending an investigation and to send in a BDDS report. The investigation indicated the following information: -GHS #6's witness statement indicated "I walked in to work at 10:50pm on December 23, 2013, the overhead (garage) door in the garage was wide open. (I) shut the door and clocked in, went to the med room and the door was locked. (I) walked to the living room and found [Discharged Staff #11] sleeping. I yelled at her 3 times before she woke up.</p>			

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	<p>She gave me the med keys, clocked out, and left."</p> <p>-GHS #2's witness statement indicated "On Monday the 23rd [Discharged Staff #11] was sleeping at work. She had mentioned being tired and was sitting with some of the clients in the living room watching TV. I had been cleaning up the kitchen area and I noticed that I had not seen her in some time. I found her asleep in the living room. This was probably around 9pm I tried waking her by calling her name but she did not move. I waited a short period of time before trying again. This time she woke up and I went about making sure everybody took their bath/shower and went to bed. I found [Discharged Staff #11] asleep again in the living room. I am pretty sure it was around 9:30pm at this point in time. I tried to wake her but she did not stir. I really did not want to get her in trouble so I decided that I would wait and see if she would wake up before I left. So at 10pm, when I was scheduled to leave I tried waking her. She appeared to wake didn't seem wholly so. So, started my car to let it warm up and came back in and managed to wake her...I gave her the keys to the med cart and left."</p> <p>-Discharged Staff #11's witness statement indicated she fell "asleep" around 8:00pm. GHS #2 "had woke her up at approximately 9:00pm when he was</p>			

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	<p>leaving but that she fell back to sleep and that [GHS #6] woke her up when he came in around 11:00pm." -"Summary of Critical Information" indicated GHS #6 reported Discharged Staff #11 "was found sleeping when he arrived at the Upland Group Home on 12/23/13...Neglect is substantiated due to [Discharged Staff #11] being asleep on the job being the only staff person in the house on 12/23/13 from 10:00pm until 11:00pm. It is recommended that [Discharged Staff #11's] employment be terminated."</p> <p>On 5/12/14 at 12:30pm, Discharged Staff #11's "Timecard Report" for the period from 12/3/13 through 1/3/14 was reviewed and indicated Discharged Staff #11 worked at the group home on 12/21, 12/23, 12/24, and 12/25/13. Discharged Staff #11's timecard report indicated she continued to work at the group home after the incident and before the agency became aware of the allegation.</p> <p>On 05/8/14 at 9:15am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the allegations of abuse, neglect, and/or mistreatment were not reported immediately to the administrator or in accordance with State Law. The QIDP indicated suspected</p>			

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W000210	<p>abuse, neglect, and/or mistreatment allegations should be reported immediately by the facility staff and were not. The QIDP indicated the facility staff who witnessed the events and failed to report the allegation exposed the client to the potential of further abuse, neglect, and/or mistreatment.</p> <p>On 5/16/14 at 10:25am, an interview with the QIDP was conducted. The QIDP indicated there was no additional corrective action, no staff training available for review, no monitoring to ensure compliance, and no documented indication of what steps staff were to take to prevent future occurrence. The QIDP indicated she did not visit the group home until after the 1/3/14 allegation was made by client #1's mother.</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 assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #1 and #3) who shared the back upper bedroom and for 2 of 2 new admissions to the facility (clients #1 and</p>	W000210	<p>W210 Individual Program Plan This item outlines that the facility failed to assess functional ability related to exiting their upper bedroom. The plan of correction</p>	06/15/2014			

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	<p>#2), the facility failed to assess client #1 and #3's functional ability related to exiting their back upper level bedroom during a disaster using a chain link ladder and failed to assess upon admission clients #1 and #2's functional abilities, physical skills, physical dexterity, and muscle dexterity.</p> <p>Findings include:</p> <p>1. On 5/7/14 from 4:30pm until 7:35pm, and on 5/8/14 from 6:00am until 8:20am, observations were conducted at the group home and clients #1 and #3 shared the upper level back bedroom. During both observation periods client #1 and #3's shared bedroom had one entry/exit through the door to the hallway. During both observation periods client #1 and #3's shared back upper level bedroom had a twenty to twenty-five foot drop from the window to the ground below. On 5/8/14 at 7:15am, clients #1 and #3 were interviewed. At 7:15am, client #1 stated she had "No idea" what a chain link ladder was and did not know how to exit the group home if she could not walk out into the hallway during an emergency. At 7:15am, client #3 stated she had "No idea" what a chain link ladder was and did not know how to exit the group home if she could not walk out into the hallway during an emergency.</p>		<p>for this tag is as follows:</p> <ul style="list-style-type: none"> ·The applicable clients and all staff have been trained on how to use the ladder. ·LPN has received 2 of 3 OT/PT evaluations. For the third client, the physician verbally stated that OT/PT was not necessary for the ladder; however we have requested this be in a written order. The LPN has been in contact with the physician office and the order to indicate OT/PT is not necessary is expected by end of business on 6/6/2014, but will be received no later than 6/15/2014. For the other 2 clients, OT/PT evaluation was ordered. These appointments are scheduled at the earliest available time. ·Carey Services has coordinated with 2 companies to receive quotations on removing the window and installing a door out to an exterior fire escape staircase for evacuation. The companies have committed to sending quotations before 6/15/2014. The agency must determine which company to use (and assure the company complies with Medicaid regulations) no later than 6/30/2014. The construction will be scheduled as soon as possible, however at this time, the timeline is not known. ·The QDDP was in contact with the Surveyor who requested she call Steve Corya with ISDH. The QDDP attempted to connect with Steve Corya and has not received 				

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	<p>On 5/8/14 at 7:45am, GHS (Group Home Staff) #3 stated client #1 and #3's shared back upper level bedroom had a drop of "at least" twenty to twenty-five feet from the window to the ground below. At 7:45am, GHS #3 located the chain link ladder piled loose on the upper shelf inside the closet and stated the ladder "was buried with stuff" (client #1 and #3's clothing, boxes, and miscellaneous items) on top of the ladder. GHS #3 stated "I thought it was exercise equipment."</p> <p>On 5/8/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the facility had not completed an assessment for clients #1 and #3 to determine if clients #1 and #3 could exit the upper level back bedroom during an emergency.</p> <p>2. Client #1's record was reviewed on 5/12/14 at 1:10pm. Client #1's record did not include an assessment related to her functional abilities client #1's physical skills, physical dexterity, and muscle dexterity. Client #1's record indicated she was admitted on 12/4/13. The facility failed to assess client #1's functional ability related to exiting her back upper level bedroom during a</p>		<p>a call back to assure a safe situation is put in place for these consumers between now and construction completion.</p> <p>Carey Services is evaluating an interim plan of having a temporary bedroom in the basement (which has secondary egress without a window ladder) or to have the consumers exit through another consumer's bedroom (with explicit permission). Carey Services has requested input from ISDH on this matter to assure the best solution is in place for the safety and security of consumers.</p>				

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	<p>disaster using a chain link ladder and failed to assess her functional abilities, physical skills, physical dexterity, and muscle dexterity upon admission to the facility.</p> <p>3. Client #2's record was reviewed on 5/8/14 at 11:00am and on 5/12/14 at 11:00am. Client #2's record did not include an assessment related to her functional abilities client #2's physical skills, physical dexterity, and muscle dexterity. Client #2's record indicated she was admitted on 12/23/13. The facility failed to assess client #2's functional abilities, physical skills, physical dexterity, and muscle dexterity upon admission to the facility.</p> <p>4. Client #3's record was reviewed on 5/12/14 at 3:15pm. Client #3's record did not include an assessment related to her functional abilities, her physical skills, physical dexterity, and muscle dexterity. Client #3's record indicated she was admitted on 2/6/2008. The facility failed to assess client #3's functional ability related to exiting her back upper level bedroom during a disaster using a chain link ladder.</p> <p>On 5/8/14 at 9:50am, an interview was conducted with the agency's LPN (Licensed Practical Nurse). The LPN</p>			

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	<p>indicated she believed clients #1, #2, and #3 had a PT (Physical Therapy) or a OT (Occupational Therapy) assessment of client #1, #2, and #3's functional ability related to their physical skills, physical dexterity, and muscle dexterity. The LPN indicated she was unsure if clients #1 and #3 had the skills to exit using a chain link ladder out the window during an emergency.</p> <p>On 5/13/14 at 10:12am, clients #1, #2, and #3's documented assessments of their functional abilities related to each clients' physical skills, physical dexterity, and muscle dexterity was requested and none were available for review. The LPN indicated no additional information was available for review.</p> <p>On 5/16/14 at 10:25am, an interview with the QIDP (Qualified Intellectual Disabilities Professional), the RM (Residential Manager), and the LPN was conducted. The three administrative staff indicated client #1, #2, and #3 did not have a documented assessment for the clients' functional abilities of their physical skills, physical dexterity, and muscle dexterity related to client #1 and #2's admission and for clients #1 and #3 exiting their back upper level bedroom during a disaster using a chain link ladder.</p>				

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W000268	<p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, for 2 of 7 clients (clients #4 and #6), the facility failed to promote client #4 and #6's dignity and ensure personal privacy to wear a robe when in common areas of the home.</p> <p>Findings include:</p> <p>1. On 5/8/14 at 6:00am, client #4 was observed to receive her medications administered by GHS #1 while wearing her night gown and did not wear a robe. From 6:00am until 6:25am, client #4 walked throughout the male/female group home in her nightgown and did not wear a robe over the sheer nightgown. At 6:25am, GHS #1 indicated client #4 should have worn a robe, and indicated client #4 was not prompted or encouraged to wear a robe.</p> <p>2. On 5/8/14 from 6:00am until 7:00am, client #6 walked around the upstairs dining room and kitchen in his boxer shorts and did not wear a robe. At</p>	W000268	<p>W268 conduct toward Client this item outlines that the facility failed to promote dignity and ensure personal privacy. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·No later than 6/15/2014 all staff will receive training on how to teach the clients about personal privacy and the importance of such. Additionally, training will occur on advocacy to assure that personal privacy is respected. ·The manager will monitor all actions at the home. The QDDP, LPN and/or COO will engage in unannounced visits to the home to monitor staff interaction with clients and assure privacy is respected. ·Anytime that the Residential Manager, LPN or the Director of Group Homes visits the home monitoring for client protections will be completed in addition to unannounced visits. Unannounced visits; the Residential Manager will visit the house at least 2 times weekly for the next 2 months unannounced (through August 31). The Director of Group Homes will visit the house at least 1 time monthly 	06/15/2014			

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W000323	<p>7:00am, client #6 sat on the floor in the lower level family room, wore only boxer shorts, shaved, and was not prompted to wear a robe.</p> <p>On 5/8/14 at 9:15am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated clients should have been redirected during formal and informal opportunities to teach and encourage personal privacy during dressing and/or the clients' morning routines.</p> <p>9-3-5(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 2 of 4 sampled clients (clients #2 and #3), the facility failed to ensure client #2's hearing and client #3's vision were assessed annually.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 5/8/14 at 11:00am and on 5/12/14 at 11:00am. Client #2's record indicated</p>	W000323	<p>for 2 months (through August 31).</p> <p>W323 PhysicianServices This item outlines that the facility failed to ensure a hearing and vision screening was completed. The plan of correction for this tag is as follows: ·LPN meets with the manager weekly (already established pattern). The agenda at these meetings have been updated and now includes items that are due and coming due as well as items that are missing. ·Chart audits will supply the LPN</p>	06/15/2014

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	<p>she was admitted on 12/23/13. Client #2's record did not indicate her hearing had been assessed. Client #2's 1/14/14 History and Physical completed by her personal physician did not include an assessment of her hearing. Client #2's 3/28/14, 1/30/14, and 12/17/13 Nursing Quarterly assessments did not include an assessment of client #2's hearing.</p> <p>Client #3's record was reviewed on 5/12/14 at 3:15pm. Client #3's record indicated she was admitted on 2/6/2008. Client #3's 1/15/14 History and Physical completed by her personal physician did not include an assessment of her vision. Client #3's 3/28/14, 1/30/14, and 10/31/13 Nursing Quarterly assessments indicated client #3 wore prescribed eye glasses and did not include an assessment of client #3's ocular health or vision. Client #3's 8/30/13 Nursing Quarterly assessment indicated client #3 did not wear prescription eye glasses. No visual/ocular assessment was available for review.</p> <p>On 5/8/14 at 9:50am, an interview with the agency LPN (Licensed Practical Nurse) was conducted. The LPN indicated client #2 did not have a completed hearing evaluation. The LPN indicated client #3 had no visual assessment which documented her ocular</p>		<p>with dates of last assessment/screening. LPN will track these dates and will assure that these are addressed in a timely fashion.</p> <ul style="list-style-type: none"> LPN will assure all annual physicals include hearing and vision screening or include an order for a hearing or vision evaluation. This record review will occur no later than 6/15/2014. The monitoring agent will be the weekly meetings between the LPN and the manager. The QDDP and the COO will receive copies of the interactions and will check to assure that there is an active plan for any screening expired, near to expire or missing. LPN will assure that this deficiency does not occur at any other home. LPN will implement same weekly agenda format as described at all homes. Client #2 is scheduled for hearing evaluation on 6/20/2014. Client #3 had an optometrist appointment on 5/30/2014. 				

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W000331	<p>health available for review.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, for 3 of 7 clients (clients #3, #4, and #5) and 1 additional client (discharged client #8), the facility's nursing staff failed to provide oversight to ensure clients #3 and #4 had routine medications refilled by the pharmacy and to ensure clients #3, #5, and #8's physician's orders were followed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 5/7/14 at 5:28pm, GHS (Group Home Staff) #2 asked client #4 to come into the medication room and no medication was available to administer. GHS #2 indicated the agency nurse was contacted and notified on 5/6/14 in the morning. <p>On 5/7/14 at 7:10pm, GHS #3 gave GHS #2 an unlabeled bottle of "Calcium Carbonate" medication. GHS #2 indicated he was to use the same bottle of Calcium medication for both clients #3 and #4. The unlabeled bottle indicated</p>	W000331	<p>W331 NursingServices</p> <p>This item outlines that the facility failed to provide oversight to ensure routine medications are refilled by the pharmacy and to ensure physician's orders are followed. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·LPN meets with the manager weekly (already established pattern). The agenda at these meetings have been updated and now include medication levels. ·LPN will retrain staff on Medication Refresher and this training will include and emphasize how to follow physician's orders, how to complete medication level checks weekly, training on passing medications that are labeled appropriately, pharmacy communication, Invega injections are not to occur in the home and food will be supplied if order states this. ·The manager is responsible to assuring discontinued medications are removed from the home in a timely fashion to prevent use. If the medication 	06/15/2014			

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	<p>"Calcium Supplement Oscal Chewable 500mg (milligrams)-600 Vit (vitamin) D3." GHS #2 indicated the medication was not from the facility pharmacy.</p> <p>On 5/7/14 at 7:12pm, client #4 was asked to come to the medication room by GHS #2. GHS #2 administered client #4 one tablet from an unlabeled bottle of Calcium. No label was available to compare the directions to client #4's 5/2014 MAR (Medication Administration Record).</p> <p>On 5/12/14 at 9:00am, client #4's 5/2014 "Physician's Order" and 5/2014 MAR both indicated "Calcium Carb (Carbonate) +D (plus vitamin D) 500-400 Chew, give one tablet by mouth 2 times daily with food (for) Calcium Def. (Deficiency)."</p> <p>2. On 5/7/14 at 6:10pm, GHS (Group Home Staff) #2 administered client #3's medications and did not administer client #3's Calcium Carbonate medication. At 6:10pm, GHS #2 indicated client #3 did not have her Calcium medication at the group home currently.</p> <p>On 5/7/14 at 7:10pm, GHS #3 gave GHS #2 an unlabeled bottle of "Calcium Carbonate" medication. GHS #2 indicated he was to use the same bottle of</p>		<p>cannot be removed immediately, the manager has a process of maintaining the medication card in a manner that emphasizes the fact that the medication is indeed discontinued and should not be used.</p> <ul style="list-style-type: none"> ·All medication changes will be sent to LPN for review and for LPN to assure MAR is updated appropriately. ·The LPN will oversee Nursing Services. The monitoring agency is the Nursing Oversight Documentation. This report will be sent to the QDDP and the COO upon each home visit monthly. 				

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	<p>Calcium medication for both clients #3 and #4. The unlabeled bottle indicated "Calcium Supplement Oscal Chewable 500mg (milligrams)-600 Vit (vitamin) D3." GHS #2 indicated the medication was not from the facility pharmacy.</p> <p>On 5/7/14 at 7:25pm, GHS administered client #3 one (1) tablet from an unlabeled bottle of Calcium and no label was available to compare the directions to client #3's 5/2014 MAR (Medication Administration Record).</p> <p>On 5/12/14 at 3:15pm, client #3's 5/2014 "Physician's Order" and 5/2014 MAR both indicated "Calcium Carb (Carbonate) +D (plus vitamin D) 500-400 Chew, give one tablet by mouth 2 times daily with food (for) Calcium Def. (Deficiency)."</p> <p>An interview with the Agency Nurse was conducted on 5/8/14 at 9:50am. The Agency Nurse indicated the facility followed the Medication Administration Core A/Core B training. The Agency Nurse indicated each medication should have a label to identify the client name, a label for the directions of its use, and document the date when the medication was opened. The Agency Nurse indicated the group home client medication was filled by the pharmacy on</p>						

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	<p>a twenty-eight (28) day cycle. The Agency Nurse indicated client #3 and #4's Calcium medication was a routine medication and the pharmacy had not sent the refill for the prescription. The Agency Nurse indicated she was not notified of the error until 5/6/14 and the pharmacy was to have refilled the medication but did not refill clients #3 and #4's Calcium medication.</p> <p>3. On 5/7/14 at 12:15pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/1/13 through 5/7/14 were reviewed and indicated the following for client #3, #5, and #8's medication errors.</p> <p>For client #3: -A 2/13/14 BDDS report for an incident on 2/12/14 at 8:00am, indicated "It was reported to [Agency] Nurse at 8:32am by [GHS #2] that he had administered [client #3's] pre-filled Invega injection (for behaviors). [GHS #2] related that he had been instructed that [client #3's] Invega was due to be administered this date. Normal protocol is that staff transports client with medicine to PCP [client #3's Doctor] office to have injection administered. Staff stated that they were under the understanding that injection could be performed hand over hand with client like an epi pen. Staff</p>						

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	<p>reported that he researched how to perform an IM injection and read the included instructions prior to administering injection. Staff stated that injection was placed into the left upper arm muscle and client pressed the plunger down to administer medication (sic)." The report indicated client #3's physician was notified and instructed the facility to monitor the client for "adverse effects" and "instructed to bring client to office for future injections." The report indicated GHS #2 was disciplined for not following policy and procedure for following "physician's orders" to administer medication "all clients receiving injectable medications have been altered to read this medication to be administered at physician's office only."</p> <p>For client #5: -A 3/18/14 BDDS report for an incident on 3/17/14 at 7am, indicated client #5 had abdominal pain and "staff administered PRN pain medication. On 3/18/14 during house visit the nurse noted that staff had administered PRN Hydrocodone/apap 5-325mg (milligrams) which was discontinued on 3/13/14." The report indicated the "medication was correctly D/C'd (discontinued) on MAR (Medication Administration Record) and Copy of Order was in the book (at the group home)." The report indicated the</p>			

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	<p>staff did not follow the facility's policy and procedure for physician's orders.</p> <p>For client #8: -A 10/7/13 BDDS report for an incident on 9/3/13 at 11:00am, indicated client #8 "had gone to psychiatrist on 9/3/13 in the AM (morning). At that time [Psychiatrist] wrote instructions to stop Atarax medication (for behaviors). Staff transporting client did not follow company policy and procedure and immediately D/C (Discontinue) the medication from the MAR or notify the pharmacy of the discontinue order. [Client #8] continued to receive the medication until 10/7/13 when error was discovered during pharmacy audit."</p> <p>On 5/12/14 at 3:15pm, client #3's 5/2014 "Physician's Order" indicated "8/12/13 (dated) Invega sust Inj (injections) 117/0.75, Inject 0.75ml (milliliters) every month to be administered at physician's office only."</p> <p>On 5/8/14 at 9:30am, a review of client #5's 5/2014 "Physician's Order" indicated "Hydroco/Apap Tab (tablet) 5-325mg, give 1-2 tablets by mouth every 6 hours as needed post Op (after his operation)." Client #5's record indicated in 1/2014 he was diagnosed with a Hernia which caused a "Bowel Obstruction" resulting</p>			

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	<p>in surgery in 2/2014. Client #5's record indicated client #5 received the medication when complaining of the abdominal pain after surgery.</p> <p>On 5/8/14 at 9:50am, a review of client #8's 10/1/13 "Physician's Order" indicated a 9/3/13 discontinue medication order for "Atarax 10mg (milligrams) /5ml (milliliters), give 12.5ml by mouth twice daily."</p> <p>On 5/8/14 at 9:50am, a record review was completed of the facility's policy and procedures, 11/2013 "Medication Administration by Staff" indicated "1. Check the information on the pharmacy medication label by comparing it to the medication administration record and the physician's order, for the individual's name, medication ordered, dosage, site of instillation, and the time...5. Check the medication listed on the medication administration record with the medication label three times...Administration of oral medication. All medication that specifies administration with food should be given within 1/2 hr [hour] of food consumption...." The policy and procedure indicated staff should administer client medications according to physician's orders.</p>			

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W000368	<p>On 5/8/14 at 9:50am, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p> <p>On 5/8/14 at 9:50am, an interview with the agency nurse was conducted. The agency nurse indicated staff should administer medications according to physician's orders. The agency nurse indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders. The agency nurse indicated she visited the home once a month and no nursing monitoring oversight was available for review.</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 2 of 7 clients (clients #3 and #5) and for 1 additional client (discharged client #8), the facility failed to administer medications without error and as prescribed by the clients' personal</p>	W000368	<p>W368 DrugAdministration This item outlines that the facility failed to administer medications without error and as prescribed by the physician. The plan of correction for this tag is as follows:</p>	06/15/2014

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	<p>physician.</p> <p>Findings include:</p> <p>On 5/7/14 at 12:15pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/1/13 through 5/7/14 were reviewed and indicated the following for client #3, #5, and #8's medication errors.</p> <p>For client #3: -A 2/13/14 BDDS report for an incident on 2/12/14 at 8:00am, indicated "It was reported to [Agency] Nurse at 8:32am by [GHS #2] that he had administered [client #3's] pre-filled Invega injection (for behaviors). [GHS #2] related that he had been instructed that [client #3's] Invega was due to be administered this date. Normal protocol is that staff transports client with medicine to PCP [client #3's Doctor] office to have injection administered. Staff stated that they were under the understanding that injection could be performed hand over hand with client like an epi pen. Staff reported that he researched how to perform an IM injection and read the included instructions prior to administering injection. Staff stated that injection was placed into the left upper arm muscle and client pressed the plunger down to administer medication</p>		<ul style="list-style-type: none"> ·LPN meets withthe manager weekly (already established pattern). The agenda at these meetings have beenupdated and now include medication levels. ·LPN will retrainstaff on Medication Refresher and this training will include and emphasize howto follow physician's orders, how to complete medication level checks weekly,training on passing medications that are labeled appropriately, pharmacycommunication, Invega injections are not to occur in the home, and food will besupplied if order states this. ·The manager isresponsible for assuring discontinued medications are removed from the home ina timely fashion to prevent use. If themedication cannot be removed immediately, the manager has a process ofmaintaining the medication card in a manner that emphasizes the fact that themedication is indeed discontinued and should not be used. ·All medicationchanges will be sent to LPN for review and for LPN to assure MAR is updatedappropriately. ·The LPN willoversee Nursing Services. The monitoringagency is the Nursing Oversight Documentation. This report will be sent to the QDDP and the COO upon each home visitmonthly. 		

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	<p>(sic)." The report indicated client #3's physician was notified and instructed the facility to monitor the client for "adverse effects" and "instructed to bring client to office for future injections." The report indicated GHS #2 was disciplined for not following policy and procedure for following "physician's orders" to administer medication "all clients receiving injectable medications have been altered to read this medication to be administered at physician's office only."</p> <p>For client #5: -A 3/18/14 BDDS report for an incident on 3/17/14 at 7am, indicated client #5 had abdominal pain and "staff administered PRN (as needed) pain medication. On 3/18/14 during house visit the nurse noted that staff had administered PRN Hydrocodone/apap 5-325mg (milligrams) which was discontinued on 3/13/14." The report indicated the "medication was correctly D/C'd (discontinued) on MAR (Medication Administration Record) and Copy of Order was in the book (at the group home)." The report indicated the staff did not follow the facility's policy and procedure for physician's orders.</p> <p>For client #8: -A 10/7/13 BDDS report for an incident on 9/3/13 at 11:00am, indicated client #8</p>						

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	<p>"had gone to psychiatrist on 9/3/13 in the AM (morning). At that time [Psychiatrist] wrote instructions to stop Atarax medication (for behaviors). Staff transporting client did not follow company policy and procedure and immediately D/C (Discontinue) the medication from the MAR or notify the pharmacy of the discontinue order. [Client #8] continued to receive the medication until 10/7/13 when error was discovered during pharmacy audit."</p> <p>On 5/12/14 at 3:15pm, client #3's 5/2014 "Physician's Order" indicated "8/12/13 (dated) Invega sust Inj (injections) 117/0.75, Inject 0.75ml (milliliters) every month to be administered at physician's office only."</p> <p>On 5/8/14 at 9:30am, a review of client #5's 5/2014 "Physician's Order" indicated "Hydroco/Apap Tab (tablet) 5-325mg, give 1-2 tablets by mouth every 6 hours as needed post Op (after his operation)." Client #5's record indicated in 1/2014 he was diagnosed with a Hernia which caused a "Bowel Obstruction" resulting in surgery in 2/2014. Client #5's record indicated client #5 received the medication when complaining of the abdominal pain after surgery.</p> <p>On 5/8/14 at 9:50am, a review of client</p>						

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	<p>#8's 10/1/13 "Physician's Order" indicated a 9/3/13 discontinue medication order for "Atarax 10mg (milligrams) /5ml (milliliters), give 12.5ml by mouth twice daily."</p> <p>On 5/8/14 at 9:50am, a record review was completed of the facility's policy and procedures, 11/2013 "Medication Administration by Staff" indicated "1. Check the information on the pharmacy medication label by comparing it to the medication administration record and the physician's order, for the individual's name, medication ordered, dosage, site of instillation, and the time...5. Check the medication listed on the medication administration record with the medication label three times...Administration of oral medication. All medication that specifies administration with food should be given within 1/2 hr [hour] of food consumption...." The policy and procedure indicated staff should administer client medications according to physician's orders.</p> <p>On 5/8/14 at 9:50am, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p>			

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W000369	<p>On 5/8/14 at 9:50am, an interview with the agency nurse was conducted. The agency nurse indicated staff should administer medications according to physician's orders. The agency nurse indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders.</p> <p>9-3-6(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview, for 1 of 7 medications administered during the evening medication administration (client #7), the facility failed to ensure medications were given without error.</p> <p>Findings include:</p> <p>On 5/7/14 at 5:34pm, Group Home Staff (GHS) #2 requested client #7 to come to the medication room, GHS #2 unlocked the medication cart, retrieved client #7's medication card of "Calcium Carb +D</p>	W000369	<p>W369 DrugAdministration This item outlines that the facility failed to ensure medications were given without error. The plan of correction for this tag is as follows: ·LPN meets with the manager weekly (already established pattern). The agenda at these meetings have been updated and now include medication levels. ·LPN will retrain staff on Medication Refresher and this training will include and emphasize how to follow physician's orders, how to complete medication level checks weekly, training on passing</p>	06/15/2014

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	<p>(plus vitamin D) 600-200 chew (for bone health), give 1 tab by mouth twice daily with food." GHS #2 compared the medication card to client #7's 5/2014 MAR (Medication Administration Record), punched the medication into a souffle cup, administered the medication to client #7, client #7 took the medication with water, and no food was provided. At 5:34pm, Client #7 indicated his last bite of food was lunch at the workshop at 12:15pm. At 7:30pm, client #7 consumed his first bite of supper and GHS #2 indicated no food/meal had been provided before 7:30pm.</p> <p>Client #7's record was reviewed on 5/8/14 at 10:10am. Client #7's 5/2014 "Physician's Order" indicated "Calcium Carb +D (plus vitamin D) 600-200 chew, give 1 tab by mouth twice daily with food."</p> <p>On 5/8/14 at 9:50am, an administrative record review was completed of the facility's policy and procedures, 11/20/2013 "Medication Administration by Staff" indicated "1. Check the information on the pharmacy medication label by comparing it to the medication administration record and the physician's order, for the individual's name, medication ordered, dosage, site of instillation, and the time...5. Check the</p>		<p>medications that are labeled appropriately, pharmacycommunication, Invega injections are not to occur in the home, and food will besupplied if order states this.</p> <ul style="list-style-type: none"> -The manager isresponsible for assuring discontinued medications are removed from the home ina timely fashion to prevent use. If themedication cannot be removed immediately, the manager has a process ofmaintaining the medication card in a manner that emphasizes the fact that themedication is indeed discontinued and should not be used. -All medicationchanges will be sent to LPN for review and for LPN to assure MAR is updatedappropriately. -The LPN willoversee Nursing Services. The monitoringagency is the Nursing Oversight Documentation. This report will be sent to the QDDP and the COO upon each home visitmonthly. 		

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W000391	<p>medication listed on the medication administration record with the medication label three times...Administration of oral medication. All medication that specifies administration with food should be given within 1/2 hr [hour] of food consumption...."</p> <p>An interview with the agency's LPN (License Practical Nurse) was conducted on 5/8/14 at 9:50am. The agency LPN indicated a medication ordered "with meal" should be taken no more than 30 minutes before a meal. The agency LPN indicated facility staff should have followed client #7's physician orders to administer his medications.</p> <p>On 5/8/14 at 9:50am, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p> <p>9-3-6(a)</p> <p>483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. Based on observation, record review, and</p>	W000391	W391 DrugLabeling	06/15/2014

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	<p>interview, for 2 of 7 medications administered at the evening medication administration (clients #3 and #4), the facility failed to ensure each client had their own routine medications that was labeled.</p> <p>Findings include:</p> <p>1. On 5/7/14 at 5:28pm, GHS (Group Home Staff) #2 asked client #4 to come into the medication room and no medication was available to administer. GHS #2 indicated the agency nurse was contacted and notified on 5/6/14 in the morning.</p> <p>On 5/7/14 at 7:10pm, GHS #3 gave GHS #2 an unlabeled bottle of "Calcium Carbonate" medication. GHS #2 indicated he was to use the same bottle of Calcium medication for both clients #3 and #4. The unlabeled bottle indicated "Calcium Supplement Oscal Chewable 500mg (milligrams)-600 Vit (vitamin) D3." GHS #2 indicated the medication was not from the facility pharmacy.</p> <p>On 5/7/14 at 7:12pm, client #4 was asked to come to the medication room by GHS #2. GHS #2 administered client #4 one tablet from an unlabeled bottle of Calcium. No label was available to compare the directions to client #3's</p>		<p>This item outlines that the facility failed to ensure each client had their own routine medications that were labeled. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> ·LPN meets with the manager weekly (already established pattern). The agenda at these meetings have been updated and now include medication levels. ·LPN will retrain staff on Medication Refresher and this training will include and emphasize how to follow physician's orders, how to complete medication level checks weekly, training on passing medications that are labeled appropriately, pharmacy communication, Invega injections are not to occur in the home, and food will be supplied if order states this. ·All medication changes will be sent to LPN for review and for LPN to assure MAR is updated appropriately. ·The LPN will oversee Nursing Services. The monitoring agency is the Nursing Oversight Documentation. This report will be sent to the QDDP and the COO upon each home visit monthly. 		

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	<p>5/2014 MAR (Medication Administration Record).</p> <p>On 5/12/14 at 9:00am, client #4's 5/2014 "Physician's Order" and 5/2014 MAR both indicated "Calcium Carb (Carbonate) +D (plus vitamin D) 500-400 Chew, give one tablet by mouth 2 times daily with food (for) Calcium Def. (Deficiency)."</p> <p>2. On 5/7/14 at 6:10pm, GHS (Group Home Staff) #2 administered client #3's medications and did not administered client #3's Calcium Carbonate medication. At 6:10pm, GHS #2 indicated client #3 did not have her Calcium medication at the group home currently.</p> <p>On 5/7/14 at 7:10pm, GHS #3 gave GHS #2 an unlabeled bottle of "Calcium Carbonate" medication. GHS #2 indicated he was to use the same bottle of Calcium medication for both clients #3 and #4. The bottle indicated "Calcium Supplement Oscal Chewable 500mg (milligrams)-600 Vit (vitamin) D3." GHS #2 indicated the medication was not from the facility pharmacy.</p> <p>On 5/7/14 at 7:25pm, GHS administered client #3 one (1) tablet from an unlabeled bottle of Calcium and no label was</p>			

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	<p>available to compare the directions to client #3's 5/2014 MAR (Medication Administration Record).</p> <p>On 5/12/14 at 3:15pm, client #3's 5/2014 "Physician's Order" and 5/2014 MAR both indicated "Calcium Carb (Carbonate) +D (plus vitamin D) 500-400 Chew, give one tablet by mouth 2 times daily with food (for) Calcium Def. (Deficiency)."</p> <p>An interview with the Agency Nurse was conducted on 5/8/14 at 9:50am. The Agency Nurse indicated the facility followed the Medication Administration Core A/Core B training. The Agency Nurse indicated each medication should have a label to identify the client name, a label for the directions of its use, and document the date when the medication was opened.</p> <p>On 5/8/14 at 9:50am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be labeled. The training manual indicated each clients' medication should be dated when the medication was opened.</p> <p>9-3-6(a)</p>						

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W000438	<p>483.470(h)(1) EMERGENCY PLAN AND PROCEDURES The facility must develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients. Based on observation, record review, and interview, for 2 of 2 sampled clients (clients #1 and #3) who lived in the back upper level bedroom and for 5 additional clients (clients #2, #4, #5, #6, and #7) who lived in the group home, the facility failed to develop an emergency plan which addressed disaster preparedness for the back upper level bedroom area for clients #1, #2, #3, #4, #5, #6, and #7.</p> <p>Findings include:</p> <p>On 5/7/14 from 4:30pm until 7:35pm, and on 5/8/14 from 6:00am until 8:20am, observations were conducted at the group home. During both observation periods clients #1, #2, #3, #4, #5, #6, and #7 had access to the upper level back bedroom bathroom inside clients #1 and #3's shared bedroom. During both observation periods clients #1 and #3's shared bedroom had a functional bathroom with one entry/exit through client #1 and #3's shared bedroom. During both observation periods client #1 and #3's shared bedroom had one</p>	W000438	<p>W438 EmergencyPlan and Procedure This item outlines that the facility failed to develop an emergency plan which addressed disaster preparedness for one bedroom. The plan of correction for this tag is as follows: ·The applicable clients and all staff have been trained on how to use the ladder. ·LPN has received 2 of 3 OT/PT evaluations. For the third client, the physician verbally stated that OT/PT was not necessary for the ladder; however we have requested this be in a written order. The LPN has been in contact with the physician office and the order to indicate OT/PT is not necessary is expected by end of business on 6/6/2014, but will be received no later than 6/15/2014. For the other 2 clients, OT/PT evaluation was ordered. These appointments are scheduled at the earliest available time. ·Carey Services has coordinated with 2 companies to receive quotations on removing the window and installing a door out to an exterior fire escape staircase</p>	06/15/2014
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	<p>entry/exit through the door to the hallway. During both observation periods client #1 and #3's shared back upper level bedroom had a twenty to twenty-five foot drop from the window to the ground below. On 5/8/14 at 7:15am, clients #1 and #3 were interviewed. At 7:15am, client #1 stated she had "No idea" what a chain link ladder was and did not know how to exit the group home if she could not walk out into the hallway during an emergency. At 7:15am, client #3 stated she had "No idea" what a chain link ladder was and did not know how to exit the group home if she could not walk out into the hallway during an emergency. Both clients stated they had "only" used the hallway exit during evacuation drills.</p> <p>On 5/8/14 at 7:45am, GHS (Group Home Staff) #3 stated client #1 and #3's shared back upper level bedroom had a drop of "at least" twenty to twenty-five feet from the window to the ground below. At 7:45am, GHS #3 located the chain link ladder piled loose on the upper shelf inside the closet and stated the ladder "was buried with stuff" (client #1 and #3's clothing, boxes, and miscellaneous items) on top of the ladder. GHS #3 stated "I thought it was exercise equipment." GHS #3 stated she had "No idea" how to use the chain link ladder to</p>		<p>forevacuation. The companies have committed to sending quotations before 6/15/2014. The agency must determine which company to use (and assure the company complies with Medicaid regulations) no later than 6/30/2014. The construction will be scheduled as soon as possible, however at this time, the timeline is not known.</p> <p>·The QDDP was in contact with the Surveyor who requested she call Steve Corya with ISDH. The QDDP attempted to connect with Steve Corya and has not received a call back to assure a safe situation is put in place for these consumers between now and construction completion.</p> <p>·Carey Services is evaluating an interim plan of having a temporary bedroom in the basement (which has secondary egress without a window ladder) or to have the consumers exit through another consumer's bedroom (with explicit permission). Carey Services has requested input from ISDH on this matter to assure the best solution is in place for the safety and security of consumers.</p>				

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	<p>exit the back upper level bedroom in the event of an emergency. GHS #3 stated she had been employed at the group home for two years and had "never seen or heard" the use of the chain link ladder to exit the group home during a drill.</p> <p>On 5/8/14 at 8:20am, GHS #1 indicated he had not seen the chain link ladder at the group home and did not know the ladder exited until 5/8/14.</p> <p>On 5/8/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP provided the facility's 11/2013 "Health and Safety Policy 7.2.1" "Fire Watch for ICF/MR Group Homes." The policy did not include directions for evacuation of client #1 and #3's upper level shared back bedroom and did not include the use of the chain link ladder for exiting during a disaster. The QIDP indicated the facility's 11/2013 "Fire Evacuation Procedures (for the) Upland Group Home" plan did not indicate the use of the chain link ladder and did not indicate instructions for exiting the upper level back bedroom during a disaster. The QIDP stated "No, Our plan does not include" the use of the chain link ladder and did not include how to exit the upper level back bedroom.</p>						

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W000439	<p>9-3-7(a)</p> <p>483.470(h)(2) EMERGENCY PLAN AND PROCEDURES The facility must communicate, periodically review, make the plan available, and provide training to the staff. Based on observation, record review, and interview, for 2 of 2 sampled clients (clients #1 and #3) who lived in the back upper level bedroom and for 5 additional clients (clients #2, #4, #5, #6, and #7) who lived in the group home, the facility failed to provide training for their emergency plan which addressed disaster preparedness for the back upper level bedroom area for clients #1, #2, #3, #4, #5, #6, and #7.</p> <p>Findings include: On 5/7/14 from 4:30pm until 7:35pm, and on 5/8/14 from 6:00am until 8:20am, observations were conducted at the group home. During both observation periods clients #1, #2, #3, #4, #5, #6, and #7 had access to the upper level back bedroom bathroom inside clients #1 and #3's shared bedroom. During both observation periods clients #1 and #3's shared bedroom had a functional bathroom with one entry/exit through client #1 and #3's shared bedroom. During both observation periods client #1</p>	W000439	<p>W439 EmergencyPlan and Procedure</p> <p>This item outlines that the facility failed to provide training for their emergency plan which addressed disaster preparedness for one bedroom. The plan of correction for this tag is as follows: ·The applicable clients and all staff have been trained on how to use the ladder. ·LPN has received 2 of 3 OT/PT evaluations. For the third client, the physician verbally stated that OT/PT was not necessary for the ladder; however we have requested this be in a written order. The LPN has been in contact with the physician office and the order to indicate OT/PT is not necessary is expected by end of business on 6/6/2014, but will be received no later than 6/15/2014. For the other 2 clients, OT/PT evaluation was ordered. These appointments are scheduled at the earliest available time. ·Carey Services has coordinated with 2 companies to receive quotations on removing the window and installing a door out to an exterior fire escape staircase for evacuation. The companies</p>	06/15/2014	

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	<p>and #3's shared bedroom had one entry/exit through the door to the hallway. During both observation periods client #1 and #3's shared back upper level bedroom had a twenty to twenty-five foot drop from the window to the ground below. On 5/8/14 at 7:15am, clients #1 and #3 were interviewed. At 7:15am, client #1 stated she had "No idea" what a chain link ladder was and did not know how to exit the group home if she could not walk out into the hallway during an emergency. At 7:15am, client #3 stated she had "No idea" what a chain link ladder was and did not know how to exit the group home if she could not walk out into the hallway during an emergency. Both clients stated they had "only" used the hallway exit during evacuation drills.</p> <p>On 5/8/14 at 7:45am, GHS (Group Home Staff) #3 stated client #1 and #3's shared back upper level bedroom had a drop of "at least" twenty to twenty-five feet from the window to the ground below. At 7:45am, GHS #3 located the chain link ladder piled loose on the upper shelf inside the closet and stated the ladder "was buried with stuff" (client #1 and #3's clothing, boxes, and miscellaneous items) on top of the ladder. GHS #3 stated "I thought it was exercise equipment." GHS #3 stated she had "No</p>		<p>have committed to sending quotations before 6/15/2014. The agency must determine which company to use (and assure the company complies with Medicaid regulations) no later than 6/30/2014. The construction will be scheduled as soon as possible, however at this time, the timeline is not known.</p> <ul style="list-style-type: none"> The QDDP was in contact with the Surveyor who requested she call Steve Corya with ISDH. The QDDP attempted to connect with Steve Corya and has not received a call back to assure a safe situation is in place for these consumers between now and construction completion. Carey Services is evaluating an interim plan of having a temporary bedroom in the basement (which has secondary egress without a window ladder) or to have the consumers exit through another consumer's bedroom (with explicit permission). Carey Services has requested input from ISDH on this matter to assure the best solution is in place for the safety and security of consumers. 				

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	<p>idea" how to use the chain link ladder to exit the back upper level bedroom in the event of an emergency. GHS #3 stated she had been employed at the group home for two years and had "never seen or heard" the use of the chain link ladder to exit the group home during a drill.</p> <p>On 5/8/14 at 8:20am, GHS #1 indicated he had not seen the chain link ladder at the group home and did not know the ladder existed until 5/8/14.</p> <p>On 5/8/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the facility had not completed an emergency drill during the past year which included the use of the chain link ladder inside client #1 and #3's shared upper level back bedroom. The QIDP indicated client #1 and #3's shared bedroom had a bathroom attached without a second exit. The QIDP indicated clients #1, #2, #3, #4, #5, #6, and #7 had the potential to use that bathroom if needed. The QIDP indicated the facility's 11/2013 "Health and Safety Policy 7.2.1" and the 11/2013 "Fire Evacuation Procedures (for the) Upland Group Home" plan did not indicate the use of the chain link ladder and did not indicate instructions for exiting the upper level back bedroom during a disaster.</p>						

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	The QIDP stated "No" staff had not been trained on the how to exit the upper level back bedroom in the event of an emergency and the hallway was blocked. 9-3-7(a)				