STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G742	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL SERVICES SUB LLC	369 W WASHINGTON ST MORGANTOWN, IN 46160

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W000000	This visit was for a fundamental recertification and state licensure survey. Survey Dates: January 21, 22, 23 and 24, 2014 Facility Number: 005659 Provider Number: 15G742 AIM Number: 100244210 Surveyor: Steven Schwing, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/28/14 by Ruth Shackelford, QIDP.	W000000		
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 2 of 4 clients in the sample (#1 and #3) and one non-sampled client (#2), the governing body failed to exercise operating direction over the facility by failing to ensure clients had waterproof mattresses.	W000104	New mattresses were purchased, delivered and installed for clients #1, 2, and 3 on 1/28/2014. The Home Manager or Program Director will check each client's mattress at least weekly to ensure mattresses are clean and in good repair.New Mattresses will be provided as needed. The monitoring of the mattresses will	02/23/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Findings include: An observation was conducted at the group home on 1/22/14 from 6:15 AM to 7:50 AM. At 7:33 AM, client #2's bedroom smelled of feces. Client #2's mattress had a 5 inch by 10 inch tan and yellowish area on the top of his mattress. Client #1 and #3's mattresses were not waterproof and were not covered with a plastic cover. On 1/22/14 at 7:33 AM, staff #2 indicated client #2 had diarrhea on 1/21/14 to 1/22/14 overnight shift. Staff #2 indicated client #2's mattress needed to be cleaned. Staff #2 indicated client #2's mattress did not have a protective cover over it to protect the mattress from being soaked with urine and feces. Staff #2 indicated clients #1, #2 and #3 needed to have a waterproof mattress or a mattress protector due to incontinence. On 1/22/14 at 11:18 AM, the Area Director (AD) indicated clients #1, #2 and #3 needed new waterproof mattresses. The AD indicated three mattresses were ordered on 1/22/14 and would be delivered to the group home on 1/28/14. 9-3-1(a)		be documented on a tracking sheet and it will be reviewed by the Area Director for monthly follow up Responsible Party: Home Manager, Program Director	

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W000125	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. Based on observation, record review and interview for 1 of 4 clients in the sample (#3), the facility failed to ensure client #3 had the right to due process in regard to staff removing his plate from him during dinner. Findings include: An observation was conducted at the group home on 1/21/14 from 4:40 PM to 5:59 PM. At 5:22 PM, client #3 started eating dinner. At 5:27 PM, staff #4 prompted client #3 several times to put his right hand in his lap (client #3 ate with his left hand). Client #3 did not put his right hand in his lap. Staff #4 removed client #3's plate from in front of him to directly in front of her until client #3 put his hand in his lap. Staff #4 returned client #3's plate of salad after a few seconds. A review of client #3's record was conducted on 1/23/14 at 10:49 AM.	W000125	Staff will be retrained by 2/16/2014 on all clients dining plans and training objectives. The Program Director or Home Manager will complete at least one weekly observation during mealtimes to ensure staff adhere to client dining plans and training objectives. The Program Director and/or Area Director will review observation forms at least monthly to ensure follow up is completed as necessary. Responsible Party: Home Manager, Program Director, Area DirectorAddendum: The Program Director or Home Manager will complete at least five weekly mealtime observations during various times to ensure dining plans are followed and training objectives are completed for one month. The mealtime observations will continue at least weekly on an on-going basis. Responsible Party: Home Manager, Program Director, Area Director	02/23/2014

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	Client #3's Individual Support Plan (ISP), dated 6/14/13, indicated he had a mealtime training objective, at each meal, to take a drink and/or wipe his face with a napkin between every two or three bites of food. Client #3's Dining Plan, dated 8/8/12 and reviewed by the nurse on 1/11/14 indicated, in part, "Staff to remind/encourage [client #3] to slow down when eating, not to shovel food, to chew food and swallow before taking another bite. (Staff to encourage [client #3] to take a drink or wipe face with napkin every 2-3 bites.)" The Dining Plan indicated the "Specific Skills to Maintain/Acquire: To eat slowly, chew food and swallow before taking another bite." Client #3's Behavior Support Plan (BSP), dated 3/4/12, did not indicate the staff should remove his plate from him during meals. There was no documentation in client #3's ISP, BSP or Dining Plan indicating the staff should remove his plate for any reason. On 1/23/14 at 12:24 PM, the Program Director (PD) indicated client #3 did not have a plan for staff to remove his plate for any reason. The PD indicated the staff violated client #3's rights by taking his plate away during dinner. On 1/23/14 at 12:24 PM, the Area			

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	Director (AD) indicated client #3 did not have a plan for staff to remove his plate for any reason. The AD indicated the staff violated client #3's rights by taking his plate away during dinner. 9-3-2(a)			
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 3 incident/investigative reports reviewed affecting clients #2, #3, and #6, the facility neglected to implement its policies and procedures to report incidents to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner and conduct an investigation of a fracture to client #6's shoulder. Findings include: A review of the facility's incident/investigative reports was conducted on 1/22/14 at 11:14 AM. 1) On 10/10/13 at 2:30 PM, the facility reporting telephone line received a call from someone, who did not give their	W000149	The Program Director was retrained on 1/24/2014 on what to do if BDDS system is not working and incidents are unable to be submitted timely. The Program Director was retrained on 1/24/2014 on what incidents require investigations. The Program Director and Area Director will meet weekly to review incidents and ensure investigations are completed as required. Responsible Party: Program Director, Area Director	02/23/2014

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	name, indicating staff left client #3 in the van unattended at the grocery store on 10/10/13. The investigation, dated 10/15/13, indicated the facility received the call on 10/10/13 and the investigation was initiated on 10/11/13. The investigation indicated, "There is no evidence to support that [staff #3] left [client #3] in the van alone while she was inside the store." The facility submitted the BDDS report on 10/14/13. 2) On 9/1/13 at 6:21 PM, client #6 had a seizure lasting approximately 2 minutes. The Seizure Description Record, dated 2013, indicated the seizure on 9/1/13 included a fall with injury. Client #6 reported afterward he felt okay. When staff examined client #6 for injuries, they observed a "scratch on his head from where he had taken off his helmet" and a "small scratch on his knee." Staff monitored client #6 throughout the night. On the morning of 9/2/13, when client #6 woke up, staff noticed his shoulder "looked swollen" and had a "light bruise." Staff immediately took client #6 to the hospital where he was examined. An x-ray showed a fracture to his left shoulder and his shoulder was immobilized. The BDDS report was submitted on 9/3/13. The facility did not conduct an investigation into the			

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	incident to verify staff followed client #6's plan for seizures and took appropriate action following the seizure. 3) On 4/22/13 at 3:00 PM, client #2 "came out of workshop punching at peers" according to the BDDS report. The report indicated, "When staff intervened, [client #2] 'hit staff several times.' Staff at first used verbal redirection as well as agency-approved avoiding and blocking techniques to defend against [client #2's] physical aggression. When [client #2] continued his physical aggression, staff used an agency-approved 2-arm standing hold to defend against it. [Client #2] eventually calmed, and there was no further incident." The facility submitted the incident report to BDDS on 4/24/13. A review of the facility's abuse and neglect policy, dated April 2011, was conducted on 1/22/14 at 10:59 AM. The policy indicated the following, "Any allegation of abuse or human rights violation is thoroughly investigated by the Area Director in consultation with Human Resources Department and/or Quality Assurance/Risk Management Department." The policy indicated, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable			

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	laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e. Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment... o. The following actions are prohibited by employees of Indiana MENTOR: 1) abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds. 2) violation of an individual's rights." The policy indicated, in part, "All incidents that require a report to the Bureau of Developmental Disabilities Services, or internal incident reports will be entered into a database maintained by The Mentor Network." The policy indicated, in part, "***Indiana MENTOR follows the BDDS Incident Reporting policy as outlined in the Provider Standards.*** An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS... A fall resulting in injury, regardless of severity of injury." The policy indicated, in part, "An initial report regarding an incident shall be submitted within twenty-four (24) hours of: a) the occurrence of the incident; or b) the reporter becoming aware of or receiving information about an incident." On 1/22/14 at 12:31 PM, the Quality			

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	Assurance Director (QAD) indicated client #6's shoulder fracture was not investigated since the facility knew the cause of the injury was from his seizure. On 1/22/14 at 12:31 PM, the Program Director (PD) indicated she was told an investigation was not needed. The PD indicated client #6's shoulder fracture should have been investigated to see if the protocols were followed. At 12:36 PM, the PD indicated BDDS reports should be submitted within 24 hours. 9-3-2(a)			
W000153	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 record review and interview for 3 of 3 incident/investigative reports reviewed affecting clients #2, #3, and #6, the facility failed to report incidents to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, in accordance with state law. Findings include:	W000153	The Program Director was retrained on 1/24/2014 on what to do if BDDS system is not working and incidents are unable to be submitted timely. The Area Director will review incidents and dates of reports and follow up with corrective action as necessary. Responsible Party: Program Director and Area Director	02/23/2014

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	A review of the facility's incident/investigative reports was conducted on 1/22/14 at 11:14 AM. 1) On 10/10/13 at 2:30 PM, the facility reporting telephone line received a call from someone, who did not give their name, indicating staff left client #3 in the van unattended at the grocery store on 10/10/13. The investigation, dated 10/15/13, indicated the facility received the call on 10/10/13 and the investigation was initiated on 10/11/13. The investigation indicated, "There is no evidence to support that [staff #3] left [client #3] in the van alone while she was inside the store." The facility submitted the BDDS report on 10/14/13. 2) On 9/1/13 at 6:21 PM, client #6 had a seizure lasting approximately 2 minutes. The Seizure Description Record, dated 2013, indicated the seizure on 9/1/13 included a fall with injury. Client #6 reported afterward he felt okay. When staff examined client #6 for injuries, they observed a "scratch on his head from where he had taken off his helmet" and a "small scratch on his knee." Staff monitored client #6 throughout the night. On the morning of 9/2/13, when client #6 woke up, staff noticed his shoulder "looked swollen" and had a "light bruise." Staff took			

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	client #6 to the hospital where he was examined. An x-ray showed a fracture to his left shoulder and his shoulder was immobilized. The BDDS report was submitted on 9/3/13. 3) On 4/22/13 at 3:00 PM, client #2 "came out of workshop punching at peers" according to the BDDS report. The report indicated, "When staff intervened, [client #2] 'hit staff several times.' Staff at first used verbal redirection as well as agency-approved avoiding and blocking techniques to defend against [client #2's] physical aggression. When [client #2] continued his physical aggression, staff used an agency-approved 2-arm standing hold to defend against it. [Client #2] eventually calmed, and there was no further incident." The facility submitted the incident report to BDDS on 4/24/13. On 1/22/14 at 12:31 PM, the Program Director (PD) indicated BDDS reports should be submitted within 24 hours. 9-3-2(a)			

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W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 3 of 3 incident/investigative reports reviewed affecting clients #2, #3, and #6, the facility to conduct an investigation of a fracture to client #6's shoulder. Findings include: A review of the facility's incident/investigative reports was conducted on 1/22/14 at 11:14 AM and indicated the following: On 9/1/13 at 6:21 PM, client #6 had a seizure lasting approximately 2 minutes. The Seizure Description Record, dated 2013, indicated the seizure on 9/1/13 included a fall with injury. Client #6 reported afterward he felt okay. When staff examined client #6 for injuries, they observed a "scratch on his head from where he had taken off his helmet" and a "small scratch on his knee." Staff monitored client #6 throughout the night. On the morning of 9/2/13, when client #6 woke up, staff noticed his shoulder "looked swollen" and had a "light bruise." Staff immediately took client #6 to the hospital where he was	W000154	The Program Director was retrained on 1/24/2014 on what incidents require investigations. The Program Director and Area Director will meet weekly to review incidents and ensure investigations are completed as required. Responsible Party: Program Director and Area DirectorAddendum:The Program Director and Area Director will meet weekly to review incidents and ensure investigations are completed as required. These weekly meetings will be held within the required five working days that investigations are to be completed and if they are not completed and findings reported to the Administrator within that time frame, corrective action will be completed with the reporting party. Responsible Party: Program Director and Area Director	02/23/2014

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	examined. An x-ray showed a fracture to his left shoulder and his shoulder was immobilized. The facility did not conduct an investigation into the incident to verify staff followed client #6's plan for seizures and took appropriate action following the seizure. On 1/22/14 at 12:31 PM, the Quality Assurance Director (QAD) indicated client #6's shoulder fracture was not investigated since the facility knew the cause of the injury was from his seizure. On 1/22/14 at 12:31 PM, the Program Director (PD) indicated she was told an investigation was not needed. The PD indicated client #6's shoulder fracture should have been investigated to see if the protocols were followed. 9-3-2(a)			
W000249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and	W000249	Staff will be retrained by	02/23/2014

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	record review for 2 of 4 clients in the sample (#3 and #6), the facility failed to ensure staff implemented client #3's mealtime training objective and client #3 and #6's Dining Plans. Findings include: An observation was conducted at the group home on 1/21/14 from 4:40 PM to 5:59 PM. At 5:22 PM, the clients started eating dinner. During the meal, clients #3 and #6 were not prompted to wipe their faces with napkins or take drinks after every 2-3 bites of food. Clients #3 and #6 scooped large portions of food into their mouths without being prompted to wipe their faces or take drinks. Client #3 was not prompted to slow down and to chew and swallow before taking another bite. A review of client #3's record was conducted on 1/23/14 at 10:49 AM. Client #3's Individual Support Plan, dated 6/14/13, indicated he had a mealtime training objective, at each meal, to take a drink and/or wipe his face with a napkin between every two or three bites of food. Client #3's Dining Plan, dated 8/8/12 and reviewed by the nurse on 1/11/14 indicated, in part, "Staff to remind/encourage [client #3] to slow down when eating, not to shovel		2/16/2014 on all clients dining plans and training objectives. The Program Director or Home Manager will complete at least one weekly observation during mealtimes to ensure staff adhere to client dining plans and training objectives. The Program Director and/or Area Director will review observation forms at least monthly to ensure follow up is completed as necessary. Responsible Party: Home Manager, Program Director, Area DirectorAddendum: The Program Director or Home Manager will complete at least five weekly mealtime observations during various times to ensure dining plans are followed and training objectives are completed for one month. The mealtime observations will continue at least weekly on an on-going basis. Responsible Party: Home Manager, Program Director, Area Director	

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	food, to chew food and swallow before taking another bite. (Staff to encourage [client #3] to take a drink or wipe face with napkin every 2-3 bites.)" The Dining Plan indicated the "Specific Skills to Maintain/Acquire: To eat slowly, chew food and swallow before taking another bite." A review of client #6's record was conducted on 1/23/14 at 11:36 AM. Client #6's Dining Plan, dated 1/31/13 and reviewed by the nurse on 1/11/14 indicated, "Staff to remind/encourage [client #6] to slow down when eating by taking a drink or wiping face with napkin every 2-3 bites." On 1/22/14 at 12:36 PM, the Program Director (PD) indicated client #3 and #6's Dining Plans should be implemented at every meal. The PD indicated client #3's training objective should be implemented at every meal. On 1/22/14 at 12:36 PM, the Registered Nurse (RN) indicated client #3 and #6's Dining Plans should be implemented at every meal. 9-3-4(a)			

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W000312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 3 of 3 clients in the sample who were prescribed psychotropic medications (#3, #4 and #6), the facility failed to ensure the clients' medication reduction plans for their psychotropic medications were attainable. Findings include: A review of client #3's record was conducted on 1/23/14 at 10:49 AM. Client #3's Behavior Support Plan (BSP), dated 3/4/12, indicated he was prescribed Prozac, Zyprexa and Lorazepam as psychotropic medications. The BSP indicated, in part, "The table also shows the average daily rate criteria that must be met in the future for a medication reduction to occur. Water seeking 0.10, Pica (ingesting non-nutritive substances) 0.00, inappropriate sex. (sexual) beh. (behavior) 0.00... If the average daily rate of each of the behaviors listed above is at or below the specified criterion for the full review period, [name of	W000312	Each client's IDT will meet by 2/23/2014 discuss a plan for medication reduction for psychotropic medications that are attainable. The Program Director will meet and review at least annually with the IDT to monitor and/or revise medication reduction plans to ensure attainability. Responsible Party: Program Director Addendum: Immediately following client's IDTs, the medication reduction plans were revised and will be monitored at least quarterly for further changes as needed. Other clients in the home were also affected by this deficiency and their IDTs also met and their medication reduction plans have also been revised and will continue to be monitored at least quarterly also. Responsible Party: Program Director, Area Director	02/23/2014

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	company] will recommend medication reduction. Such recommendations will be written in the quarterly report and presented at the quarterly meeting." A review of client #4's record was conducted on 1/23/14 at 11:15 AM. Client #4's BSP, dated 5/26/12, indicated he was prescribed Celexa as a psychotropic medication. The BSP indicated, in part, "The table also shows the average daily rate criteria that must be met in the future for a medication reduction to occur. Temper outbursts 0.00, inappropriate sexual beh. 0.00, collecting pics (pictures) of children 0.00... If the average daily rate of each of the behaviors listed above is at or below the specified criterion for the full review period, [name of company] will recommend medication reduction. Such recommendations will be written in the quarterly report and presented at the quarterly meeting." A review of client #6's record was conducted on 1/23/14 at 11:36 AM. Client #6's BSP, dated 7/13/12, indicated he was prescribed Zyprexa and Lexapro as psychotropic medications. The BSP indicated, in part, "The table also shows the average daily rate criteria that must be met in the future for a medication reduction to occur. Physical			

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	assault 0.00, verbal abuse 0.01, bossing 0.01, manipulative behavior 0.05... If the average daily rate of each of the behaviors listed above is at or below the specified criterion for the full review period, [name of company] will recommend medication reduction. Such recommendations will be written in the quarterly report and presented at the quarterly meeting." On 1/23/14 at 12:24 PM, the Area Director (AD) indicated the medication reduction plans in client #3, #4 and #6's behavior plans were not attainable. The AD indicated the clients would never go off their meds until the clients hit zero instances of targeted behaviors, which was not attainable. On 1/23/14 at 11:32 AM, the behavior specialist stated, "It's a ridiculous notion" a client could go without having a targeted behavior in order to reduce their psychotropic medication(s). The behavior specialist indicated the medication reduction plans were not attainable. 9-3-5(a)			

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 4 clients in the sample (#6), the facility's nursing services failed to ensure client #6 went to all of his scheduled physical therapy (PT) appointments. Findings include: A review of the facility's incident/investigative reports was conducted on 1/22/14 at 11:14 AM and indicated the following: On 9/1/13 at 6:21 PM, client #6 had a seizure lasting approximately 2 minutes. The Seizure Description Record, dated 2013, indicated the seizure on 9/1/13 included a fall with injury. Client #6 reported afterward he felt okay. When staff examined client #6 for injuries, they observed a "scratch on his head from where he had taken off his helmet" and a "small scratch on his knee." Staff monitored client #6 throughout the night. On the morning of 9/2/13, when client #6 woke up, staff noticed his shoulder "looked swollen" and had a "light bruise." Staff immediately took client #6 to the hospital where he was examined. An x-ray showed a fracture to his left shoulder and his shoulder was	W000331	Staff will be retrained by 2/23/2014 on ensuring client appointments are completed or documentation are completed or documentation is obtained for refusals of treatment. The Program Director will review appointment schedule weekly to monitor that appointments are kept. Responsible Party: Program Director Addendum:No other clients were affected by this deficiency. Schedules will be reviewed by the Home Manager at the beginning of each week to ensure that arrangements are made to meet all scheduled appointments and the Program Direcor will review the schedules at the end of each week to ensure appointments were completed and will administer corrective action as necessary. If appointments are missed due to continuous client refusals, IDTs will meet to discuss as needed. Responsible Party: Home Manager, Program Director	02/23/2014

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	immobilized. A review of client #6's record was conducted on 1/23/14 at 11:36 AM. Client #6's PT Discharge Summary, dated 11/27/13, indicated, in part, "[Client #6] has been seen in physical therapy for 11 visits since the initial evaluation on 10/7/13. He has had issues with transportation to PT visits." On 10/23/13, the Medical Appointment Form (MAF) indicated client #6 had a follow-up appointment scheduled on 10/25/13. There was no documentation client #6 attended the 10/25/13 appointment. On 10/28/13, the MAF indicated client #6 had a follow-up appointment scheduled on 10/30/13. There was no documentation client #6 attended the 10/30/13 appointment. On 11/6/13, the MAF indicated client #6 had a follow-up appointment scheduled on 11/8/13. There was no documentation client #6 attended the 11/8/13 appointment. On 11/13/13, the MAF indicated client #6 had a follow-up appointment scheduled on 11/15/13. There was no documentation client #6 attended the 11/15/13 appointment. On 1/24/14 at 9:19 AM, the Home Manager (HM) indicated there was one appointment client #6 missed due to transportation issues. The HM indicated			

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	the other three appointments were missed due to client #6 refusing to attend the appointments. The HM indicated there was no documentation indicating client #6 refused to attend the appointments. The HM indicated client #6 did not like therapy. The HM indicated there were also issues with the PT office scheduling appointments. The HM indicated when client #6 initially went in, the office scheduled several appointments in advance. The HM indicated when client #6 went in for therapy, the office would schedule the next appointment for a different date than previously scheduled. On 1/24/14 at 8:53 AM, the Registered Nurse (RN) indicated she was not informed client #6 missed several appointments. The RN indicated she read the PT Discharge Summary and did not understand why it was documented he missed appointments due to transportation issues. The nurse stated she, "probably should've followed up." The RN indicated the missed appointments may have been transportation related or due to client #6's refusals. The RN stated, "I was surprised myself" and "I have no idea what happened." The RN indicated client #6's appointments should have been held as scheduled. The RN			

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	indicated she informed the group home a while ago that appointments could not be changed without prior authorization from the RN, the Area Director or the Program Director. The RN indicated she was not informed of the missed appointments. 9-3-6(a)			
W000369	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 3 clients (#3) observed to receive their medications from staff #2, the facility failed to ensure staff administered client #3's medication (Omeprazole) as ordered by the physician. Findings include: An observation was conducted at the group home on 1/22/14 from 6:15 AM to 7:50 AM. At 6:45 AM, client #3 received Omeprazole (heartburn) from staff #2. On 1/22/14 at 6:45 AM, staff #2 indicated client #3 ate his breakfast prior to receiving his medications.	W000369	Staff will be retrained by 2/16/2014 on administering medications as written without error. Staff that completed the medication error for Client #3 received corrective action. Weekly morning medication observations will be completed for four weeks and the 1 time monthly on an on-going basis with alternating staff. Responsbile Party: Nurse and Program Director Addendum: Weekly morning medication observations will be completed three weekly for four weeks with alternating staff, and then one time monthly on an ongoing basis after. Responsible Party: Home Manager, Program Director, Nurse	02/23/2014

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	A review of client #3's record was conducted on 1/23/14 at 10:49 AM. Client #3's Physician's Orders, dated 12/7/13, indicated Omeprazole was to be administered "before a meal." On 1/23/14 at 12:24 PM, the Area Director (AD) indicated client #3's medication should be administered as ordered. The AD indicated it was a medication error since the medication was not administered as ordered before a meal. On 1/23/14 at 12:24 PM, the nurse indicated client #3's Omeprazole being administered after a meal was a medication error. The nurse indicated the medication should have been administered as ordered before a meal. On 1/23/14 at 12:24 PM, the Program Director (PD) indicated client #3's Omeprazole should have been administered before a meal as ordered. 9-3-6(a)			