STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	10707 BERNADETTE DR EVANSVILLE, IN 47725

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W000000	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: 10/22, 10/23, 10/24, 10/25, 10/28 and 11/8/13 Facility Number: 000637 Provider Number: 15G098 AIMS Number: 100234000 Surveyor: Paula Chika, QIDP-TC These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/18/13 by Ruth Shackelford, QIDP.	W000000		
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, interview and record review for 1 of 4 sampled clients (#3), the facility failed to ensure the client's right to due process to make	W000125	W125 -The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients	12/31/2013

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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	phone calls and/or to keep her personal cell phone. The facility also failed to ensure client #3 had the right to due process in regard to obtaining an appropriate guardian for a client whose legal guardian was no longer able to act in a guardianship capacity. Findings include: 1. During the 10/24/13 observation period between 4:45 AM and 7:20 AM, at the group home, client #3 asked staff #2 if she could make a phone call. Staff #2 redirected client #3 to make her bed. Throughout the above mentioned observation period, client #3 stated "Call [name of aunt]." At 6:15 AM, client #3 asked staff #2 if she could call her aunt. Staff #2 told client #3 to clear the table before she made her call. At 6:32 AM, staff #2 retrieved a cell phone from the desk in the office area. Client #3 went to her bedroom and used the cell phone. Once client #3 called her aunt, facility staff took the phone and returned it to the office area. Client #3's record was reviewed on 10/25/13 at 3:17 PM. Client #3's 8/4/13 Individual Support Plan (ISP) did not indicate client #3 was on a phone restriction and/or indicated client #3 could not maintain/keep a cell phone.		of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. -The facility has a policy regarding client rights and modifications which remains appropriate, as well as, policy regarding Grievance procedures which are to be offered to the consumer any time they have a complaint. -Staff responsible for assuring that client's rights are always a foremost consideration will be trained regarding this policy as well as, the policy regarding the grievance procedure. -Staff responsible for assuring that this policy is implemented accordingly will be retrained. -Specifically for Clients #3 the IDT will meet to determine if Client #3 is in need of a guardian. If the IDT agrees to a guardian, then the process will begin to get a guardian. -Specifically for Client #3, the IDT will meet to discuss restriction of Client #3's cell phone - Any changes shall be reviewed by the Human Rights Committee to assure that no rights are being violated for all clients. - The Residential Manager will be retrained on Client rights in regards to obtaining approval from guardians, HRC, and the IDT for any restrictions - The Program Manager will be retrained on Client rights in regards to obtaining approval from guardians, HRC, and the IDT for	

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	Client #3's ISP indicated client #3 had a guardian. The ISP did not indicate the client's guardian approved client #3's phone restriction and/or indicated the facility's Human Rights Committee reviewed and/or approved the rights restriction. Interview with the Program Manager (PM) on 10/28/13 at 10:05 AM indicated the cell phone belonged to client #3 as the client had purchased the cell phone 2 months ago. The PM indicated client #3 would call her aunt all the time but the client's aunt only wanted the client to call 3 times a week. The PM indicated client #3's phone was kept in the office area on the desk as client #3 had to ask staff to use the phone. The PM indicated client #3's ISP did not indicate client #3's phone calls should be restricted and/or indicate client #3's cell phone should be kept by the facility in the office area. The PM indicated the facility's Human Rights Committee had not reviewed and/or approved the rights restriction. 2. Client #3's record was reviewed on 10/25/13 at 3:17 PM. Client #3's Human Rights (HR) approval Forms and/or E-mails indicated the following: -8/9/13 Client #3 was started on		any restrictions -Residential Manager will oversee through daily visits in the home to assure programs and objectives are implemented appropriately and no client rights are being violated. -Program Manager will oversee through weekly visits in the home to assure programs and objectives are implemented and no client rights are being violated. Persons Responsible: Residential Manager, Program Manager, Executive DirectorADDEDUM:W125 -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. -The facility has a policy regarding client rights and modifications which remains appropriate, as well as, policy regarding Grievance procedures which are to be offered to the consumer any time they have a complaint. -Staff responsible for assuring that client's rights are always a foremost consideration will be trained regarding this policy as well as, the policy regarding the grievance procedure. -Staff responsible for assuring that this policy is implemented accordingly will be retrained. -Specifically for Clients #3 the IDT will meet to determine if Client #3 is in need of a	

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	Gabitril (psychotropic medication for behavior) 2 milligrams two times a day for 1 week and then 4 milligrams two times a day thereafter. The 8/9/13 HR form indicated in area "...Guardian (if applicable): BDDS (Bureau of Developmental Disabilities Services) approval Date 8/12/13...." -7/10/13 Client #3's Klonopin (psychotropic behavior medication) was increased to 1 milligram three times a day. The HR form indicated "...Guardian (if applicable): Per BDDS 7/15/13...." -7/3/13 Client #3's Risperdal (behavior medication) was increased to 4 milligrams two times a day. The HR form indicated Guardian (if applicable): Per BDDS Date (blank)...." -6/13/13 Email to Human Rights Committee (HRC) members indicated "I am needing HRC approval for a client at the Bernadette group home. Dr. (doctor) has recommended increasing Amytriptylene (behavior medication) to 100mg (milligrams) daily and increase Risperdal (behavior medication) to3mg (sic) in the AM. This has been ordered for increased behaviors as well as increased nervousness/anxiety. We have obtained GDN (guardian) approval for		guardian. If the IDT agrees to a guardian, then the process will begin to get a guardian. -Specifically for Client #3, the IDT will meet to discuss restriction of Client #3's cell phone - Any changes shall be reviewed by the Human Rights Committee to assure that no rights are being violated for all clients. - The Residential Manager will be retrained on Client rights in regards to obtaining approval from guardians, HRC, and the IDT for any restrictions - The Program Manager will be retrained on Client rights in regards to obtaining approval from guardians, HRC, and the IDT for any restrictions -Residential Manager will oversee through daily visits in the home to assure programs and objectives are implemented appropriately and no client rights are being violated. -Program Manager will oversee through weekly visits in the home to assure programs and objectives are implemented and no client rights are being violated. Persons Responsible: Residential Manager, Program Manager, Executive Director	

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	this increase...." Client #3's 6/13/13 HR form indicated BDDS approved the client's medication increases. Client #3's 8/8/13 Comprehensive Functional Assessment (CFA) indicated in the area of Informed Consent Assessment client #3 did not have the ability to understand/make decisions regarding the following: -Routine care in regard to medical and dental services -Elective procedures and surgeries -Programming -Behavior Support Plan -Finances -Sexual Awareness Client #3's 8/8/13 CFA indicated client #3 was in need of a Health Care Representative for the above areas. Client #3's 8/4/13 Individual Support Plan (ISP) indicated a section entitled Modification of Rights. The Modification of Rights indicated client #3 had rights restrictions in regard to money, movement, medications, privacy, Behavior Support Plan and You're Safe, I'm Safe (YSIS) (behavior intervention techniques). Client #3's 8/4/13 ISP indicated client #3's legal guardian was the client's mother. Client #3's 8/4/13 ISP indicated client #3's guardian did not sign/give written			

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	informed consent for the client's restrictive program as only client #3 signed the ISP. Client #3's 8/4/13 ISP and/or 2013 interdisciplinary team meeting notes did not indicate client #3's mother could no longer participate in the capacity of being client #3's legal guardian, and/or indicate client #3's guardianship had been resolved. Interview with the Program Manager (PM) on 10/25/13 at 3:54 PM indicated client #3's guardian/mother was no longer acting in the capacity of client #3's guardian. The PM indicated client #3's guardian/mother had stage 4 cancer and was no longer able to make decisions for client #3. The PM indicated an involved aunt was also ill. The PM stated "There is no one else." The PM indicated the facility was seeking approval from BDDS (state agency responsible for placement) to give approval for the client's restrictive program and medications. The PM indicated client #3 was not able to give written informed consent for the restrictions. 9-3-2(a)			

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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 interview and record review for 2 of 4 sampled clients (#1, #4) and for 1 additional client (#8), the facility failed to implement its written policy and procedures to conduct thorough investigations, to put in place corrective measures and/or to address to recommended corrective actions in a timely manner. Findings include: The facility's policy and procedures were reviewed on 10/22/13 at 2:17 PM. The facility's 3/3/09 policy and procedures entitled Procedures: Abuse/Neglect/Exploitation, Death, Incident Reporting & (and) Investigation indicated "To ensure that all allegations of Abuse/Neglect/Exploitation, significant injuries of unknown origin and Death are reported and investigated as required by regulations, local, state, federal and ResCare guidelines...." The facility's policy indicated the facility's Quality Assurance Coordinator (QAC) would be responsible to conduct thorough investigations of allegations of abuse, neglect and injuries of unknown source. The 3/09 policy indicated the	W000149	W149 - The facility must ensure to follow all policies and procedures to prevent neglect of a client in regards to falls -QIDP will be retrained on conducting thorough investigations in regards to allegations of abuse, neglect, and injuries of unknown source -QIPD will review all investigations with Executive Director to determine appropriate recommendations. -Residential Manager will be retrained on ensuring that all protective and preventative measures are put into place by recommendations of the QIDP - Residential Manager will be retrained on conducting an IDT meeting after each fall to review the high risk plan for appropriateness and training all staff on any updates made to the clients plans. -Residential Manager will monitor through daily visits to the home. - Program Manager will be retrained on ensuring that all protective and preventative measures are put into place by recommendations of the QIDP - Program Manager will be retrained on ensuring an IDT meeting after each fall to review the high risk plan for appropriateness and training all staff on any updates made to the clients plans. Program Manager	12/31/2013

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	Program Coordinators were responsible for submitting all protective and preventive measures put in place to the Quality Assurance department. The facility's policy indicated these measures were to be out in place within 5 days of the allegation/incident. The facility's policy indicated the QAC was to "...Ensure that documentation of all protective and preventative measures is obtained as required...." The facility failed to conduct thorough investigations in regard to all allegations of abuse, neglect and/or injuries of unknown source for clients #1 and #8. Please see W154. The facility failed to put appropriate corrective action in place in a timely manner manner for a client (#4) who obtained a fracture from a fall and for a client (#8) who fell after her eyes were dilated. Please see W157. 9-3-2(a)		will monitor trough weekly visits to the home. Persons Responsible: Residential Manger, Program Manger, QIDP, Executive Director. ADDENDUM:W149 - The facility must ensure to follow all policies and procedures to prevent neglect of a client in regards to falls -QIDP will be retrained on conducting thorough investigations in regards to allegations of abuse, neglect, and injuries of unknown source -QIPD will review all investigations with Executive Director to determine appropriate recommendations. -Residential Manager will be retrained on ensuring that all protective and preventative measures are put into place by recommendations of the QIDP - Residential Manager will be retrained on conducting an IDT meeting after each fall to review the high risk plan for appropriateness and training all staff on any updates made to the clients plans. -Residential Manager will monitor through daily visits to the home. - Program Manager will be retrained on ensuring that all protective and preventative measures are put into place by recommendations of the QIDP - Program Manager will be retrained on ensuring an IDT meeting after each fall to review the high risk plan for appropriateness and training all staff on any updates made to the clients plans. Program Manager	

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			will monitor trough weekly visits to the home. Persons Responsible: Residential Manger, Program Manger, QIDP, Executive Director.	
W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 4 of 11 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct thorough investigations in regard to all allegations of abuse, neglect and/or injuries of unknown source for clients #1 and #8. Findings include: 1. The facility's reportable incident reports, facility's Incident Reports and/or investigations were reviewed on 10/22/13 at 2:12 PM. The facility's 3/6/13 reportable incident report indicated "An allegation was made that staff [staff #3] was disrespectful to [client #1] during a doctor's appointment. [Client #1] is safe. Staff was put on administrative leave and QA (Quality Assurance) has initiated an investigation." The facility's 3/21/13 follow up report indicated the allegation of verbal abuse	W000154	W154 - The facility must ensure that evidence that all alleged violations are thoroughly investigated - The facility has a policy for conducting investigations which remains appropriate - QIDP will be retrained on conducting a thorough investigation in regards to allegations of abuse, neglect, and/or injuries of unknown source including if a pattern exists - Persons Responsible: QIDP and Executive Director ADDENDUM: W154 -Th e facility must have evidence that all alleged violations are thoroughly investigated. -The facility has a policy regarding abuse & neglect which has been reviewed and remains appropriate. -The facility has a policy regarding thorough investigations which has been reviewed and remains appropriate. -Staff responsible for assuring proper implementation of this policy will be trained on this policy. -The Training Director will assure that staff participate in training at least annually regarding the abuse &	12/31/2013

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	was substantiated. The facility's 3/12/13 Incident Investigation Review indicated client #1's doctor called the facility's nurse on 3/6/13 and told the nurse she saw client #1 at her office on 3/5/13 and the staff who was with client #1 was "...disrespectful toward [client #1]...staff was very unprofessional...." The investigation indicated staff #3 laughed about the client's symptoms and why the client went to see her doctor. The investigation indicated "...[LPN #1] stated that [name of doctor] reported that [client #1] said to her (staff #3) 'what is so funny about me having diabetes'...." The investigation indicated client #1 had a new diagnosis of diabetes. The 3/12/13 investigation indicated "CONCLUSION AND FINDINGS: After review of all statements and documentation, the investigation committee concludes that the allegation that staff [staff #3] was disrespectful to [client #1] during a doctors (sic) appointment is substantiated." The facility's 3/12/13 investigation indicated client #1, staff #3 and LPN #1 were interviewed. The facility's investigation did not indicate any additional clients and/or staff were interviewed to determine if any other staff were being verbally abusive and/or disrespectful		neglect policy to assure ongoing understanding and compliance. -QIDP will be re-trained on assuring thorough investigations are completed and that all investigations are reviewed with the Executive Director within 5 business days. -QIDP will ensure that thorough documentation is kept on file regarding any investigation. -QIPD will review and oversee and incidents daily and ensure that all alleged incidents or abuse & neglect are investigated thoroughly and reviewed within five business days. -QIDP will be trained on ensuring that all relevant parties are interviewed during an investigation to look for tends of abuse and/or neglect. -QIPD will be trained on ensuring that environmental issues are reviewed and included in all investigations of injuries of unknown origin. - Program Manger will be trained on ensuring that an environmental check is completed following any injury of unknown origin - Program Manger will be trained on ensuring that an environmental check is completed following any injury of unknown origin. -The Executive Director shall assure through review of incidents to assure proper documentation and review occurs within five business days. Any issues shall be dealt with through ResCare policy and	

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	toward clients at the group home. Interview with the Director of Quality Assurance on 10/28/13 at 9:54 AM indicated no other clients and /or staff were interviewed in regard to verbal abuse and/or staff being disrespectful to clients. The Director of Quality Assurance stated "Only investigated that incident." 2. The facility's reportable incident reports, facility's Incident Reports and/or investigations were reviewed on 10/22/13 at 2:12 PM. The facility's reportable incident reports indicated the following: -9/8/13 "Staff noticed that [client #1] had a 1/2 inch bluish area on anterior side of 4th finger of left hand. [Client #1] does not know how she hurt her hand. She has minor discomfort... [Client #1] is safe. Per policy an investigation has been initiated." The facility's 9/16/13 Incident Investigation Review indicated "...CONCLUSION AND FINDINGS: After review of all statements and information collected, it is the consensus of the investigation committee that it could not be determined what caused the injury to [client #1's] finger, but not		procedure. - Persons Responsible: Executive Director, Program Manager, Training Coordinator & QIDP.	

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	thought to be due to any inappropriate act of a staff member or peer." -6/29/13 "[Client #1] woke up with a bruise near her wrist and some swelling. [Client #1] stated that she did not know how she got the bruise. [Client #1] did not complain of pain and can move her wrist. [Client #1] is safe. Ice was applied to her wrist. [Client #1] was taken to [name of local medical facility]. Doctor put a wrap on the wrist for support and said it looked like she just bumped it...An investigation has been initiated." The facility's 7/8/13 Incident Investigation review indicated "...CONCLUSION AND FINDINGS: After reviewing statements and documentation the investigation committee concludes that it is undetermined how [client #1] received the injury to her wrist, however it is not suspected to be due to inappropriate acts of staff or peers." The facility's above mentioned investigations indicated staff and clients were interviewed. The investigations indicated facility staff did not know how client #1 injured her finger and/or her wrist as they did not see the client "bump" into anything, fall or "anyone			

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	harm her." The above mentioned investigations did not indicate the client's record was reviewed, the day program/workshop staff were interviewed, and/or indicate the physical environment was checked at the group home/the client's bedroom to assist in determining a cause for the client's injuries of unknown source. Interview with the Director of Quality Assurance on 10/28/13 at 9:54 AM indicated he did not look at the environment at the group home, and/or check the client's record for any indication on how the client may have received the injuries of unknown source. The Director indicated he did look at client #1's skin assessment sheet which indicated the client did not have any areas on her body. 3. The facility's reportable incident reports, facility's Incident Reports and/or investigations were reviewed on 10/22/13 at 2:12 PM. The facility's 8/15/13 reportable incident report indicated "While [client #8] was walking out of the eye doctors after getting her eyes dilated, she tripped and fell while stepping off of the curb resulting in an abrasion to her right shin and knee. [Client #8] is safe. [Client #8] does have a fall prevention plan and			

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	it remains appropriate at this time. Staff will continue to monitor." The facility's 8/15/13 Internal Incident Report indicated "[Client #8] and staff was (sic)coming out of the doctor office. [Client #8's] eyes were dilated and she was complaining of not being able to see the (sic). She missed her step and fell and hit her knee and shin. both (sic) are scraped. Shin has a bruise. Staff provided first-aid, and called the nurse." The back of the incident report indicated a physical therapy evaluation would be completed. The reportable incident report and/or internal incident report did not indicate the facility conducted an investigation in regard to possible neglect as client #8 was a fall risk and staff did not assist the client to ambulate when her eyes were dilated. Interview with the Director of Quality Assurance (QA) on 10/28/13 at 9:54 AM indicated no investigation was conducted in regard to client #8's fall as possible neglect as the client was not injured. Interview with the Program Manager (PM) on 10/28/13 at 10:05 AM indicated facility staff should have assisted the client to ambulate as the client's eyes were dilated and the client			

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	had a history of falls. The PM indicated the facility staff should have utilized a wheelchair for the doctor's appointment for which the client had an order for. The PM indicated an investigation for possible neglect should have been conducted. 9-3-2(a)			
W000157	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 7 incidents of allegations of abuse and/or neglect reviewed, the facility failed to put appropriate corrective action in place in a timely manner manner for a client (#4) who obtained a fracture from a fall and for client (#8) who fell after her eyes were dilated. Findings include: 1. The facility's reportable incident reports, facility's Incident Reports and/or investigations were reviewed on 10/22/13 at 2:12 PM. The facility's 8/15/13 reportable incident report indicated "While [client #8] was walking out of the eye doctors after getting her eyes dilated, she tripped and	W000157	W157 - The facility must ensure that evidence that all alleged violations are thoroughly investigated - The facility has a policy for conducting investigations which remains appropriate - QIDP will be retrained on conducting a thorough investigation in regards to allegations of abuse, neglect, and/or injuries of unknown source in a timely manner - Residential Manager will be retrained on ensuring that all QA recommendations are completed in a timely manner -Program Manager will be retrained on ensuring that all QA recommendations are completed in a timely manner - Persons Responsible: QIDP, Residential Manner, Program Manager, and Executive Director ADDENDUM: W157 -Th e facility must have evidence that	12/31/2013

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	fell while stepping off of the curb resulting in an abrasion to her right shin and knee. [Client #8] is safe. [Client #8] does have a fall prevention plan and it remains appropriate at this time. Staff will continue to monitor." The facility's 8/15/13 Internal Incident Report indicated "[Client #8] and staff was (sic) coming out of the doctor office. [Client #8's] eyes were dilated and she was complaining of not being able to see the (sic). She missed her step and fell and hit her knee and shin. both (sic) are scraped. Shin has a bruise. Staff provided first-aid, and called the nurse." The back of the incident report indicated a physical evaluation would be completed. The reportable incident report did not indicate/include facility staff would be retrained on monitoring/assisting clients to ambulate when their eyes were dilated to prevent falls. Interview with the Program Manager (PM) on 10/28/13 at 10:05 AM indicated facility staff should have assisted the client to ambulate as the client's eyes were dilated and the client had a history of falls. The PM indicated the facility staff should have utilized a wheelchair for the doctor's appointment which the client had an order for. The		all alleged violations are thoroughly investigated. -The facility has a policy regarding abuse & neglect which has been reviewed and remains appropriate. -The facility has a policy regarding thorough investigations which has been reviewed and remains appropriate. -Staff responsible for assuring proper implementation of this policy will be trained on this policy. -The Training Director will assure that staff participate in training at least annually regarding the abuse & neglect policy to assure ongoing understanding and compliance. -QIDP will be re-trained on assuring thorough investigations are completed and that all investigations are reviewed with the Executive Director within five business days. -QIDP will ensure that thorough documentation is kept on file regarding any investigation. -QIPD will review and oversee and incidents daily and ensure that all alleged incidents or abuse & neglect are investigated thoroughly and reviewed within five business days. -QIDP will be trained on ensuring that all relevant parties are interviewed during an investigation to look for tends of abuse and/or neglect. -QIPD will be trained on ensuring that environmental issues are reviewed and included in all investigations of injuries of	

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	PM indicated facility staff would need to be retrained. 2. The facility's reportable incident reports, facility's Incident Reports and/or investigations were reviewed on 10/22/13 at 2:12 PM. The facility's 3/4/13 reportable incident reports indicated the following: -3/4/13 "[Client #4] was released from a recent hospitalization that was reported on 03/06/13 (incident #511572). During the hospitalization [client #4] was given an x-ray of her side which revealed that she had a fractures (sic) rib from a previous fall on 03/04/13 (incident #510982). The reportable incident report indicated an investigation was conducted in regard to the 3/4/13 fall, and an objective was put in place for client #4 "...to tell staff when she is hurting or injured." -3/4/13 "At 310pm (sic) [client #4] was stepping off the curb heading to her van. She was leaning over to the left while walking and lost her balance when she stepped off the curb. She fell to the left side and hit her head on the an van door in the adjacent parking space. [Client #4's] head had a small laceration...." The reportable incident report indicated the nurse was contacted and the client		unknown origin. - Residential Manager will be retrained on ensuring that all investigations recommendations are being completed in a timely manor. - Program Manger will be trained on ensuring that an environmental check is completed following any injury of unknown origin. - Program Manger will be retrained on ensuring that all investigations recommendations are being completed in a timely manor. -The Executive Director shall assure through review of incidents to assure proper documentation and review occurs within five business days. Any issues shall be dealt with through ResCare policy and procedure. - Persons Responsible: Executive Director, Program Manager, Residential Manger, Training Coordinator & QIDP.	

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	taken to a local medical facility for treatment. The reportable incident report indicated client #4 received 3 sutures and a tetanus injection. The facility's 3/9/13 Incident Investigation Review indicated client #4 was interviewed on 3/9/13. Client #4's 3/9/13 witness statement indicated client #4 was "...staring down at the ground and not looking where she was walking. [Client #4] indicated she stepped off of the curb and fell into the van...." Client #4's witness statement indicated the client's side was hurting after the fall. Client #4's witness statement indicated "...a couple of days later that she was was not feeling well and she went to the hospital (sic). [Client #4] indicated that her side was hurting from where she fell. [Client #4] indicated that they took x-rays which revealed that she had a broken rib...." The facility's 3/9/13 investigation indicated "...CONCLUSION AND FINDINGS: After review of all statements and information collected, it is the consensus of the investigation committee that the cut to [client #4's] head resulted from her tripping and falling while stepping off the curb at [name of workshop] and hitting her head on the van door (sic). It was also the consensus of the investigation committee that the fall			

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	resulted in [client #4] breaking a rib." The facility's investigation recommended the following: "1.) Review of High Risk plans for falls for appropriateness. 2.) Goal in place for [client #4] to tell staff immediately when she is hurt and or injured. 3.) Goal in place for [client #4] to look where she is walking and not stare at the ground." Client #4's record was reviewed on 10/25/13 at 2:22 PM. Client #4's 6/3/13 Interdisciplinary Team (IDT) Meeting note indicated the client's IDT did not meet to address the above mentioned recommendations until 6/3/13. The IDT note indicated goals/objectives were put in place to teach the client to immediately tell staff when she is hurt/injured, and to look where the client is walking and not stare at the ground. The facility/client's IDT failed to put corrective actions/measures in place, in a timely manner, as the recommendations were made on 3/9/13. Interview with the Director of Quality Assurance (QDA) and the Program Manager (PM) on 10/28/13 at 9:54 AM indicated they did not know why the 3/9/13 recommendations were not			

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	addressed prior to 6/3/13. The PM stated "It should have been sooner." 9-3-2(a)			
W000262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to ensure its Human Rights Committee HRC reviewed and/or approved all restrictive programs/plans versus only the Chairman of the HRC reviewing/approving. The facility failed to ensure a quorum of HRC members approved psychotropic medication, changes and/or increases to ensure the protection of rights of the clients. Findings include: 1. Client #3's record was reviewed on 10/25/13 at 3:17 PM. Client #3's 8/4/13 BSP (Behavior Support Plan) indicated facility staff could utilize YSIS (You're Safe, I'm Safe) (behavior techniques/restraints) with the client when she demonstrated physical aggression.	W000262	W262 The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. -The Human Rights Committee will review all clients plans in there entirety including modifications of rights at least quarterly. -The Residential Manger will monitor through monthly chart reviews to ensure all clients plans and modification of rights are approved by the Human Rights Committee at least quarterly. -The Program Manger will monitor through quarterly chart reviews to ensure all clients plans and modification of rights are approved by the Human Rights Committee at least quarterly. - Meeting will be held for all clients to review their plans in there entirety including modifications of rights. Any adjustments made to any clients	12/31/2013

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	Client #3's 8/4/13 ISP indicated client #3 had a Behavior Medication Restrictions form for the following: -Clonazepam 1 milligram three times a day for Intermittent Explosive Disorder demonstrated by verbal aggression and physical aggression. The plan indicated "...Reduction Strategies Psychiatric Consultation BSP (Behavior Support Plan) Consistent staff direction. Reduction Plan: When the criteria in the objectives have been met, IDT (interdisciplinary team) will meet to discuss a reduction in Clonazepam...." -Risperdal 4 milligrams two times a day for Intermittent Explosive Disorder demonstrated by verbal aggression and physical aggression. The plan indicated "...Reduction Strategies Psychiatric Consultation BSP Consistent staff direction. Reduction Plan: When the criteria in the objectives have been met, IDT will meet to discuss a reduction in Risperdal...." -Gabitril 4 milligrams daily for Mood Disorder demonstrated by verbal aggression and physical aggression. The plan indicated "...Reduction Strategies Psychiatric Consultation BSP Consistent staff direction. Reduction Plan: When		plans and/or modification of rights will be given to the Human Rights Committee for approval prior to the changes being implemented. Person Responsible: Residential Manager, Program Manger, Executive Director. ADDENDUM: W262 The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. -The Human Rights Committee will review all clients plans in there entirety including modifications of rights at least quarterly. -The Residential Manger will monitor through monthly chart reviews to ensure all clients plans and modification of rights are approved by the Human Rights Committee at least quarterly. -The Program Manger will monitor through quarterly chart reviews to ensure all clients plans and modification of rights are approved by the Human Rights Committee at least quarterly. - Meeting will be held for all clients to review their plans in there entirety including modifications of rights. Any adjustments made to any clients plans and/or modification of rights will be given to the Human Rights Committee for approval prior to the changes being implemented. - All HRC minutes will be turned into the Executive Director at the	

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	the criteria in the objectives have been met, IDT will meet to discuss a reduction in Gabitril...." The 8/4/13 Behavior Medication Restrictions form also included the side effects for all of the above mentioned medications. Client #3's 8/1/13 ISP indicated the facility's HRC Chairman (The Director of Quality Assurance) reviewed and approved the restrictive program on 10/21/13. Client #3's Human Rights Approval Forms indicated the following (not all inclusive): -8/9/13 "Start Gabitril 2 mg (milligrams) two times a day x (time) 1 wk (week) then to 4 mg BID thereafter." An attached 8/12/13 Email indicated 2 outside HRC members were sent the email for approval for the medication to start. The Attached Emails indicated the 2 outside members approved the Gabitril to start. -6/13/13 Email sent to 4 HRC members indicated "I am needing HRC approval for a client at the Bernadette group home. Dr. (doctor) has recommended increasing Amytriptylene (behavior medication) to 100mg (milligrams) daily and increase Risperdal (behavior		end of each quarter. - The Program Manger will be trained on ensuring that the HRC members receive a copy of all individuals' plans along with their modifications of rights and behavior medication restrictions to review and approve prior to any psychiatric medication changes. - All member of the HRC meeting will be notified of quarterly meeting dates and a sign in sheet will be kept on all members in attendance. Person Responsible: Residential Manager, Program Manger, Executive Director.	

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	medication) to3mg (sic) in the AM. This has been ordered for increased behaviors as well as increased nervousness/anxiety...." Client #3's 6/13/13 Human Rights form indicated one outside member returned an Email which indicated "Approved." 2. Client #4's record was reviewed on 10/25/13 at 2:22 PM. Client #4's 8/1/13 Behavior Support Plan (BSP) indicated facility staff could utilize YSIS with the client when she demonstrated physical aggression. Client #4's 8/1/13 Individual Support Plan (ISP) indicated client #4 had a Behavior Medication Restrictions form for the following: -Lexapro 20 milligrams daily for Paranoid Schizophrenia demonstrated by verbal aggression and physical aggression. The plan indicated "...Reduction Strategies Psychiatric Consultation BSP Consistent staff direction. Reduction Plan: When the criteria in the objectives have been met, IDT will meet to discuss a reduction in Lexapro...." -Zyprexa 30 milligrams daily for Paranoid Schizophrenia demonstrated by verbal aggression and physical			

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	aggression. The plan indicated "...Reduction Strategies Psychiatric Consultation BSP Consistent staff direction. Reduction Plan: When the criteria in the objectives have been met, IDT will meet to discuss a reduction in Zyprexa...." The 8/1/13 Behavior Medication Restrictions form also included the side effects for both of the above mentioned medications. Client #4's 8/1/13 ISP indicated the facility's HRC Chairman (The Director of Quality Assurance) reviewed and approved the restrictive program on 10/21/13. Client #4's 2/8/13 Human Rights Approval Forms indicated client #4's Zyprexa was increased to 15 milligrams two times a day. An attached 2/11/13 Email indicated the Program Manager sent an email asking for approval from 5 of HRC members. A second email dated 2/11/13 indicated one outside HRC member responded and indicated "Approved." There were no additional attachments to indicate any other HRC members had approved the medication increase. 3. Client #1's record was reviewed on 10/25/13 at 11:19 AM. Client #1's 8/1/13 ISP indicated client #1 had a			

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	Behavior Medication Restrictions form for the following: -Clonazepam 1 milligram daily for Anxiety demonstrated by verbal and physical aggression, "interpreting (mocking) others" and manipulative behavior. The plan indicated "Reduction Strategies Psychiatric Consultation BSP Consistent staff direction. Reduction Plan: When the criteria in the objectives have been met, IDT will meet to discuss a reduction in Clonazepam...." -Paxil 40 milligrams daily for Anxiety demonstrated by verbal aggression and physical aggression, manipulative behavior and "interpreting others." The plan indicated "...Reduction Strategies Psychiatric Consultation BSP Consistent staff direction. Reduction Plan: When the criteria in the objectives have been met, IDT will meet to discuss a reduction in Paxil...." The 8/1/13 Behavior Medication Restrictions plan also included the side effects for both of the above mentioned medications. -Risperdal 1 milligram daily for Anxiety demonstrated by verbal aggression and physical aggression, manipulative behavior and "interpreting others." The plan indicated "...Reduction Strategies			

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	Psychiatric Consultation BSP Consistent staff direction. Reduction Plan: When the criteria in the objectives have been met, IDT will meet to discuss a reduction in Risperdal...." The 8/1/13 Behavior Medication Restrictions form also included the side effects for the above mentioned medications. Client #1's 8/1/13 ISP indicated the facility's HRC Chairman (The Director of Quality Assurance) reviewed and approved the restrictive program on 10/21/13. Client #1's 2/8/13 IDT Meeting Note indicated client #1's psychiatrist added Risperdal 1 milligram in the morning due to the client's behavior. A 2/27/13 attached Email indicated the Program Manager sent an email to one outside member for approval. No additional HRC members were asked to approve the medication restriction. 4. Client #2's record was reviewed on 10/25/13 at 11:19 AM. Client #2's 10/9/13 BSP indicated facility staff could utilize YSIS with the client when she demonstrated physical aggression. Client #2's 10/9/13 ISP indicated client #2 had a Behavior Medication			

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	Restrictions form for Risperdone 3 milligrams daily for Major Depression Recurrent demonstrated by verbal and physical aggression, anxiety, manipulative behavior and interrupting others. The plan indicated "...Reduction Strategies Psychiatric Consultation BSP (Behavior Support Plan) Consistent staff direction. Reduction Plan: When the criteria in the objectives have been met, IDT (interdisciplinary team) will meet to discuss a reduction in Risperdal...." The 10/9/13 Behavior Medication Restriction form also included the side effects for the Risperdone. Client #2's 10/9/13 ISP indicated the facility's HRC Chairman (The Director of Quality Assurance) reviewed and approved the restrictive program on 10/21/13. Interview with the Director of Quality Assurance (DQA) and the Program Manager (PM) on 10/25/13 at 12:33 PM indicated the facility's HRC did not review clients' restrictive behavior plans. The DQA and PM indicated the HRC reviewed the Behavior Modification of Rights and Behavior Medication Restriction sheets which did not include the active treatment program for the clients' rights restrictions. The DQA indicated any restrictive interventions			

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	would be listed on the Behavior Modification form like YSIS, but it did not include what restraint and/or details of the specific rights restriction. The DQA indicated he was the chairman of the HRC and he was the only HRC member who reviewed and approved the actual behavior plans of clients #1, #2, #3 and #4. The PM and the DQA indicated when there were medication changes/increases, an e-mail would be sent out to HRC members on the medication changes/increase. The PM and DQA indicated they would need to get 3 responses/approvals (quorum) to initiate the medication and/or changes. The PM indicated the responses/approvals were attached to the Human Rights form. The PM and DQA indicated the HRC members were not given any additional information of a program being in place other than to approve the medication/changes. 9-3-4(a)			
W000263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on interview and record review for 4 of 4 sampled clients (#1, #2, #3	W000263	W263 The committee should ensure that these programs are conducted only with the written	12/31/2013

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	and #4), the facility failed to ensure the clients' legal guardians gave written informed consent for the restrictive programs. Findings include: 1. Client #4's record was reviewed on 10/25/13 at 2:22 PM. Client #4's 8/1/13 Behavior Support Plan (BSP) indicated facility staff could utilize YSIS (You're Safe, I'm Safe) (behavior technique/restraint) with the client when she demonstrated physical aggression. Client #4's 8/1/13 Behavior Medication Restrictions form indicated the client received Lexapro 20 milligrams daily for Paranoid Schizophrenia demonstrated by verbal/physical aggression and Zyprexa 30 milligrams daily for Paranoid Schizophrenia demonstrated by verbal aggression and physical aggression. Client #4's 8/1/13 Documentation of Phone Contact indicated "You (client #4's guardian) approved annual ISP/BSP. Thank you!" Client #4's 8/1/13 Individual Support Plan (ISP) indicated client #4 had a guardian. Client #4's 8/1/13 ISP indicated the client had signed the ISP		informed consent of the client, parents (if the client is a minor) or legal guardian The facility has a policy regarding ISP process which includes obtaining written approval from the client, parent, or legal guardian which remains appropriate. Staff responsible for assuring this policy is followed shall be trained regarding this policy. A complete review of all clients residing in the facility shall be conducted to assure that written informed consent and proof of such is current and in each clients file. Residential Manager will be retrained on ensuring that approval has been obtained from the client and/or guardian on any restrictions and Individual Support Plans Program Manager will be retrained on ensuring that approval has been obtained from the client and/or guardian on any restrictions and Individual Support Plans -Residential Manager will oversee through daily visits in the home to assure programs and objectives are implemented appropriately and no client rights are being violated. -Program Manager will oversee through weekly visits in the home to assure programs and objectives are implemented and no client rights are being violated. Persons Responsible: Residential Manager, Program Manager, Executive Director ADDENDUM: W263 The committee should ensure that	

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	but facility had not obtained written informed consent from the guardian. Interview with the the Program Manager (PM) on 10/28/13 at 10:05 AM indicated client #4's guardian gave verbal consent in regard to client #4's ISP and BSP by phone on 8/1/13. The PM indicated they needed to obtain written informed consent from the guardian. 2. Client #1's record was reviewed on 10/25/13 at 11:19 AM. Client #1's 8/1/13 ISP indicated client #1 had a Behavior Medication Restrictions form for the following: -Clonazepam 1 milligram daily for Anxiety demonstrated by verbal and physical aggression, "interpreting (mocking) others" and manipulative behavior. -Paxil 40 milligrams daily for Anxiety demonstrated by verbal aggression and physical aggression, manipulative behavior and "interpreting others." -Risperdal 1 milligram daily for Anxiety demonstrated by verbal aggression and physical aggression, manipulative behavior and "interpreting others."		these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian The facility has a policy regarding ISP process which includes obtaining written approval from the client, parent, or legal guardian which remains appropriate. Staff responsible for assuring this policy is followed shall be trained regarding this policy. A complete review of all clients residing in the facility shall be conducted to assure that written informed consent and proof of such is current and in each clients file. Residential Manager will be retrained on ensuring that approval has been obtained from the client and/or guardian on any restrictions and Individual Support Plans Program Manager will be retrained on ensuring that approval has been obtained from the client and/or guardian on any restrictions and Individual Support Plans -Residential Manager will oversee through daily visits in the home to assure programs and objectives are implemented appropriately and no client rights are being violated. -Program Manager will oversee through weekly visits in the home to assure programs and objectives are implemented and no client rights are being violated. Persons Responsible: Residential Manager, Program Manager, Executive Director	

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	Client #1's 8/1/13 ISP indicated client #1 had a guardian. Client #1's 8/1/13 ISP indicated client #1 signed/gave written consent for the ISP/BSP. Client #1's guardian did sign/give written informed consent in regard to the client's restrictive program. Client #1's 8/1/13 Documentation of Phone Change indicated the facility obtained verbal consent for client #1's restrictive program/plan. Interview with the PM on 10/28/13 at 10:05 AM indicated client #1 had a legal guardian. The PM indicated the facility had not obtained written informed consent for client #1's restrictive program. 3. Client #2's record was reviewed on 10/25/13 at 11:19 AM. Client #2's 10/11/13 physician's order indicated client #2 was placed on Elavil 50 milligrams HS and Remeron 30 milligrams HS for the client's depression/behavior. Client #2's 10/9/13 BSP indicated facility staff could utilize YSIS when client #2 continued to demonstrate physical aggression. Client #2's 10/9/13 ISP indicated client			

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	#2's sister was the client's guardian. The ISP indicated client #2 signed the ISP but client #2's guardian did not sign/give written informed consent for the restrictive program. Client #2's 10/21/13 Documentation of Phone Contact indicated client #2's guardian gave verbal consent for the use of the Elavil and Remeron. Client #2's 10/22/13 Documentation of Phone Contact indicated "Contacted [name of guardian] regarding ISP/BSP. She agreed to goals and guidelines. A copy will be sent to her for signature and returned." Interview with the PM on 10/28/13 at 10:05 AM indicated the facility had not obtained written informed consent for the use of the restrictive behavior medications and/or program/plan for client #2. 4. Client #3's record was reviewed on 10/25/13 at 3:17 PM. Client #3's Human Rights (HR) approval Forms and/or E-mails indicated the following: -8/9/13 Client #3 was started on Gabitril (psychotropic medication for behavior) 2 milligrams two times a day for 1 week and then 4 milligrams two			

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	times a day thereafter. The 8/9/13 HR form indicated in area "...Guardian (if applicable): BDDS (Bureau of Developmental Disabilities Services) approval Date 8/12/13...." -7/10/13 Client #3's Klonopin (psychotropic behavior medication) was increased to 1 milligram three times a day. The HR form indicated "...Guardian (if applicable): Per BDDS 7/15/13...." -7/3/13 Client #3's Risperdal (behavior medication) was increased to 4 milligrams two times a day. The HR form indicated Guardian (if applicable): Per BDDS Date (blank)...." -6/13/13 Email to Human Rights Committee (HRC) members indicated "I am needing HRC approval for a client at the Bernadette group home. Dr. (doctor) has recommended increasing Amytriptylene (behavior medication) to 100mg (milligrams) daily and increase Risperdal (behavior medication) to3mg (sic) in the AM. This has been ordered for increased behaviors as well as increased nervousness/anxiety. We have obtained GDN (guardian) approval for this increase...." Client #3's 6/13/13 HR form indicated BDDS approved the client's medication increases.			

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	Client #3's 8/4/13 Individual Support Plan (ISP) indicated a section entitled Modification of Rights. The Modification of Rights indicated client #3 had rights restrictions in regard to money, movement, medications, privacy, Behavior Support Plan and You're Safe, I'm Safe (YSIS) (behavior intervention techniques). Client #3's 8/4/13 ISP indicated client #3's legal guardian was the client's mother. Client #3's 8/4/13 ISP indicated client #3's guardian did not sign/give written informed consent for the client's restrictive program as only client #3 signed the ISP. Interview with the Program Manager (PM) on 10/25/13 at 3:54 PM indicated client #3's guardian/mother was no longer acting in the capacity of client #3's guardian. The PM indicated client #3's guardian/mother had stage 4 cancer and was no longer able to make decisions for client #3. The PM indicated an involved aunt was also ill. The PM stated "There is no one else." The PM indicated the facility was seeking approval from BDDS (state agency responsible for placement) to give approval for the client's restrictive program and medications. The PM indicated client #3 was not able to give			

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	written informed consent for the restrictions. 9-3-4(a)			
W000264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Based on observation, interview and record review for 1 of 4 sampled clients (#3), the facility failed to have its Human Rights Committee (HRC) review the client's cell phone being kept in the facility's office to ensure the client's rights were not violated. Findings include: During the 10/24/13 observation period between 4:45 AM and 7:20 AM, at the group home, client #3 asked staff #2 if she could make a phone call. Staff #2 redirected client #3 to make her bed. Throughout the above mentioned observation period, client #3 stated "Call [name of aunt]." At 6:15 AM, client #3 asked staff #2 if she could call her aunt. Staff #2 told client #3 to clear the table	W000264	W264 The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. -The facility has a policy regarding approval of restrictions which includes obtaining written approval from the client, parent, or legal guardian which remains appropriate. -Specifically for Client #3, the IDT will meet to discuss restriction of Client #3's cell phone - The Residential Manager will be retrained on Client rights in regards to obtaining approval from guardians, HRC, and the IDT for	12/31/2013

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	before she made her call. At 6:32 AM, staff #2 retrieved a cell phone from the desk in the office area. Client #3 went to her bedroom and used the cell phone. Once client #3 called her aunt, facility staff took the phone and returned it to the office area. Client #3's record was reviewed on 10/25/13 at 3:17 PM. Client #3's 8/4/13 Individual Support Plan (ISP) and/or Behavior Support Plan did not indicate the facility's Human Rights Committee reviewed and/or approved the rights restriction. Interview with the Program Manager (PM) on 10/28/13 at 10:05 AM indicated the cell phone belonged to client #3 as the client had purchased the cell phone 2 months ago. The PM indicated client #3 had to ask the staff to obtain the cell phone. The PM indicated client #3 would call her aunt all the time but the client's aunt only wanted the client to call 3 times a week. The PM indicated the facility's Human Rights Committee had not reviewed and/or approved the rights restriction. 9-3-4(a)		any restrictions - The Program Manager will be retrained on Client rights in regards to obtaining approval from guardians, HRC, and the IDT for any restrictions -Residential Manager will oversee through daily visits in the home to assure programs and objectives are implemented appropriately and no client rights are being violated. -Program Manager will oversee through weekly visits in the home to assure programs and objectives are implemented and no client rights are being violated. Persons Responsible: Residential Manager, Program Manager, Executive Director ADDENDUM: W264 The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. - Meeting will be held for all clients to review their plans in there entirety including modifications of rights. Any adjustments made to any clients plans and/or modification of rights will be given to the Human Rights Committee for approval prior to the changes being implemented. - An IDT meeting will be held with all clients to review each	

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			individual's program plan and modifications of rights to ensure that they remain appropriate. - Staff will be retrained on not locking up clients personal belongings unless addressed in that client's plans and approved by the HRC committee. - Residential Manager will conduct a monthly review of each individual's plan to ensure that there are no violations to any client's rights - The Residential Manager will be retrained on Client rights in regards to obtaining approval from guardians HRC, and the IDT for any restrictions. -Residential Manager will oversee through daily visits in the home to assure programs and objectives are implemented appropriately and no client rights are being violated. - Residential Manager will be retrained on not locking up clients personal belongings unless addressed in that client's plans and approved by the HRC committee. -Program Manager will oversee through weekly visits in the home to assure programs and objectives are implemented and no client rights are being violated. - Program manger will conduct a quarterly review of each individual's plans to ensure that there are no violations to any client's rights - The Program Manager will be retrained on Client rights in regards to obtaining approval from guardians, HRC, and the IDT for	

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			any restrictions - Program Manager will be retrained on not locking up clients personal belongings unless addressed in that client's plans and approved by the HRC committee. -Specifically for Client #3, the IDT will meet to discuss restriction of Client #3's cell phone. -All HRC minutes will be turned into the Executive Director at the end of each quarter. - The facility has a policy regarding client rights which remains appropriate, as well as, a policy regarding grievance procedures which remains appropriate; these policies will be reviewed with all clients in the home. Persons Responsible: Staff, Residential Manager, Program Manager, Executive Director	
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 interview and record review for 1 of 4 sampled clients (#1), the facility failed to ensure the use of a behavioral medication had an active treatment program for which the medication was prescribed. Findings include: Client #1's record was reviewed on	W000312	W312 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. -An IDT will be completed with Client #1 to discuss any updates to Behavior Support Plan in regards to	12/31/2013

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	10/25/13 at 1:09 PM. Client #1's 8/6/13 physician's order indicated client #1 received Clonazepam 1 milligram at bedtime for anxiety. Client #1's 8/1/13 BSP indicated client #1 demonstrated the behaviors associated with her diagnosis of Mood Disorder (verbal aggression, manipulative behavior and interrupting others). Client #1's 8/1/13 BSP (Behavior Support Plan) did not address/include an active treatment program for anxiety. Interview with the Program Manager (PM) on 10/28/13 at 10:05 AM indicated client #1 received Clonazepam for anxiety. When asked if client #1 had an active treatment program for anxiety, the PM stated "No, needs one." 9-3-5(a)		Anxiety. -The Human Rights Committee will review any restrictions to Client #1's plan -The Residential Manager will be retrained on Behavior Support Plans including all psychotropic medication and a reduction plan for each medication -The Program Manager will be retrained on Behavior Support Plans including all psychotropic medication and a reduction plan for each medication - -Residential Manager will oversee through daily visits in the home to assure programs and objectives are implemented appropriately -Program Manager will oversee through weekly visits in the home to assure programs and objectives are implemented appropriately Persons Responsible: Residential Manager, Program Manager, Executive Director ADDENDUM: W312 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. - An IDT will be completed with Client #1 to discuss any updates to their Individuals Support Plan, Behavioral Support Plan in regards to Anxiety and the use of behavioral medications. - An IDT	

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			will be completed with all individuals living in the home to ensure that appropriate reduction plans are in place for all behavioral medications. -The Human Rights Committee will review any restrictions to Client #1's plan -The Residential Manager will be retrained on Behavior Support Plans including all psychotropic medication and a reduction plan for each medication -The Program Manager will be retrained on Behavior Support Plans including all psychotropic medication and a reduction plan for each medication -Residential Manager will oversee through daily visits in the home to assure programs and objectives are implemented appropriately -Program Manager will oversee through weekly visits in the home to assure programs and objectives are implemented appropriately - The facility has a policy regarding client rights which remains appropriate, as well as, a policy regarding grievance procedures which remains appropriate; these policies will be reviewed with all clients in the home. Persons Responsible: Residential Manager, Program Manager, Executive Director	
W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 2 of 4 sampled clients	W000331	W331 -The facility must provide clients with nursing services in	12/31/2013

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	(#2 and #4), the facility's nursing services failed to meet the healthcare needs of the clients. The nursing services failed to ensure the dietician's recommendations were addressed in regard to client's (#2) weight loss and/or to develop a risk plan in regard to the client's weight/refusal to eat. The facility's nursing services failed to monitor client's (#4) fractured tooth as the client was not able to see an oral surgeon for 2 months. Findings include: 1. During the 10/24/13 observation period between 4:45 AM and 7:20 AM, at the group home, client #2 was small in size (underweight). Client #2 utilized a roller walker to ambulate and moved slowly. During the above observation period, client #2 received her Carnation Instant Breakfast (supplement) prior to eating breakfast. Client #2 laid on the couch with her eyes closed and refused to get up to eat even though staff verbally prompted her to eat. Facility staff did not offer the client any other food than the menued hot or cold cereal and toast with butter and jelly. Client #2 left for work without eating any breakfast. During the 10/24/13 observation period		accordance with their needs. -A complete audit of dietary reviews will be completed to ensure that all dietary recommendations are reviewed by the nurse and implemented in a timely manner. - All staff will be trained on dietary recommendations and ensuring that the nutritional intake forms are being completed daily. - All staff will be trained on ensuring that a substitution is offered if a client refuses their meal. - All staff will be trained on client # 4's high risk plan for tooth fracture and reporting and changes to the nurse as well as their chain of command. - Residential Manager will monitor through weekly observations or as needed to ensure that all dietary recommendations are being implemented. - Residential Manger will be trained on client # 4's high risk plan for tooth fracture and reporting and changes to the nurse as well as their chain of command. - Residential Manager will monitor through daily observations or as needed to ensure that all nutritional intake forms are being completed daily. - Residential Manager will trained on ensuring IDT are completing are being completed in regards to clients weight loss and/or meal refusals. - Residential Manger will be trained on contacting the oral surgeon to weekly to ensure that client # 4 is on a waiting list for next available appointment. -	

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	between 4:05 PM and 5:15 PM, at the group home, client #2 received her Carnation Instant Breakfast at 5:10 PM prior to eating dinner. Interview with client #2 on 10/24/13 at 4:15 PM indicated the client did not eat her lunch on 10/24/13. Client #2 indicated she took a couple of bites of mashed potatoes. Client #2 indicated she did not get hungry. Client #2 stated she was a "picky eater." Client #2's Daily Food Logs were reviewed on 10/28/13 at 11:00 AM. Client #2's daily food logs indicated the following: -10/10/13 Client #2 did not eat breakfast. The form indicated client #2 ate "2 large orders of onion rings at [name of community event]. 20 oz (ounce) Pepsi (1/2)." For dinner, the 10/10/13 form indicated client #2 ate 3/4 of a medium pork chop and drank 1/2 of a 20 ounce Pepsi. -10/11/13 Client #2 did not eat breakfast and/or lunch. -10/12/13 Client #2 did not eat her breakfast. -10/13/13 Client #2 did not eat breakfast but did have her Carnation		Residential Manager will be trained on ensuring that a substitution is offered if a client refuses their meal. - Program Manager will monitor through weekly observations or as needed to ensure that all dietary recommendations are being implemented. - Program Manger will be trained on client # 4's high risk plan for tooth fracture and reporting and changes to the nurse as well as their chain of command. - Program Manger will monitor through weekly observations or as needed to ensure that all nutritional intake forms are being completed daily. - Program Manager will trained on ensuring IDT are completing are being completed in regards to clients weight loss and/or meal refusals. - Program Manager will be trained on ensuring that a substitution is offered if a client refuses their meal. - Nursing will complete a monthly summary to ensure that all dietary orders are completed, reviewed by the physician and are being implemented appropriately. - Nurse will complete quarterly chart reviews to ensure that all dietary recommendations have been reviewed by the physician and implemented appropriately. - Nurse will monitor through weekly observations or as needed to ensure that all nutritional intake forms are being completed daily. - Nurse will be train on implementing a high risk plan for	

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	Instant Breakfast (CIB). -10/14/13 Client #2 did not eat her breakfast but did consume her CIB. The daily log indicated client #2 ate 5 crackers, 4 ounces of Sprite Zero, 2 ounces of chicken flavored noodles and her CIB for lunch. The daily log indicated client #2 ate 1 cup of mashed potatoes, her CIB, 3 ounces of ham and "...0.8 ounces of a sugar free dessert shell." -10/15/13 Client #2 did not eat her breakfast but did consume her CIB, and 1 serving of instant mashed potatoes with 3 ounces of water for lunch. Client #2 ate 1 cup of instant mashed potatoes, 2 ounces of hamburger and 4 ounces of tea for dinner. -10/16/13 Client #2 did not eat her breakfast and/or her lunch but did eat a snack of Ritz Crackers and Teddy Grahams for her lunch. The log indicated client #2 ate 1 1/2 cup of mashed potatoes with diced ham and 8 ounces of Mango punch. The note indicated client #2 received her CIB at 4:00 PM. -10/17/13 Client #2 had her CIB for breakfast, mashed potatoes and crackers for lunch and mashed potatoes with		issue of weight loss and/or refusal to eat. - Nurse will be train on implementing a high risk plan specifically for client #4 to monitor a fractured tooth, while the facility is awaiting an appointment with an oral surgeon. - Nurse will be trained on monitoring client #4 fractured tooth and documenting their findings weekly until client # 4 appointment is held with the oral surgeon. - Nurse will be trained on monitoring all clients' medical issues and documenting weekly while awaiting any follow-up appointments with their PCP and/or specialist. - An IDT will be held to discuss client # 4's fracture tooth and plans of treatment. - An IDT will be held with all clients to discuss current dietary recommendations. Persons Responsible: Staff, Residential Manager, Program Manager, Nurse, Nursing Manager & Executive Director. ADDENDUM: W331 -The facility must provide clients with nursing services in accordance with their needs. -A complete audit of dietary reviews will be completed to ensure that all dietary recommendations are reviewed by the nurse and implemented in a timely manner. - All staff will be trained on dietary recommendations and ensuring that the nutritional intake forms are being completed daily. - All staff will be trained on ensuring that a substitution is	

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	diced ham, 3 chicken nuggets, Mango juice and her CIB. -10/19/13 Client #2 drank her CIB for breakfast and ate mashed potatoes for lunch. The daily food log indicated client #2 ate 2 hotdogs for dinner, a sugar cookie and kool-aid. -10/20/13 client #2 did not eat breakfast but drank her CIB. The log indicated for lunch, the client ate a Sloppy Joe sandwich and had Koolaid. For dinner, client #2 ate chicken strips, onion rings and sweet tea. -10/22/13 Client #2 did not eat breakfast but consumed her CIB. The client had pudding cups, 4 crackers and a Mt. Dew for lunch. The daily log indicated client #2 did not eat dinner. -10/23/13 Client #2 did not eat breakfast but consumed her CIB. Client #2 ate 3 saltine crackers and 1/2 cup mashed potatoes for lunch. Client #2 had 1 piece of fish minced up and mashed potatoes for dinner. -10/24/13 Client #2 did not eat breakfast but consumed her CIB. The log indicated client #2 ate 1/2 cup mashed potatoes for lunch and mashed sweet potatoes, baked chicken and milk		offered if a client refuses their meal. - All staff will be trained on client # 4's high risk plan for tooth fracture and reporting and changes to the nurse as well as their chain of command. - Residential Manager will monitor through weekly observations or as needed to ensure that all dietary recommendations are being implemented. - Residential Manger will be trained on client # 4's high risk plan for tooth fracture and reporting and changes to the nurse as well as their chain of command. - Residential Manager will monitor through daily observations or as needed to ensure that all nutritional intake forms are being completed daily. - Residential Manager will trained on ensuring IDT are completing are being completed in regards to clients weight loss and/or meal refusals. - Residential Manger will be trained on contacting the oral surgeon to weekly to ensure that client # 4 is on a waiting list for next available appointment. - Residential Manager will be trained on ensuring that a substitution is offered if a client refuses their meal. - Program Manager will monitor through weekly observations or as needed to ensure that all dietary recommendations are being implemented. - Program Manger will be trained on client # 4's high risk plan for tooth fracture and reporting and changes to the	

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	for dinner. Client #2's record was reviewed on 10/25/13 at 11:19 AM. Client #2's 10/13 Resident Monthly Nutritional Intake Record indicated client #2 had not eaten breakfast and/or lunch since she was admitted to the group home on 10/8/13 as there was no documentation of what she ate. The form further indicated client #2 had refused to eat vegetables since she was admitted to the group home. The form indicated the client did eat her dinner and snack. Client #2's 10/15/13 physical examination form indicated client #2 weighed 109 pounds. Client #2's 10/11/13 physician order indicated client #2's doctor increased the client's CIB with whole milk three times a day. Client #2's Nursing Notes indicated the following (not all inclusive): -10/22/13 "Reviewed food intake (with) Dietician Rec (recommend) to cont (continue) to offer foods of choice when declines menu items." -10/15/13 Client #2 saw her doctor for her admission physical.		nurse as well as their chain of command. - Program Manger will monitor through weekly observations or as needed to ensure that all nutritional intake forms are being completed daily. - Program Manager will trained on ensuring IDT are completing are being completed in regards to clients weight loss and/or meal refusals. - Program Manager will be trained on ensuring that a substitution is offered if a client refuses their meal. - Nursing will complete a monthly summary to ensure that all dietary orders are completed, reviewed by the physician and are being implemented appropriately. - Nurse will complete quarterly chart reviews to ensure that all dietary recommendations have been reviewed by the physician and implemented appropriately. - Nurse will monitor through weekly observations or as needed to ensure that all nutritional intake forms are being completed daily. - Nurse will be train on implementing a high risk plan for issue of weight loss and/or refusal to eat. - Nurse will be train on implementing a high risk plan specifically for client #4 to monitor a fractured tooth, while the facility is awaiting an appointment with an oral surgeon. - Nurse will be trained on monitoring client #4 fractured tooth and documenting their findings weekly until client # 4 appointment is held with the oral surgeon. - Nurse will be	

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	-10/8/13 Client #2 was readmitted to the group home. The note indicated client #2 was admitted on a regular diet with food to be cut into bite size pieces. Client #2's nursing notes did not indicate any additional documentation in regard to client #2's weight and/or refusals to eat. Client #2's 10/9/13 Individual Support Plan (ISP) indicated the client was admitted to the group home on 10/8/13. The ISP indicated client #2 was a re-admission from a nursing home. Client #2's 10/9/13 ISP indicated client #2's ISP included risk plans for the client's health/medical needs (Mitral Valve Prolapse, Cerebral Palsy, Constipation, Hypertension, Hypothyroidism, Hormone Imbalance, Irregular Heartbeat, Kyphosis, Tuberous Sclerosis, Potential for Choking, Gastroesophageal Reflux Disorder, Falls/Benign Positional Vertigo, Avitaminosis and Moderate hearing Loss). Client #2's record and/or 10/9/13 ISP indicated client #2's interdisciplinary team (IDT) had not met in regard to the client's weight and/or refusal to eat. Client #2's risk plans and/or ISP did not indicate nursing services had developed a risk plan for client #2's refusal to eat, and/or formally		trained on monitoring all clients' medical issues and documenting weekly while awaiting any follow-up appointments with their PCP and/or specialist. - The facility will have the dietician complete a review of all clients' diets to ensure that they remain appropriate for each clients needs. - Client #2 passed away in the hospital on November 3, 2013 due to Sepsis from UTI. - An IDT will be held to discuss client # 4's fracture tooth and plans of treatment. - An IDT will be held with all clients to discuss current dietary recommendations. Persons Responsible: Staff, Residential Manager, Program Manager, Nurse, Nursing Manager & Executive Director.	

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	addressed the 10/22/13 dietary recommendation to ensure staff offered the client food she liked to eat to prevent weight loss and/or health decline. Interview with the Director of Health Care Services (DHCS) and the Program Manager (PM) on 10/28/13 at 10:35 AM indicated they did not know why facility staff was not documenting anything on the Food Intake Record for breakfast and lunch. The DHCS and the PM indicated the form should not be blank. Interview with LPN #1, the Program Manager (PM) and the Qualified Intellectual Disabilities Professional (QIDP) on 10/28/13 at 10:45 AM indicated client #2 was readmitted to the group home from a nursing home. LPN #1 stated client #2 was "struggling with food." LPN #1 indicated client #2 was not eating when she was in the nursing home. LPN #1 indicated the client was not allowed to eat while she was in the hospital waiting for a Colonoscopy to be done which went on for 2 weeks due to other complications. LPN #1 indicated client #2 would not eat after the procedure was completed and was sent to a nursing home for rehabilitation. LPN #1 indicated client #2's sister did not want client #2 to have a G-Tube (feeding tube). The PM, the QIDP and			

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	LPN #1 indicated client #2 was eating more now than when she was at the nursing home. The PM indicated facility staff had complained about the client not eating and a food log was initiated which was sent to LPN #1. LPN #1 indicated she had spoken with the Dietician in regard to client #2's refusals to eat and it was decided to allow the client to eat the foods she liked. LPN #1 indicated client #2 would eat mashed potatoes. LPN #1 indicated the Dietician recommended to add meat/gravy to her mashed potatoes to get client #2 to consume more calories. LPN #1 indicated the client was to see her primary care doctor in regard to her weight and refusal to eat. LPN #1 also indicated the Dietician would get involved. LPN #1, the QIDP and the PM indicated client #2's IDT had not met in regard to the client's weight/refusal to eat. LPN #1 indicated she had not developed a risk plan for the client's weight/refusal to eat. The PM, LPN #1 and the QIDP indicated facility staff should be filling out the food intake log daily and document what client #2 ate and/or when client #2 refused to eat. 2. The facility's reportable incident reports, internal Incident Reports and/or investigations were reviewed on 10/22/13 at 2:12 AM. The facility's			

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	reportable incident reports, internal incident reports and/or investigations indicated the following (not all inclusive): -8/28/13 "[Client #4] was eating a piece of candy and broke a small portion of her tooth. [Client #4] was taken to [name of dentist] to be evaluated. [Client #4] is safe. [Name of dentist] notes #31 Fractured tooth will need extracted (sic). [Client #4] is being referred to an oral surgeon." A 9/5/13 follow-up report indicated client #4 would see the oral surgeon on 10/16/13. -9/5/13 "[Client #4] was eating her lunch when she chipped her tooth. This is the same tooth that she chipped eating candy...[Client #4] has an appointment with the Oral Surgery Group on 10/16/13." The facility's 9/5/13 Incident Report indicated the chipped tooth was the same tooth as fractured on 9/5/13. The incident report indicated "...Continue to monitor." The 9/16/13 follow up report indicated client #4 had not complained of any pain.			

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	Client #4's record was reviewed on 10/25/13 at 2:22 PM. Client #4's Medical Consult Reports indicated the following (not all inclusive): -6/7/13 Client #4 saw her dentist for a "severely fractured tooth." The consult report indicated client #4 had fractured tooth #18 "but treatable at this time." -8/28/13 Medical Consult Report indicated "1.) Limited oral evaluation. 2.) PAX-ray #31- class IV Fracture. 3.) We are referring [client #4] to oral surgeon (name of oral surgeon group) their office will send you information." Client #4's Nursing Notes indicated the following in regard to the client's fractured tooth: - 8/28/13 "Yesterday afternoon [client #4] reported a small piece of tooth broke off while eating candy. Seen by [name of dentist] today. #31 class IV FX (fracture). Referred to oral surgeon for extraction." -10/16/13 "Seen by oral surgeon. Plan extraction of 3 teeth. Sched (scheduled) for 11-13-13." Client #4's nursing notes and/or record did not indicate any additional documentation of client #4's			

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	fractured tooth, pain and/or monitoring. Client #4's 8/1/13 Individual Support Plan (ISP) did not indicate client #4 had a risk plan/protocol in regard to the client's fractured to tooth to prevent further harm while the client waited to see an oral surgeon. Interview with LPN #1 on 10/28/13 at 10:45 AM indicated client #4 had a fractured tooth. LPN #1 indicated client #4 had chipped the tooth since she first fractured the tooth on 8/28/13. LPN #1 indicated client #4 was to see the oral surgeon on 10/16/13. When asked why it took 2 months for client #4 to get into the oral surgeon, LPN #1 indicated there were only a couple of oral surgeons who would take Medicaid. LPN #1 stated "That's when they had the first available appointment." LPN #1 indicated client #1 was not having any pain with the fractured tooth. When asked how client #4's fractured tooth was being monitored, LPN #1 stated "I saw her every week and asked if her tooth was bothering her." LPN #1 indicated she did not document her assessment/monitoring of client #4's fractured tooth and/or develop a risk plan/protocol for the fractured tooth until client #4 could get the tooth taken care of.			

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	9-3-6(a)			
W000488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and for 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the clients were involved in all aspects of cooking the breakfast meal to the extent of their capabilities. Findings include: During the 10/24/13 observation period between 4:45 AM and 7:20 AM, at the group home, client #7 unloaded the dishwasher without staff assistance and clients #1, #4, #5, #7 made and packed their lunch for the day. Client #5 independently made toast for the breakfast meal. The Qualified Intellectual Disabilities Professional (QIDP) custodially made the oatmeal for clients #1, #2, #3, #4, #5, #6, #7 and #8 while clients #1, #3, #5 and #7 sat at the dining room table and clients #2 and #8 laid on the 2 living room couches. The QIDP poured the oatmeal into a serving bowl and carried the oatmeal to the table	W000488	W488 - The facility must assure that each eats in a manner consistent with his or her developmental level. - IDT will be held with all clients to discuss a goal being put into place for all clients to serve condiments independently with appropriate serving sizes. - Staff will be trained on new goals of serving condiments independently with appropriate severing sizes. - Staff will be trained on meal time preparation in regards to encouraging clients to fix meal independently and give staff assistance when needed. -Residential Manager will monitor through daily observations to ensure that all client's goals are being implemented appropriately. -Program Manager will monitor through monthly observations to ensure that all client's goals are being implemented appropriately. Persons Responsible: Staff, Residential Manager, Program Manager & Executive Director. ADDENDUM: W488 - The facility must assure that each eats in a manner consistent with	12/31/2013

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	without involving any client. The QIDP poured juice into clients #3 and #6's cup without encouraging the clients to pour their own juice and/or to assist the clients hand over hand. During the above mentioned observation period, client #7 placed 1 teaspoon of butter and one teaspoon of jelly into small individual medication cups for clients #1, #2, #3, #4, #5, #6, #7 and #8 to use on their slice of toast. The QIDP, staff #1 and #2 did not encourage and/or teach clients to use condiments in a manner that was not institutionalized. Client #1's record was reviewed on 10/25/13 at 1:09 PM. Client #1's 8/1/13 ISP (Individual Support Plan) indicated client #1 had an objective to prepare a main dish. Client #2's record was reviewed on 10/25/13 at 11:19 AM. Client #2's 10/9/13 ISP indicated client #2 had an objective to prepare a side dish from the dinner menu. Client #4's record was reviewed on 10/25/13 at 2:22 PM. Client #4's 8/1/13 ISP indicated the client had an objective to prepare a side dish for the dinner meal. Interview with the Program Manager		his or her developmental level. - IDT will be held with all clients to discuss a goal being put into place for all clients to serve condiments independently with appropriate serving sizes. - Staff will be trained on new goals of serving condiments independently with appropriate severing sizes. - Staff will be trained on meal time preparation in regards to encouraging clients to fix meal independently and give staff assistance when needed. -Residential Manager will monitor through daily observations to ensure that all client's goals are being implemented appropriately. -Program Manager will monitor through monthly observations to ensure that all client's goals are being implemented appropriately. Persons Responsible: Staff, Residential Manager, Program Manager & Executive Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
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	(PM) on 10/28/13 at 10:05 AM indicated facility staff should involve and encourage clients #1, #2, #3, #4, #5, #6, #7 and #8 to participate in making oatmeal for breakfast. The PM indicated clients #3 and #6 were capable of pouring their own drinks, and/or staff should have used hand over hand assistance as needed. When asked why butter and jelly were placed in small medication cups, the PM stated "To go by menu and to be accurate." 9-3-8(a)			