

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/22/2015
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330
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W 0000  Bldg. 00	<p>This visit was for a post-certification revisit (PCR) survey to the extended annual recertification and state licensure survey completed on 4/13/15.</p> <p>Dates of Survey: May 21 and 22, 2015.</p> <p>Facility Number: 012632 Provider Number: 15G807 AIMS Number: 201065000</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0149  Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 2 sampled clients (#1 and #2) and 2 additional clients (#3 and #4), the facility failed to implement its policy and procedures to prevent the abuse of clients #1, #2, #3 and #4 and to ensure the facility staff immediately reported all allegations of abuse to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult</p>	W 0149	<p><b>CORRECTION:</b></p> <p><i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically:</i></p> <p>The staff responsible for failing to report the allegation, has received written corrective action.</p>	06/21/2015

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

TITLE

(X6) DATE

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

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	<p>Protective Services) per IC 12-10-3 according to state law and to ensure the plan of corrective action included the retraining of the facility staff in recognizing and reporting abuse immediately to the administrator for clients #1, #2, #3 and #4.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 5/21/15 at 1 PM.</p> <p>The 5/1/15 BDDS (Bureau of Developmental Disabilities Services) report indicated "[Client #1] was writing a letter with staff when she made an allegation towards staff, [staff #4]. [Client #1] stated that her hand hurt because [staff #4] pulled/pushed it back during her last behavior."</p> <p>The investigative summary dated 5/7/15 indicated: __ Staff #5 stated "On Friday (5/1/15), I (staff #5) met with [client #1] and we began to write a letter to [client #1's] mother. [Client #1] started writing about how she (client #1) had a rough week. I (staff #5) asked her why she thinks she had a rough week. [Client #1] said, 'Well it's just been on second shift.' She (client #1) started talking about [staff #4] and</p>		<p>All facility staff will receive additional retraining regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. The training will focus on identifying observed and suspected abuse, neglect and mistreatment to facilitate immediate reporting. The training will stress that facility staff who fail to report allegations of abuse, neglect and mistreatment immediately will receive corrective action up to and including termination of employment. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients.</p> <p>All facility staff will receive additional retraining regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. The training will focus on identifying observed and suspected abuse, neglect and mistreatment to facilitate immediate reporting. The training will stress that facility staff who</p>				

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	<p>how she (staff #4) grabbed her (client #1's) arm. She (client #1) said this happened during her (client #1's) last behavior. [Staff #4] bent her (client #1's) wrist all the way back. This past Sunday (5/3/15) [client #1] brought me back to the living room and asked if she could write [staff #4] an apology letter for 'making [staff #4] so mad'."</p> <p>__Staff #5 indicated she had previously witnessed staff #4 bending client #1's fingers back and stated, "[Staff #4] is very verbally aggressive with the girls. Also, when I [staff #5] witnessed the hand being bent I told her (staff #4) we (the staff) can't do that."</p> <p>__Staff #5 indicated she did not remember when she had witnessed staff #4 bending client #1's hand back and stated, "I (staff #5) don't remember exactly when, maybe a couple of months ago."</p> <p>__Staff #6 stated, "I didn't witness this behavior but I have witnessed [staff #4] do this before. It lasted only about two seconds and she (staff #4) said it didn't hurt them. This is something she (staff #4) learned at the state hospital."</p> <p>__Client #3 indicated she had witnessed staff #4 bending client #1's fingers/wrist back during a behavior and stated she (client #3) had witnessed staff #4 do this to client #1, "Sometime last week."</p> <p>__Client #3 stated, "[Staff #4] does that</p>		<p>fail to report allegations of abuse, neglect and mistreatment immediately will receive corrective action up to and including termination of employment. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients.</p> <p><b>PREVENTION:</b></p> <p>Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, the QIDP will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective</p>	

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	<p>to everyone when they are in a behavior." __ Client #4 stated, "[Staff #4] has done that to me (client #4) before and [client #2] too." __ Client #2 indicated she (client #2) had witnessed staff #4 bend client #1's fingers/wrist back during a behavior. __ Client #2 stated, "When she (staff #4) puts us (clients #1, #2, #3 and #4) in a hold she (staff #4) twists our arms. I (client #2) lied the first time because I didn't want to get her (staff #4) fired."</p> <p>The plan of corrective action/peer review dated 5/7/15 was reviewed on 5/22/15 at 2:40 PM. The record indicated the following recommendations: "1. When allegations of physical abuse occur, the individual must be assessed by a nurse on the day the allegations are made, regardless of whether or not apparent injuries are present. If injuries are present, photographs must be taken and an external medical evaluation [Immediate Care, ER (Emergency Room) or PCP (Primary Care Physician)] must occur. - Revise Operating Standard. 2. Train all RC (Residential Coordinators) - (name of town) supervisors on the above protocol. 3. Terminate DSP (Direct Support</p>		<p>action up to and including termination of employment. Members of the Operations Team will conduct documentation reviews no less than twice weekly for the next 21 days, weekly for an additional 30 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. These administrative documentation reviews will focus on identifying potentially reportable incidents, providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely manner.</p> <p>Monthly training refreshers toward identifying observed and suspected abuse, neglect and the requirement for immediate reporting will occur with all staff. The Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, met with the behaviorist and the QIDP to develop training protocols to avoid unnecessary use of advanced safety techniques (manual restraints), in an effort to reduce the frequency</p>				

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	<p>Professional) [staff #4] for substantiated abuse.</p> <p>4. Administrative staff including... to meet with [name of street of facility] interdisciplinary team to develop plan to reduce and eventually eliminate the use of YSIS (You're Safe I'm Safe) advanced personal safety techniques."</p> <p>The plan of corrective action did not indicate training and/or retraining staff in regard to recognizing and reporting abuse/neglect immediately to the administrator.</p> <p>Client #1's record was reviewed on 5/22/15 at 1 PM. Client #1's Record of Visit dated 5/6/15 indicated client #1 saw her primary care physician due to having a fever, cough and right wrist pain. The record indicated diagnoses of Acute Bronchitis and right wrist sprain. The record indicated client #1 was to take Naproxen (an anti-inflammatory medicine) 500 milligrams twice a day for one week for the wrist sprain.</p> <p>During interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 5/22/15 at 2 PM, the QIDPD: __ Indicated all allegations of</p>		<p>of manual restraint and the risk of improper implementation that could result in physical abuse.</p> <p>The QIDP will be expected to observe no less than Five active treatment sessionS per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring appropriate implementation of behavior supports.</p> <p>Members of the Operations Team, will conduct observations during active Treatment sessions and documentation reviews no less than two times weekly for the next 21 days, no less than weekly for an additional 30 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following:</p>	

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	<p>abuse/neglect were to be reported immediately to the administrator and to BDDS and APS within 24 hours of the knowledge of the abuse/neglect.</p> <p>__ Indicated interviews with clients #2, #3 and #4 substantiated allegations of abuse against staff #4.</p> <p>__ Indicated the allegations made by clients #2, #3 and #4 against staff #4 were not reported to BDDS and/or APS.</p> <p>__ Indicated through the investigative process the abuse was substantiated and staff #4 was terminated.</p> <p>__ Indicated no retraining had been provided to the staff in regard to recognizing and immediately reporting all abuse/neglect to the administrator.</p> <p>__ Stated, "I plan on including that (retraining of the staff) at the next house meeting which is scheduled for June 16th (2015)."</p> <p>The facility's policies and procedures were reviewed on 5/22/15 at 10 AM. The 9/14/07 facility policy entitled "Abuse, Neglect, Exploitation" indicated:</p> <p>__ "Adept employees actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and exploitation shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of Adept, Rescare, and local,</p>		<p>Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/General Manager (area manager) will</p>	

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W 0153  Bldg. 00	<p>state and federal guidelines."            ___ "Intimidation/emotional abuse: the act of failure to act that results or could result in emotional injury to an individual. The act of insulting or coarse language or gestures directed toward an individual that subject him/her to humiliation or degradation. Discouraging or inhibiting behavior by threatening both actual or implied. Attitude or acts that interfere with the psychological and social well being of an individual."            ___ "Emotional/physical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment."</p> <p>This deficiency was cited on 04/13/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations</p>		<p>review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will focus on:</p> <ol style="list-style-type: none"> <li>1. Mentorship and training of supervisory staff, monitoring and coaching of direct support staff</li> <li>2. Assuring behavior support plans are implemented as written.</li> </ol> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager</p>		

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	<p>of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 1 allegation of abuse reviewed, the facility failed to ensure the staff immediately reported all allegations of abuse to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for clients #1, #2, #3 and #4.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 5/21/15 at 1 PM.</p> <p>The 5/1/15 BDDS (Bureau of Developmental Disabilities Services) report indicated "[Client #1] was writing a letter with staff when she made an allegation towards staff, [staff #4]. [Client #1] stated that her hand hurt because [staff #4] pulled/pushed it back during her last behavior."</p> <p>The investigative summary dated 5/7/15 indicated: __Staff #5 stated "On Friday (5/1/15), I (staff #5) met with [client #1] and we</p>	W 0153	<p><b>CORRECTION:</b></p> <p><i>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. Specifically the staff responsible for failing to report the allegation, has received written corrective action. All facility staff will receive additional retraining regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. The training will focus on identifying observed and suspected abuse, neglect and mistreatment to facilitate immediate reporting. The training will stress that facility staff who fail to report allegations of abuse, neglect and mistreatment immediately will receive corrective action up to and including termination of employment. A review of progress notes, behavior tracking and incident documentation</i></p>	06/21/2015

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	<p>began to write a letter to [client #1's] mother. [Client #1] started writing about how she (client #1) had a rough week. I (staff #5) asked her why she thinks she had a rough week. [Client #1] said, 'Well it's just been on second shift.' She (client #1) started talking about [staff #4] and how she (staff #4) grabbed her (client #1's) arm. She (client #1) said this happened during her (client #1's) last behavior. [Staff #4] bent her (client #1's) wrist all the way back. This past Sunday (5/3/15) [client #1] brought me back to the living room and asked if she could write [staff #4] an apology letter for 'making [staff #4] so mad'."</p> <p>__Staff #5 indicated she had previously witnessed staff #4 bending client #1's fingers back and stated, "[Staff #4] is very verbally aggressive with the girls. Also, when I [staff #5] witnessed the hand being bent I told her (staff #4) we (the staff) can't do that."</p> <p>__Staff #5 indicated she did not remember when she had witnessed staff #4 bending client #1's hand back and stated, "I (staff #5) don't remember exactly when, maybe a couple of months ago."</p> <p>__Staff #6 stated, "I didn't witness this behavior but I have witnessed [staff #4] do this before. It lasted only about two seconds and she (staff #4) said it didn't hurt them. This is something she (staff</p>		<p>confirmed that this deficient practice did not affect other clients.</p> <p><b>PREVENTION:</b></p> <p>Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, the QIDP will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment. Members of the Operations Team will conduct documentation reviews no less than twice weekly for the next 21 days, weekly for</p>	

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	<p>#4) learned at the state hospital."            __ Client #3 indicated she had witnessed staff #4 bending client #1's fingers/wrist back during a behavior and stated she (client #3) had witnessed staff #4 do this to client #1, "Sometime last week."            __ Client #3 stated, "[Staff #4] does that to everyone when they are in a behavior."            __ Client #4 stated, "[Staff #4] has done that to me (client #4) before and [client #2] too."            __ Client #2 indicated she (client #2) had witnessed staff #4 bend client #1's fingers/wrist back during a behavior.            __ Client #2 stated, "When she (staff #4) puts us (clients #1, #2, #3 and #4) in a hold she (staff #4) twists our arms. I (client #2) lied the first time because I didn't want to get her (staff #4) fired."</p> <p>Client #1's record was reviewed on 5/22/15 at 1 PM. Client #1's Record of Visit dated 5/6/15 indicated client #1 saw her primary care physician due to having a fever, cough and right wrist pain. The record indicated diagnoses of Acute Bronchitis and right wrist sprain.</p> <p>During interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 5/22/15 at 2 PM, the QIDPD:            __ Indicated all allegations of abuse/neglect were to be reported</p>		<p>an additional 30 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. These administrative documentation reviews will focus on identifying potentially reportable incidents, providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely manner.</p> <p><b>RESPONSIBLE PARTIES:</b>            QIDP, Direct Support Staff, Operations Team</p>	

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W 0157 Bldg. 00	<p>immediately to the administrator and to BDDS and APS within 24 hours of the knowledge of the abuse/neglect. __ Indicated no report for the allegations of abuse made during the investigative report by clients #2, #3 and #4 to BDDS and APS.</p> <p>This deficiency was cited on 04/13/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 1 allegation of abuse reviewed, the facility failed to ensure staff training and/or retraining in regard to recognizing and reporting abuse/neglect immediately to the administrator was included in the corrective plan of action to prevent further abuse of clients #1, #2, #3 and #4.</p> <p>Findings include:  The facility's reportable and investigative records were reviewed on 5/21/15 at 1</p>	W 0157	<p><b>CORRECTION:</b></p> <p><i>If the alleged violation is verified, appropriate corrective action must be taken. Specifically: All facility staff will receive additional retraining regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. The training will focus on identifying observed and suspected abuse, neglect and mistreatment to</i></p>	06/21/2015

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330
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	<p>PM.</p> <p>The 5/1/15 BDDS (Bureau of Developmental Disabilities Services) report indicated "[Client #1] was writing a letter with staff when she made an allegation towards staff, [staff #4]. [Client #1] stated that her hand hurt because [staff #4] pulled/pushed it back during her last behavior."</p> <p>The investigative summary dated 5/7/15 indicated:            __Staff #5 stated "On Friday (5/1/15), I (staff #5) met with [client #1] and we began to write a letter to [client #1's] mother. [Client #1] started writing about how she (client #1) had a rough week. I (staff #5) asked her why she thinks she had a rough week. [Client #1] said, 'Well it's just been on second shift.' She (client #1) started talking about [staff #4] and how she (staff #4) grabbed her (client #1's) arm. She (client #1) said this happened during her (client #1's) last behavior. [Staff #4] bent her (client #1's) wrist all the way back. This past Sunday (5/3/15) [client #1] brought me back to the living room and asked if she could write [staff #4] an apology letter for 'making [staff #4] so mad'."            __Staff #5 indicated she had previously witnessed staff #4 bending client #1's fingers back and stated, "[Staff #4] is</p>		<p>facilitate immediate reporting. The training will stress that facility staff who fail to report allegations of abuse, neglect and mistreatment immediately will receive corrective action up to and including termination of employment. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients.</p> <p><b>PREVENTION:</b></p> <p>Monthly training refreshers toward identifying observed and suspected abuse, neglect and the requirement for immediate reporting will occur with all staff. The Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, met with the behaviorist and the QIDP to develop training protocols to avoid unnecessary use of advanced safety techniques (manual restraints), in an effort to reduce the frequency of manual restraint and the risk of improper implementation that could result in physical abuse.</p>	

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	<p>very verbally aggressive with the girls. Also, when I [staff #5] witnessed the hand being bent I told her (staff #4) we (the staff) can't do that."</p> <p>__Staff #5 indicated she did not remember when she had witnessed staff #4 bending client #1's hand back and stated, "I (staff #5) don't remember exactly when, maybe a couple of months ago."</p> <p>__Staff #6 stated, "I didn't witness this behavior but I have witnessed [staff #4] do this before. It lasted only about two seconds and she (staff #4) said it didn't hurt them. This is something she (staff #4) learned at the state hospital."</p> <p>__Client #3 indicated she had witnessed staff #4 bending client #1's fingers/wrist back during a behavior and stated she (client #3) had witnessed staff #4 do this to client #1, "Sometime last week."</p> <p>__Client #3 stated, "[Staff #4] does that to everyone when they are in a behavior."</p> <p>__Client #4 stated, "[Staff #4] has done that to me (client #4) before and [client #2] too."</p> <p>__Client #2 indicated she (client #2) had witnessed staff #4 bend client #1's fingers/wrist back during a behavior.</p> <p>__Client #2 stated, "When she (staff #4) puts us (clients #1, #2, #3 and #4) in a hold she (staff #4) twists our arms. I (client #2) lied the first time because I didn't want to get her (staff #4) fired."</p>		<p>The QIDP will be expected to observe no less than Five active treatment sessionS per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring appropriate implementation of behavior supports.</p> <p>Members of the Operations Team, will conduct observations during active Treatment sessions and documentation reviews no less than two times weekly for the next 21 days, no less than weekly for an additional 30 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning</p>	

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	<p>The plan of corrective action/peer review dated 5/7/15 was reviewed on 5/22/15 at 2:40 PM. The record indicated the following recommendations:</p> <p>"1. When allegations of physical abuse occur, the individual must be assessed by a nurse on the day the allegations are made, regardless of whether or not apparent injuries are present. If injuries are present, photographs must be taken and an external medical evaluation [Immediate Care, ER (Emergency Room) or PCP (Primary Care Physician)] must occur. - Revise Operating Standard.</p> <p>2. Train all RC (Residential Coordinators) - (name of town) supervisors on the above protocol.</p> <p>3. Terminate DSP (Direct Support Professional) [staff #4] for substantiated abuse.</p> <p>4. Administrative staff including... to meet with [name of street] interdisciplinary team to develop plan to reduce and eventually eliminate the use of YSIS (You're Safe I'm Safe) advanced personal safety techniques."</p> <p>The plan of corrective action did not indicate training and/or retraining of staff</p>		<p>active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/General Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive</p>	

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	<p>in regard to recognizing and reporting abuse immediately to the administrator.</p> <p>Client #1's record was reviewed on 5/22/15 at 1 PM. Client #1's Record of Visit dated 5/6/15 indicated client #1 saw her primary care physician due to having a fever, cough and right wrist pain. The record indicated diagnoses of Acute Bronchitis and right wrist sprain. The record indicated client #1 was to take Naproxen (an anti-inflammatory medicine) 500 milligrams twice a day for one week for the wrist sprain.</p> <p>During interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 5/22/15 at 2 PM, the QIDPD:          ___ Indicated no retraining had been provided the staff in regard to recognizing and immediately reporting abuse/neglect to the administrator.          ___ Stated, "I plan on including that (retraining of the staff) at the next house meeting which is scheduled for June 16th (2015)."</p> <p>9-3-2(a)</p>		<p>Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will focus on:</p> <ol style="list-style-type: none"> <li>1. Mentorship and training of supervisory staff, monitoring and coaching of direct support staff</li> <li>2. Assuring behavior support plans are implemented as written.</li> </ol> <p><b>RESPONSIBLE PARTIES:</b></p> <p>QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager</p>		