STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G141	A. BUILDING 00 B. WING	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PUTNAM COUNTY COMPREHENSIVE SERVICES INC	914 TENNESSEE ST GREENCASTLE, IN 46135

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W 0000 Bldg. 00	This visit was for a fundamental annual recertification and state licensure survey. Survey Dates: April 16, 17, 18 and 19, 2018 Facility Number: 000678 Provider Number: 15G141 AIM Number: 100234430 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review of this report completed May 1, 2018 by #09182.	W 0000		
W 0149 Bldg. 00	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 12 of 39 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility failed to prevent incidents of client to client aggression and ensure investigations were conducted for two incidents of client to client aggression and one incident of inappropriate touching. Findings include: On 4/16/18 at 12:03 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 5/24/17 at 8:00 PM, client #5 hit client #6 on the back as they packed their lunches. Client #6 was not injured.	W 0149	W149: All staff members have been retrained on PCCS's policy: "Incident Reporting/Adminsitrative On-Call" Policy (attachment 1) at the home and at the day services/sheltered workshop. Additionally, the staff agenda and sign-in sheet (attachment 2) from May 4, 2018 addressed precautionary measures to be taken when transporting consumers, as well as proactive and reactive steps to be taken when a consumer begins to exhibit aggressive behaviors which could escalate to the point of	05/11/2018

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

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	On 4/17/18 at 9:28 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. On 4/17/18 at 9:28 AM, the Home Manager (HM) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The HM indicated the facility had a policy and procedure prohibiting abuse of the clients. 2) On 7/15/17 at 3:25 PM, client #2 reported earlier that morning, client #1 kicked him on the right shin. Client #6 also indicated the incident occurred at reported by client #2. Client #2 did not have an injury. Staff did not witness the incident. On 4/17/18 at 9:28 AM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. On 4/17/18 at 9:28 AM, the HM indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The HM indicated the facility had a policy and procedure prohibiting abuse of the clients. 3) On 7/15/17 at 3:25 PM, client #1 kicked client #3 on the left leg after client #3 picked up a pillow that client #1 threw onto the floor. Client #3 was not injured. On 4/17/18 at 9:28 AM, the QIDP indicated client to client aggression was abuse and the facility		peer-to-peer aggression. The IDT meeting minutes from May 3, 2018 (attachment 3) between the Quality Assurance Director, Director of Residential Services, Adult Day Service Coordinator, Residential House Manager, and QIDP also addresses the "Incident Reporting/Administrative On-Call" Policy. Since all consumers were cited in the tag, proactive and reactive strategies to be taken when a consumer begins to exhibit aggressive behaviors was discussed and will be implemented in the future as stated above. These strategies can include, but are not limited to: requiring staff members to be seated amongst the other consumers while transporting, redirection of consumer(s) to another area when aggressiveness is exhibited, and separation of consumer(s) until de-escalation is observed. The "Incident Reporting/Administrative On-Call" Policy has been reviewed with all DSPs, the QIDP, the Adult Day Services Coordinator, the Residential House Manager, and the Director of Residential Services in the home and at the day services/sheltered workshop settings. Additionally, the "Incident Reporting/Administrative On-Call" Policy will be sent out through Accel – the time reporting system	

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	should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. On 4/17/18 at 9:28 AM, the HM indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The HM indicated the facility had a policy and procedure prohibiting abuse of the clients. 4) On 7/19/17 at 3:28 PM, client #1 hit client #2 on the left hand while at the facility operated workshop. Client #2 was not injured. On 4/17/18 at 9:28 AM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. On 4/17/18 at 9:28 AM, the HM indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The HM indicated the facility had a policy and procedure prohibiting abuse of the clients. 5) On 8/4/17 at 6:20 PM, client #1 hit client #4 on the left arm while in the van. Client #4 was not injured. The investigation indicated both staff were sitting in the van's front seats at the time of the incident. There were no additional staff in the van at the time. There was no documentation the facility addressed both staff sitting in the front seats. On 4/17/18 at 9:28 AM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients.		used by PCCS – once monthly by the Director of Residential Services to all Supervised Group Living staff members. Director of Residential Services will run and save a report at the end of the month to ensure that all Supervised Group Living staff members have viewed the policy that was sent through the Accel messaging system.	

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	On 4/17/18 at 9:28 AM, the HM indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The HM indicated the facility had a policy and procedure prohibiting abuse of the clients. 6) On 11/3/17 at 9:00 AM, client #5 hit client #3 on the right arm accidentally when he tried to hit client #2. Client #3 was not injured. On 4/17/18 at 9:28 AM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. On 4/17/18 at 9:28 AM, the HM indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The HM indicated the facility had a policy and procedure prohibiting abuse of the clients. 7) On 11/14/17 at 8:40 AM at the facility operated workshop, client #6 was pushed to the ground by a peer. Client #6 had bruising, swelling and a scratch on his right knee. Client #6 was taken for an assessment by his physician. During the assessment, client #6 was found to have a one centimeter wide open wound to his right elbow requiring Tagaderm (transparent medical dressing). On 4/17/18 at 9:28 AM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. On 4/17/18 at 9:28 AM, the HM indicated client to			

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	client aggression was abuse and the facility should prevent abuse of the clients. The HM indicated the facility had a policy and procedure prohibiting abuse of the clients. 8) On 11/27/17 (no time indicated), client #1 hit client #4 on the arm while in the van going home from the workshop. Client #4 reported the incident to staff. Staff did not witness the incident. The 12/1/17 investigation indicated, "...After review of documents and statements the conclusion is determined to be partially substantiated...." The investigation indicated both staff were sitting in the van's front seats at the time of the incident. There were no additional staff in the van at the time. There was no documentation the facility addressed both staff sitting in the front seats. On 4/17/18 at 9:28 AM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. On 4/17/18 at 9:28 AM, the HM indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The HM indicated the facility had a policy and procedure prohibiting abuse of the clients. On 4/18/18 at 2:57 PM, the Director of Residential Services indicated the staff was instructed to have one staff in the back of the van with the clients. 9) On 1/4/18 at 2:00 PM while at a restaurant, a female peer alleged client #3 touched her on the buttocks. The peer reported client #3 slapped her buttocks more than once after she told him to stop. The peer indicated she was not in pain but			

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	uncomfortable. When staff approached client #3, the 1/5/18 BDDS report indicated he stated, "I know I should not have slapped her on the [buttocks]. I know I should have stopped after she told me. I know I should not have been flirting." The staff indicated client #3 stated this before she asked him anything about the incident. The BDDS report indicated, "[Client #3] admitted to the accusations." There was no documentation the facility conducted an investigation into client #3's peer's allegation. On 4/16/18 at 2:42 PM, the Quality Assurance Director (QAD) indicated the facility did not conduct an investigation into the incident. The QAD indicated since the inappropriate touch was not directed toward client #3, an investigation was not conducted. On 4/18/18 at 2:57 PM, the Residential Services Director (RSD) indicated the incident should have been investigated due to client #3's history of inappropriate touching. 10) On 3/6/18 at 9:37 AM, client #5 hit client #2 when entering the van to go to the workshop. Client #2 was not injured. The 3/6/18 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "...QIDP (Qualified Intellectual Disabilities Professional) has since begun an investigation regarding the incident...." The 3/14/18 BDDS Incident Follow-Up Report indicated, "...QIDP completed an investigation regarding the incident. After review of documents and statements the conclusion of the investigation is substantiated...." The facility did not provide documentation an investigation was completed. On 4/16/18 at 2:42 PM, the QAD indicated an			

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	investigation was not conducted. The QAD indicated an investigation should have been conducted. On 4/17/18 at 9:28 AM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. On 4/17/18 at 9:28 AM, the HM indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The HM indicated the facility had a policy and procedure prohibiting abuse of the clients. 11) On 3/9/18 at 6:00 PM, client #2 hit client #3. Client #3 was not injured. There was no documentation the facility conducted an investigation. On 4/16/18 at 2:42 PM, the QAD indicated an investigation was not conducted. The QAD indicated an investigation should have been conducted. On 4/17/18 at 9:28 AM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. On 4/17/18 at 9:28 AM, the HM indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The HM indicated the facility had a policy and procedure prohibiting abuse of the clients. 12) On 3/27/18 at noon at the facility operated workshop, client #1 hit client #4 on the right hand.			

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	Client #1 indicated he was angry at client #4 for dating his former girlfriend. Client #4 was not injured. On 4/17/18 at 9:28 AM, the QIDP indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. On 4/17/18 at 9:28 AM, the HM indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The HM indicated the facility had a policy and procedure prohibiting abuse of the clients. On 4/17/18 at 9:30 AM, a review was conducted of the facility's January 2006 Individual Abuse and Neglect/Mistreatment Policy. The policy indicated the following, "PCCS (Putnam County Comprehensive Services) shall prohibit any form of mistreatment, neglect or abuse, including physical, verbal, mental or sexual abuse. Any form of abuse, including but not limited to humiliation, harassment and threats of punishment or deprivation will not be tolerated." The policy indicated, "Any reports of such mistreatments, abuse or neglect shall be thoroughly investigated by the Investigation Committee, reviewed by the Executive Director and reported to the Human Rights Committee." The policy indicated, "Physical abuse includes, but not limited to, any physical motion or action, i.e., slapping, punching, kicking, pinching, by which intentional bodily harm or trauma occurs. It include the use of corporal punishment as well as the use of any restrictive, intrusive procedure to control challenging behaviors for purpose of punishment. Physical abuse also occurs when too much intentional force is used during restraint			

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	procedures." The January 2006 Abuse and Neglect policy indicated, "To insure that battery, neglect or exploitation of clients by staff members, other clientele or others will not be tolerated, all alleged incidents will be immediately and thoroughly investigated...." 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 3 of 39 incident/investigative reports reviewed affecting clients #2, #3 and #5, the facility failed to conduct investigations of two incidents of client to client aggression and one incident of client #3's inappropriately touching a peer. Findings include: On 4/16/18 at 12:03 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 1/4/18 at 2:00 PM while at a restaurant, a female peer alleged client #3 touched her on the buttocks. The peer reported client #3 slapped her buttocks more than once after she told him to stop. The peer indicated she was not in pain but uncomfortable. When staff approached client #3, the 1/5/18 the Bureau of Developmental Disabilities Services (BDDS) report indicated he stated, "I know I should not have slapped her on the [buttocks]. I know I should have stopped after she told me. I know I should not have been flirting." The staff indicated client #3 stated this before she asked him anything about the incident. The BDDS report indicated, "[Client #3] admitted	W 0154	W154 The investigations for the incidents noted in this tag were completed and reviewed on May 10, 2018 (attachment 4). Additionally, the new QIDP and Adult Day Services coordinator have been retrained on investigation protocol as is noted in the IDT Meeting Minutes from May 3, 2018 (attachment 3). All other incident reports were reviewed for the other consumers, and there were no further investigations that were missing. In order to ensure that the deficient practice does not recur, the Director of Residential Services will also be emailed a copy of the investigation to ensure that it is done according to all state guidelines. In the future, when an investigation is initiated, all staff member statements of the incident will be sent to the QIDP or Adult Services Coordinator through Accel – the time reporting	05/11/2018

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	to the accusations." There was no documentation the facility conducted an investigation into client #3's peer's allegation. On 4/16/18 at 2:42 PM, the Quality Assurance Director (QAD) indicated the facility did not conduct an investigation into the incident. The QAD indicated since the inappropriate touch was not directed toward client #3, an investigation was not conducted. 2) On 3/6/18 at 9:37 AM, client #5 hit client #2 when entering the van to go to the workshop. Client #2 was not injured. The 3/6/18 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "...QIDP (Qualified Intellectual Disabilities Professional) has since begun an investigation regarding the incident...." The 3/14/18 BDDS Incident Follow-Up Report indicated, "...QIDP completed an investigation regarding the incident. After review of documents and statements the conclusion of the investigation is substantiated...." The facility did not provide documentation an investigation was completed. On 4/16/18 at 2:42 PM, the QAD indicated an investigation was not conducted. The QAD indicated an investigation should have been conducted. 3) On 3/9/18 at 6:00 PM, client #2 hit client #3. Client #3 was not injured. There was no documentation the facility conducted an investigation. On 4/16/18 at 2:42 PM, the QAD indicated an investigation was not conducted. The QAD indicated an investigation should have been conducted.		system used by PCCS. Executive Director, Quality Assurance Director, Director of Residential Services, QIDP, Residential House Manager, and Adult Day Services Coordinator will be notified of any and all reportable incidents to ensure that if an investigation is needed, that it is stated within the text message that one is being initiated.	

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	9-3-2(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 1 of 3 non-sampled clients (#4), the facility failed to ensure staff implemented client #4's Health Related Incident Management Plan as written for his gait belt. Findings include: Observations were conducted at the group home on 4/16/18 from 3:20 PM to 6:13 PM and on 4/17/18 from 6:11 AM to 8:16 AM. During the observations, client #4 wore a gait belt. Client #4's gait belt was used two times by staff when he was ambulating - one time during the evening observation by the Home Manager and one time during the morning observation by staff #2 after client #4 tripped (did not fall) over a dining room chair leg. Client #4 ambulated throughout the observation around the group home without direct staff supervision and without staff holding onto his gait belt. Client #4's gait was unsteady. Client #4 walked quickly while leaning forward, at times holding onto the walls to steady himself. Client #4 was prompted by staff numerous times to sit down once he made it to a specific area (dining room, living room, office, etc.).	W 0249	W249 A gait belt retraining on client #4's Health Related Incident Management Plan was conducted on May 4, 2018 at SGL and on May 11, 2018 at Day Services Workshop (attachment 5). The team determined that the current Health Related Incident Management Plan for client #4 was effective and needed no changes. The facility also covered gait belt retraining on client #5 and client #6 on May 4, 2018 (attachment 5). An addendum (attachment 6) to client #5's Health Related Incident Management Plan due to determination from the PCP (attachment 7) that he needs assistance at all times in which he is ambulatory. Client #4, #5, and #6 have received orders for PT evaluations (attachment 8), the PT evaluations are scheduled for May 23, 2018. A staff retraining was held on May	05/11/2018

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	On 4/17/18 at 12:22 PM, a focused review of client #4's record was conducted. Client #4's 3/8/18 Health Related Incident Management Plan indicated in the skeletal deformities section, "... [Client #4] has leg deformities that have caused him to need braces and a gait belt... [Client #4] also requires assistance with ambulating safely, due to skeletal deformities. [Client #4] builds momentum when walking, which will often result in running if not continuously prompted... To ensure [client #4's] safety he was prescribed a gait belt. The gait belt is to be utilized as an effective aid when walking with [client #4]... Staff will assist [client #4] by having a hold of the gait belt when [client #4] (sic) ambulatory, preventing [client #4] from building momentum and running...." A 3/28/18 Physician Continuation Note from the Physical Therapist indicated, "Pt (patient) needs supervision during ambulation. Pt needs constant verbal cues to slow down and not to lean forward... Also use gait belt for safety." On 4/17/18 at 12:05 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated staff was to hold onto the gait belt while walking with client #4. The QIDP stated, "the plan says he requires supervision when ambulating." The QIDP indicated client #4's risk plan should be implemented as written. On 4/17/18 at 12:05 PM, the Home Manager indicated client #4's risk plan should be implemented as written. On 4/17/18 at 12:05 PM, the Residential Services Director indicated client #4's risk plan should be implemented as written. 9-3-4(a)		4, 2018 discussing all gait belt requirements for clients #4, #5, and #6. Any staff member witnessed not following a Health Related Incident Management Plan, or any other aspect of the IPP will initially receive a verbal warning and written warning for any further occurrence following, which will also result in a loss of bonus. Monitoring will take place in the form of observation from QIDP, Residential House Manager, Director of Residential Services, Day Program Coordinator, and Sheltered Workshop Supervisor.	

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PUTNAM COUNTY COMPREHENSIVE SERVICES INC	914 TENNESSEE ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0262 Bldg. 00	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 record review and interview for 1 of 3 clients in the sample (#3), the facility's specially constituted committee (Human Rights Committee/HRC) failed to review, approve and monitor client #3's restrictive behavior plan. Findings include: On 4/17/18 at 10:56 AM, a review of client #3's record was conducted. Client #3's 3/8/18 Behavior Support Plan (BSP) indicated he was prescribed psychotropic medications (Cymbalta and Wellbutrin for depression and Lamictal for post traumatic stress disorder). The BSP included the use of physical restraint as a reactive measure to tantrum and aggressive behavior. The BSP indicated, "...Should aggression escalate to the point that the safety of [client #3] or others is in danger, employ Crisis Prevention Intervention (CPI) procedures/techniques such as kick block, arm block, hand release, hair release, choke release, bite release, 2 man CPI, interim control position (arm), as the situation requires, as trained and authorized by a Putnam County Comprehensive Services, Inc. agency CPI instructor...." There was no documentation in client #3's record the HRC reviewed, approved and monitored client #3's restrictive BSP. On 4/17/18 at 11:51 AM, the Residential Services Director (RSD) indicated the facility should obtain the HRC's approval for restrictive plans annually	W 0262	W262 For client #3, HRC review and approval has been obtained for the March 8, 2018 BSP (attachment 9). A review was completed by the QIDP, and PCCS has obtained HRC approval for all other consumers within the facility which have programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protections and rights. In the future, the behaviorist will send all annual BSPs and addenda to the Director of Residential Services and QIDP via email to ensure that they are forwarded to the HRC in a timely manner for review and approval. Residential Director will monitor text messaging and email to ensure that HRC approval is obtained prior to any implementation of BSP which involve risks to client protections and rights.	05/11/2018

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	or as changes were made to the plan. The RSD indicated the HRC should have reviewed and approved client #3's behavior plan. 9-3-4(a)			
W 0312 Bldg. 00	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 3 clients in the sample with psychotropic medications (#2), the facility failed to ensure client #2 had a plan to reduce the use of his psychotropic medications. Findings include: On 4/17/18 at 10:16 AM, a review of client #2's record was conducted. Client #2's 10/5/17 Medication Reduction Plan indicated his current psychotropic medications included Navane, Cymbalta and Abilify. The plan indicated, "[Client #2] continues to need his current medications listed above due to his aggressive and tantrumous (sic) behaviors...." The Plan of Reduction section indicated, "[Client #2] will reduce his Prozac by 10 mg (milligrams) before his next annual review in October 2016 given his meeting Plan of Reduction objectives...." A 4/5/18 Case Conference Meeting form indicated, in part, "...QIDP (Qualified Intellectual Disabilities Professional) explained that there has not been a change in behavior since [client #2] has started the Clozaril... [Name of psychiatrist] recommended decreasing the Clozaril by 1/2 a tab	W 0312	W312 For client #2, the Medication Reduction Plan has been updated as of May 10, 2018 (attachment 10). A review was completed by the QIDP, and updates to the Medication Reduction Plans of Clients #1, #3, and #4 were completed on May 10, 2018 (attachment 10). Director of Residential Services met with the QIDP to discuss how and when to complete medication reduction plans, and subsequently any medication change that would need HRC approval. Following any medical appointment, QIDP will be notified by Residential House Manager of any medication additions or changes and QIDP will, in conjunction with Director of Residential Services determine the need for HRC approval.	05/11/2018

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	every 4 days for 12 days until discontinuing it. Once discontinued, he will began Invega 6 mg. He will also increase Cymbalta from 60 mg to 90 mg...." On 4/17/18 at 10:28 AM, the Home Manager (HM) indicated client #2's 10/5/17 Medication Reduction Plan did not include his current psychotropic medications. The HM indicated client #2's current psychotropic medications included Invega, Cymbalta and Depakote. The HM indicated Cymbalta was recently increased. The HM indicated Invega was recently added. The HM indicated Depakote was added in November 2017. On 4/17/18 at 11:51 AM, the HM indicated client #2's Medication Reduction Plan should include his current psychotropic medications and should have been revised when changes were made to his medications. On 4/17/18 at 11:51 AM, the Residential Services Director (RSD) indicated client #2's Medication Reduction Plan should have been revised when his medications changed. The RSD indicated client #2 should have a plan to reduce the use of psychotropic medications. 9-3-5(a)			
W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 3 clients in the sample (#2), the facility failed to ensure client #2 had an evaluation of his vision. Findings include:	W 0323	W323 For client #2, the vision screening was completed on May 10, 2018 (attachment #11). However, at his annual physical, dated October	05/11/2018

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	On 4/17/18 at 10:16 AM, a review of client #2's record was conducted. Client #2's most recent vision examination was conducted on 10/16/15. The 10/16/15 Resident Vision Examination Form indicated, "...Eye exam recommended every 1-2 years to check health & (and) acuity." On 4/17/18 at 10:46 AM, the Home Manager (HM) stated, "I missed it." The HM indicated client #2's vision examination needed to be scheduled. The HM indicated client #2 should have a vision examination every two years unless otherwise noted. 9-3-6(a)		17, 2017 there was a whisper test and Snellen chart completed (attachment 12). A review was completed by the Residential House Manager and all other visual and hearing screenings have been completed within the appropriate timeframes. Residential House Manager will, in the future, set calendar reminders for all annual, bi-annual, quarterly, and monthly screenings to ensure that no further appointments are missed. QIDP will monitor any upcoming appointments noted in the monthly nursing review, which, in turn, will become a portion of the QIDP Notes.	