STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G486	A. BUILDING 00 B. WING	08/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0000 Bldg. 00	This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00234659. Complaint #IN00234659: Substantiated, Federal and state deficiencies related to the allegations are cited at W153 and W154. Survey dates: August 8, 9, 10, 11, 14 and 18, 2017. Facility Number: 001000 Provider Number: 15G486 AIMS Number: 100245010 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/13/17.	W 0000		
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law			

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

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	through established procedures. Based on record review and interview for 1 of 12 allegations of abuse, neglect and mistreatment reviewed, the facility failed to report immediately to the administrator and to BDDS (Bureau of Developmental Disabilities Services) within 24 hours regarding the elopement of FC (Former Client A). Findings include: BDDS reports and investigations were reviewed on 8/8/17 at 2:02 PM. A BDDS report dated 6/21/17 indicated on 6/20/17, "...Staff reported that [FC A] went to the neighbor's yard and took their cable television cord. Staff returned the cable cord and there were no further issues with [FC A] that night....[FC A] has a history of leaving his assigned area which is addressed in his behavior support plan. Due to [FC A's] previous display of leaving his assigned area, for the next 48 hours, [FC A] will be placed on line of sight supervision in common area's (sic) of the home and 15 minute checks while he is sleeping...". -An Internal Incident report dated 6/18/17 at 9:00 AM and completed by staff #1 indicated, "[FC A] walked out of the house from the front door while staff was	W 0153	**CORRECTION:** *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, all staff have been retrained to report suspected abuse, neglect, mistreatment and exploitation, including but not limited to elopement immediately to assure that the administrator is notified and that the allegations are reported to the Bureau of Developmental Disabilities Services as required by state law. A review of incident documentation indicates no clients other than former client A were affected by failure to report incidents to the administrator and the State of Indiana as required. **PREVENTION:** Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to the administrator. The Quality Assurance Manager will coordinate and follow-up with the	09/27/2017

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	cleaning. Staff stopped him and asked him to come back in the house and [FC A] followed staff direction. Staff step (sic) outside to smoke when neighbor walked up to staff and said [FC A] pulled wires out of his house from the back yard. Staff then walked to [FC A's] room were (sic) the wires were at in his (FC A's) (sic) on floor... Neighbor walked over to house and told staff that his wife heard a sound in back yard and he saw [FC A] walking out of his back yard. When he (Neighbor) walked outside to find out what the sound was and where it was coming from...Neighbors (sic) cable wires from back yard were pulled out of house from backyard (sic) by [FC A]." A review of the incident report dated 6/18/17 indicated the facility did not report the incident of FC A eloping/destroying neighbor's property (allegation of neglect) until 6/21/17. QIDP (Qualified Intellectual Disabilities Professional #1) was interviewed on 8/11/17 at 10:28 AM. QIDP #1 indicated all allegations of abuse, neglect and mistreatment should be reported immediately to the administrator and to BDDS within 24 hours. This federal tag relates to complaint #IN00234659.		Quality Assurance Coordinator and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an elopement, the governing body will administer written corrective action up to and including termination of employment. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Site Supervisor, Direct Support Staff, Operations Team, Regional Director	

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	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 8 allegations of abuse, neglect and mistreatment reviewed, the facility failed to thoroughly investigate 3 incidents of elopement regarding FC (Former Client A). Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 8/8/17 at 2:02 PM. 1. A BDDS report dated 4/10/17 indicated on 4/9/17, ..."The neighbor next door came over and stated he observed [FC A] in his (neighbor's) yard taking a pink dog collar and leash. Staff searched [FC A's] belongings and found the missing items and returned them to the neighbor...". -A review of the BDDS report dated 4/10/17 indicated FC A eloped from the	W 0154	**CORRECTION:** *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically: The Quality Assurance Team comprised of the Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinator, will review all incident documentation to determine if incidents could have occurred or been exacerbated as a result of abuse, neglect, mistreatment or exploitation. When allegations are identified through documentation review and/or follow-up with front line supervisors, the team will initiate agency investigation protocols, notifying the administrator, suspending alleged staff perpetrators and reporting the allegations to state government entities as required. The Operations Team, including the Operations Managers, Program Managers, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance	09/27/2017

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	group home on 4/9/17 and was out of sight of the staff for an unknown amount of time. -The Investigation Final report (IFR) dated 4/11/17 was reviewed on 8/8/17 at 4:09 PM. The IFR did not include any interviews with staff on duty or the neighbor who reported FC A's elopement. IDT (Interdisciplinary Team)/Plan to Resolve form dated 4/9/17 indicated, "[FC A] did not sustain any injuries as a result of this incident and was out of line of sight of staff for approximately 3 minutes. [FC A] has a Behavior Support Plan (BSP) that addresses: ..."Leaving assigned area," ..." The staff will follow the BSP and will report any concerns to the team." -A review of the Investigation/IDT Plan to resolve dated 4/11/17 did not indicate interviews with all staff on duty or the group home's neighbor as part of the investigation. 2. A BDDS report dated 4/26/17 indicated on 4/25/17 indicated, "...[FC A] was assisting with unloading the groceries from the van (group home's) when he (FC A) evaded staff's line of sight for less than two minutes and returned to the driveway carrying a flower pot belonging to the next door		Manager, Quality Assurance Coordinators and QIDP Manager, will directly oversee all investigations and will assure that conclusions are developed that match the collected evidence. The Quality Assurance Manager and the QIDP Manager will review the scope of all open investigations to assure all allegations receive appropriate examination and analysis. **PREVENTION:** The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of incident documentation, focusing on serious incidents that could potentially have occurred as a result of staff negligence.	

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	neighbor...". -A review of the BDDS report dated 4/26/17 indicated FC A was out of staff's line of sight for 2 minutes. -An IFR/IDT Plan to Resolve dated 4/26/17, reviewed on 8/8/17 at 4:09 PM, indicated, "[FC A] was assisting with unloading the groceries from the van when he evaded staff's line of sight for less than two minutes and returned to the driveway (group home's) carrying a flower pot belonging to the next door neighbor..." "Elopement/leaving assigned area is addressed in [FC A's] Behavior Support Plan. Staff implemented the plan...". -A review of the IFR/IDT indicated FC A was out of the line of sight of staff for a minimum of 2 minutes. The review did not indicate interviews with staff present at the time of the elopement or with the next door neighbor were conducted to determine the cause of FC A's elopement. 3. A BDDS report dated 6/21/17 indicated on 6/20/17, "...Staff reported that [FC A] went to the neighbor's yard and took their cable television cord. Staff returned the cable cord and there were no further issues with [FC A] that night.... [FC A] has a history of leaving his		**RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Site Supervisor, Direct Support Staff, Operations Team, Regional Director	

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	assigned area which is addressed in his behavior support plan. Due to [FC A's] previous display of leaving his assigned area, for the next 48 hours, [FC A] will be placed on line of sight supervision in common area's (sic) of the home and 15 minute checks while he is sleeping...". -A review of the BDDS report dated 6/21/17 indicated FC A went to the neighbor's yard for an undetermined amount of time. The review indicated the facility implemented line of sight/15 minute checks for FC A for 48 hours following the incident of FC A's elopement on 6/20/17. -An Internal Incident report dated 6/18/17 at 9:00 AM and completed by staff #1 indicated, "[FC A] walked out of the house from the front door while staff was cleaning. Staff stopped him and asked him to come back in the house and [FC A] followed staff direction. Staff step (sic) outside to smoke when neighbor walked up to staff and said [FC A] pulled wires out of his house from the back yard. Staff then walked to [FC A's] room were (sic) the wires were at in his (FC A's) on floor... Neighbor walked over to house and told staff that his wife heard a sound in back yard and he (sic) saw [FC A] walking out of his (sic) back yard. When he (Neighbor) walked outside to			

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	find out what the sound was and where it was coming from...Neighbors (sic) cable wires from back yard were pulled out of house from backyard (sic) by [FC A]." A review of the incident report dated 6/18/17 indicated the facility did not report the incident of FC A eloping/destroying neighbor's property until 6/21/17. The IFR/IDT dated 6/22/17, reviewed on 8/8/17 at 4:09 PM, indicated, "Rescare staff will continue to monitor [FC A] to prevent further incidents and follow his proactive and reactive strategies. The IDT agrees due to [FC A's] escalating cycle of leaving assigned area, the interdisciplinary team will works (sic) with the Bureau of Developmental Disability Services to explore alternate placement options." A review of the IFR/IDT dated 6/22/17 did not indicate the facility interviewed staff #1 regarding FC A's elopement on 6/18/17. The review did not indicate the facility interviewed the neighbor regarding FC A's elopement/destruction of neighbor's property on 6/18/17. The review did indicate FC A was transferred to another group home within the agency on 7/11/17.			

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	QIDP (Qualified Intellectual Disabilities Professional #1) was interviewed on 8/10/17 at 11:45 AM. QIDP #1 indicated all allegations of abuse, neglect and mistreatment should be thoroughly investigated. QIDP #1 indicated all witnesses or potential witnesses should be interviewed. This federal tag relates to complaint #IN00234659. 9-3-2(a)			
W 0159 Bldg. 00	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 4 of 4 sampled clients (A, B, C and D), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor the clients' program plans by failing to monitor the clients' progress on their training objectives for 11 of 12 months	W 0159	**CORRECTION:** *Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.* Specifically the governing body will assure that:	09/27/2017

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	during the past year. Findings include: Client A's record was reviewed on 8/9/17 at 11:25 AM. Client A's ISP (Individual Support Plan) dated 4/14/17 was reviewed on 8/9/17 at 11:25 AM. Client A's record did not contain documentation the QIDP reviewed, revised, updated and monitored his individualized training objectives for 11 of 12 months from July 2016 to July 2017. Client B's record was reviewed on 8/9/17 at 1:45 PM. Client B's ISP (Individual Support Plan) dated 7/6/17 was reviewed on 8/9/17 at 1:45 PM. Client B's record did not contain documentation the QIDP reviewed, revised, updated and monitored his individualized training objectives for 11 of 12 months from July 2016 to July 2017. Client C's record was reviewed on 8/9/17 at 12:13 PM. Client C's ISP dated 7/12/17 was reviewed on 8/9/17 at 12:13 PM. Client C's record did not contain documentation the QIDP reviewed, revised, updated and monitored his individualized training objectives for 11 of 12 months from July 2016 to July 2017.		The QIDP will complete ISP summaries for the past quarter that includes analysis of progression and regression on prioritized learning objectives. Moving forward, the QIDP will turn in copies of monthly ISP summaries to the QIDP Manager no later than the seventh calendar day of each month for review and guidance. Additionally the QIDP will turn in quarterly ISP summaries to the QIDP Manager for review prior to scheduled quarterly meetings. Failure to complete monthly and quarterly analysis of progression/regression of progress on ISP objectives will result in progressive performance action. A review of facility documentation indicated this deficient practice affected all clients. **PREVENTION:** The QIDP has been retrained regarding the need analyze progression and regression on prioritized learning objectives and make appropriate modifications and revisions.	

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	Client D's record was reviewed on 8/10/17 at 10:04 AM. Client D's ISP dated 5/26/17 was reviewed on 8/10/17 at 10:04 AM. Client D's record did not contain documentation the QIDP reviewed, revised, updated and monitored his individualized training objectives for 11 of 12 months from July 2016 to July 2017. QIDP (Qualified Intellectual Disabilities Professional #1) was interviewed on 8/10/17 at 11:45 AM. QIDP #1 indicated the facility did not have documentation the QIDP reviewed, revised, updated and monitored the clients' individualized training objectives for 11 of 12 months from July 2016 to July 2017. QIDP #1 stated, "I do not have documentation prior to July, 2017." 9-3-3(a)		Members of the Operations Team comprised of the Operations Managers, Program Managers, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager will incorporate chart reviews of goal data and QIDP summaries into their formal audit process, which will occur no less than twice monthly to assure that prioritized learning objectives are analyzed and revised as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Site Supervisor, Direct Support Staff, Operations Team, Regional Director	
W 0322 Bldg. 00	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 4 of 4 sampled clients (A, B, C and D), the facility failed to ensure clients A, B, C and D had annual physical examinations.	W 0322	**CORRECTION:** The facility must provide or obtain preventive and general medical care. Specifically, the facility has obtained annual physical examinations for client A,	09/27/2017

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	Findings include: 1. Client A's record was reviewed on 8/9/17 at 11:25 AM. Client A's annual physical form dated 6/13/16 indicated client A had an annual physical examination on 6/13/16. Client A's record did not indicate documentation of a physical since 6/13/16. 2. Client B's record was reviewed on 8/9/17 at 1:45 PM. Client B's annual physical form dated 7/8/16 indicated client B had an annual physical examination on 7/8/16. Client B's record did not indicate documentation of a physical since 7/8/16. 3. Client C's record was reviewed on 8/9/17 at 12:13 PM. Client C's annual physical form dated 6/6/16 indicated client C had an annual physical examination on 6/6/16. Client C's record did not indicate documentation of a physical since 6/6/16. 4. Client D's record was reviewed on 8/10/17 at 10:04 AM. Client D's annual physical form dated 6/27/16 indicated client D had an annual physical examination on 6/27/16. Client D's record did not indicate documentation of a physical since 6/27/16.		client B, client C and client D. A review of facility medical documentation indicated this deficient practice also affected client F and client F will receive a physical examination as well. **PREVENTION:** The QIDP and Area Supervisor will work with the facility nurse and coordinate with the facility direct support medical coach and Residential Manager to assure that all medical assessments and evaluations occur as required. The facility nurse will conduct weekly audits to assure appointments have been scheduled and occur as required. Members of the Operations Team (including the Quality Assurance Manager, Quality Assurance Coordinator, Training Coordinator, Program Managers, Nurse Manager, Registered Nurse and Executive Director) will incorporate medical chart reviews into their formal audit process, which will occur no less than twice monthly to assure that examinations including but not limited to vision evaluations take place as required. **RESPONSIBLE PARTIES:**	

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	LPN (Licensed Practical Nurse #1) was interviewed on 8/10/17 at 11:25 AM. LPN #1 was asked if the facility had documentation of current physical examinations for clients A, B, C and D. LPN #1 stated, "No, they (physical examinations) should be done annually." 9-3-6(a)		QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Health Services Team, Operations Team	
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 4 sampled clients (D), the facility failed to ensure client D was assessed by an Optometrist as recommended. Findings include: Client D's record was reviewed on 8/10/17 at 10:04 AM. Client D's Visual Care Progress Report form dated 5/2/14 indicated client D was assessed by an Optometrist on 5/2/14. Client D's Visual Care Progress Report form dated 5/2/14 indicated, "...Future Appointment Date: 2 yrs.-full exam." Client D's record did not	W 0323	**CORRECTION:** *The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.*Specifically, client D will receive a vision evaluation and additional visual evaluations thereafter per optometrist and audiologist recommendations. A review of medical records indicated this deficient practice did not affect additional clients.	09/27/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	indicate documentation of visual care/assessment since 5/2/14. LPN (Licensed Practical Nurse #1) was interviewed on 8/10/17 at 11:25 AM. LPN #1 indicated client D should have been re-assessed by the Optometrist in 2 years as indicated. 9-3-6(a)		**PREVENTION:** The QIDP will work with the facility nurse will coordinate with the facility direct support medical coach and Residential Manager to assure that all medical assessments and evaluations occur as required. When required assessments are not covered by insurance, the governing body will assume responsibility for payment for services. Members of the Operations Team (including the Quality Assurance Manager, Quality Assurance Coordinator, Training Coordinator, QIDP Manager, Program Manager, Nurse Manager and Executive Director) will incorporate medical chart reviews into their formal audit process, which will occur no less than twice monthly to assure that examinations including but not limited to vision evaluations take place as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Heath Services Team, Direct Support Staff, Operations Team, Regional Director	
W 0352 Bldg. 00	483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services			

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	15G486	A. BUILDING 00 B. WING	08/18/2017

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	include periodic examination and diagnosis performed at least annually. Based on record review and interview for 2 of 4 sampled clients (A and D), the facility failed to ensure clients A and D were assessed by an Dentist as recommended. Findings include: Client A's record was reviewed on 8/9/17 at 11:25 AM. Client A had a dental examination completed on 9/19/16. Client A's Record of Visit form dated 9/19/16 indicated, "Excessive calculus, bleeding gums-severe perio-dental (sic) disease...Follow-up appointment date: Tues. Mar. 21, 2017...". Client A's record did not indicate documentation of a dental assessment since 9/19/16. Client D's record was reviewed on 8/10/17 at 10:04 AM. Client D had an dental examination completed on 4/5/16. Client D's record did not indicate documentation of an current dental examination. LPN (Licensed Practical Nurse #1) was interviewed on 8/10/17 at 11:25 AM. LPN #1 indicated client A should have been re-assessed by the dentist as recommended. LPN #1 indicated client D should have an dental examination	W 0352	**CORRECTION:** *Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually.* Specifically, the facility has scheduled and will obtain recommended dental examination for clients A and D. An audit of facility medical charts indicated this deficient practice did not affect additional clients. **PERVENTION:** The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to dental examinations, occur within required time frames. Supervisory staff will review medical charts on an ongoing basis but no less than monthly to assure medical follow-along occurs as required. Members of the Operations Team (including the Quality Assurance Manager, Quality Assurance Coordinator, Training Coordinator, QIDP Manager, Program Manager, Nurse Manager and Executive Director) and nursing staff will incorporate medical chart reviews into their	09/27/2017

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	completed annually. LPN #1 indicated she did not have documentation of a current dental examination for client D. 9-3-6(a)		formal audit process, which will occur no less than twice monthly to assure that medical follow-along including but not limited to dental examinations take place as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Heath Services Team, Direct Support Staff, Operations Team, Regional Director	
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 2 of 4 sampled clients (B and C), the facility failed to ensure clients B and C received their medications as ordered by the physician. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 8/8/17 at 2:02 PM. 1. A BDDS report dated 5/29/17 indicated on 5/28/17, "...Rescare nurse reported that [client C] received another	W 0368	**CORRECTION:** *The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.* Specifically, all facility staff will be retrained on medication administration procedures with emphasis on comparing medication cards to the specific orders on the medication administration record prior to administering medication, as well as checking the photograph of the client in the Medication Administration Record (MAR) prior to administering medication.	09/27/2017

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	housemates' 100 mg (milligram) of Clozapine (anti-psychotic). The Rescare nurse called poison control and was instructed to have staff take [client C] to [local] Emergency Room (ER). [Client C] was assessed and vitals were normal...". -A review of the BDDS report dated 5/29/17 indicated client C received a 100 mg dose of clozapine. The review indicated client C was taken to the ER for evaluation due to client C receiving the wrong medication. Client C's physicians orders dated 7-1-17 to 7-31-17 were reviewed on 8/9/17 at 12:13 PM. A review of Client C's physicians orders did not indicate an order for 100 mg of Clozapine. 2. A BDDS report dated 6/5/17 indicated on 6/4/17, "...Staff called the Area Supervisor and reported that she had administered the following medications to [client B] for which he was not prescribed. (sic) Benztropine (side effects) 2 mg, Clozapine 100 mg, Lamictal (anticonvulsant) 25 mg, Oxybutynin (urinary incontinence) and Ranitidine (antacid) 150 mg. The supervisor notified the Rescare nurse on-call and as a precaution, the Residential Manager transported [client B] to the [local] Emergency Department		**PREVENTION:** The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to assuring medications are administered as ordered. The Area Supervisor will be present at the facility observing the staff's provision of skills training and documentation no less than twice weekly for the next 30 days and no less than weekly thereafter. Members of the Operations Team, comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Registered Nurse, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than twice weekly for until staff demonstrate competence. 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	

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	for evaluation. The ER physician monitored [client B] for 2 hours, noted that his vital signs were normal and released him (client B)...". A review of the BDDS report dated 6/5/17 indicated client B did not receive his medications as ordered by the physician. Client B's physicians orders dated 8/1/17 to 8/31/17 were reviewed on 8/9/17 at 1:45 PM. The review indicated client B was observed by the physician in the ER for 2 hours for evaluation. A review of client B's physicians orders did not indicate an order for: Benztropine, 2 mg, clozapine 100 mg, Lamictal 25 mg, oxybutynin and Ranitidine 150 mg. LPN (Licensed Practical Nurse #1) was interviewed on 8/10/17 at 11:25 AM. LPN #1 indicated clients B and C should have been administered their medications as ordered by the physician. 9-3-6(a)		monitored are defined as: 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 active treatment monitoring will include staff from both the day and overnight shifts. 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. 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	

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			discovered. The Executive Director and Director of Operations/Regional Manager (area manager) will 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*.Administrative support at the home will include assuring staff administer medications without error. Administrative oversight will include assuring medications are administered as ordered. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, facility nurse, Direct Support Staff, Operations Team	
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 1 additional client (E), the facility failed to ensure staff administered medications as ordered.	W 0369	**CORRECTION:** *The system for drug administration must assure that all drugs, including those that are*	09/27/2017

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	Findings include: Observations were conducted at the group home on 8/8/17 from from 1:10 PM through 6:00 PM and on 8/9/17 from 6:03 AM through 7:55 AM. On 8/9/17 at 6:07 AM, staff #5 was observed administering medications. At 6:22 AM a plastic container with client E's name written on it was observed on the counter in the medication room. Staff was observed holding client E's medication cards/bubble packs. Client E was not in the medication room as staff #5 reviewed client E's MAR (Medication Administration Record) and dispensed the following medications into a paper souffle cup: Oxybutynin (urinary incontinence) 5 mg (milligram), Natural Fiber Powder (constipation) 1 teaspoon 10 mg, Lamotrigine (Anticonvulsant) 50 mg, Fluoxetine (anti-depressant) 60 mg and Benazepril (high blood pressure) 10 mg. After staff #5 had finished popping client E's medications into a paper souffle cup, staff #5 stated, "[Client B] come get your meds." Client B walked to the medication room where staff #5 indicated it was time for client B to take his medications. Surveyor stopped staff #5 and pointed to the plastic container with client E's name written on it. Staff #5 stated, "I meant to say [client E] not		*self-administered, are administered without error.* Specifically, all facility staff will be retrained on medication administration procedures with emphasis on comparing medication cards to the specific orders on the medication administration record prior to administering medication. **PREVENTION:** The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to assuring staff administer medications without error. The Area Supervisor will be present at the facility observing the staff's provision of skills training and documentation no less than twice weekly for the next 30 days and no less than weekly thereafter. Members of the Operations Team comprised of the Quality Assurance Manager, Quality Assurance Coordinator, Training Coordinator, Program Managers, Nurse Manager, Registered Nurse and Executive Director will conduct observations during active Treatment sessions and documentation reviews no less	

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	[client B]." Staff #5 called client E into the medication room and administered client E his medications as ordered. Client B's record was reviewed on 8/9/17 at 1:45 PM. Client B's MAR (Medication Administration Record) dated 8/1/17 to 8/31/17 was reviewed on 8/9/17 at 1:45 PM. Client B's MAR did not indicate orders for the following medications: Oxybutynin 5 mg, Natural Fiber Powder 1 teaspoon 10 mg, Lamotrigine 50 mg, Fluoxetine 60 mg and Benazepril 10 mg. LPN #1 was interviewed on 8/10/17 at 11:25 AM. LPN #1 indicated staff #5 should have administered client E's medications as ordered and identified client E prior to administering his medications. 9-3-6(a)		than twice weekly for 30 days, and no less than weekly until all staff demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative monitoring is defined as: 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 active treatment monitoring will include staff from both the day and overnight shifts. 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.	

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			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. The Executive Director and Director of Operations/Regional Manager (area manager) will 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.* Administrative support at the home will include assuring staff administer medications without error. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Health Services Team, Operations Team	
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at			

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	least quarterly for each shift of personnel. Based on record review and interview for 4 of 4 sampled clients (A, B, C and D) plus 4 additional clients (E, F, G and H), the facility failed to conduct fire drills quarterly for of each shift of personnel. Findings include: The facility's fire evacuation drills were reviewed on 8/9/17 at 7:15 AM. The review did not indicate documentation of a fire evacuation drill being conducted on the 11:00 PM to 7:00 AM shift for the second quarter of 2017 (April, May, June) for clients A, B, C, D, E, F, G and H. The review did not indicate documentation of a fire evacuation drill being conducted on the 3:00 PM to 11:00 PM shift for the third quarter of 2016 (July, August, September) for clients A, B, C, D, E, F, G and H. The review did not indicate documentation of a fire evacuation drill being conducted on the 7:00 AM to 3:00 PM shift or the 11:00 PM to 7:00 AM shift for the fourth quarter of 2016 (October, November, December). QIDP (Qualified Intellectual Disabilities Professional #1) was interviewed on 8/10/17 at 11:45 AM. QIDP #1 indicated the facility should complete fire evacuation drills for every shift of	W 0440	**CORRECTION:** The facility must hold evacuation drills at least quarterly for each shift of personnel. Specifically, the facility has conducted additional evacuation drills on each shift during the current quarter. **PREVENTION:** Professional staff will be retrained regarding the need to conduct evacuation drills on each shift for all staff each quarter. The Operations Team will review all facility evacuation drill reports and follow up with professional staff as needed to assure drills occur as scheduled. Program Manager will track evacuation drill compliance and follow up with facility professional staff and the agency Safety Committee accordingly. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	09/27/2017

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	personnel and every quarter of the year. QIDP #1 indicated he did not have documentation of fire evacuation drills for the 11:00 PM to 7:00 AM shift for the second quarter of 2017, the 3:00 PM to 11:00 PM shift for the third quarter of 2016 and the 7:00 AM to 3:00 PM shift and the 11:00 PM to 7:00 AM shift for the fourth quarter of 2016 (October, November, December) for clients A, B, C, D, E, F, G and H. 9-3-7(a)			