STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G449	A. BUILDING 00 B. WING	11/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

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W 0000 Bldg. 00	This visit was for the annual recertification and state licensure survey. This visit included the investigation of complaint #IN00185435. Complaint #IN00185435: Substantiated, federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W154, W156, W318 and W331. Dates of Survey: 11/9/15, 11/10/15, 11/12/15, 11/13/15 and 11/16/15. Facility Number: 000963 Provider Number: 15G449 AIMS Number: 100244740 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/23/15.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.			

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

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	Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 3 of 4 sampled clients (A, B and C), plus 2 additional clients (DCs (Discharged Client) H and G). The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of clients A, B and C, to complete thorough investigations regarding three incidents of alleged neglect regarding clients A, B and C and failed to report the results of an investigation regarding alleged neglect of client A to the facility administrator within 5 business days of the incident. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored clients A, B, C and DC H and DC H's active treatment programs. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility developed discharge summaries of client A, DCs G and H's developmental, behavioral, social and health needs, to ensure clients A and B	W 0102	**CORRECTION:** *The facility must ensure that specific governing body and management requirements are met.* Specifically: The staff responsible for failing to follow Client A's high risk plan and follow instructions to access emergency medical services for Client A has been terminated. The governing body has established a Quality Assurance Department to assist with and coordinate the investigation process. The Operations Team, comprised of the Program Manager, the Quality Assurance Manager, Quality Assurance Coordinator, Training Manager, Nurse Manager and Executive Director, and the QIDP will directly oversee all investigations. When, during the course of an investigation, additional allegations arise, the governing body will assure that a separate investigation is initiated and completed thoroughly, within required time lines. Oversight will include but not be limited to reconciling conflicting testimony and determining of staff	12/16/2015

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	participated in the development of their ISPs (Individual Support Plans), to ensure client C had a CFA (Comprehensive Functional Assessment) completed and to ensure the facility's HRC (Human Rights Committee) reviewed, approved and monitored clients A, B and C's restrictive programs. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility nursing services ensured client A had an annual physical examination and ensured client C's vision was assessed annually, ensured clients B and C received annual TB (Tuberculosis) testing, x-ray or symptom screenings, to develop and implement a care plan or high risk health plan to address client A's recurring skin infections, to ensure client C's laboratory monitoring orders were implemented and to ensure client A was evaluated for dental health needs. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections for 3 of 4 sampled clients. The facility failed to implement its policy and procedures to prevent neglect of clients A, B and C, to complete thorough investigations		negligence or neglect contributed to the alleged incidents and reconciliation of conflicting testimony. The Quality Assurance Department will assist with and coordinate the investigation process, including but not limited to assuring results of investigations are reported to the administrator within five working days as required. The QIDP will complete discharge summaries for Client A, and DC Client G and DC Client H. For Clients A and B the QIDP and will be trained regarding the need to bring all elements of the interdisciplinary team including the clients themselves, to assist with the development of individual support plans. A review of facility support documents indicated this deficient practice affected additional clients D and E. Client C's Comprehensive Functional Assessment will be	

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	regarding three incidents of alleged neglect regarding clients A, B and C and failed to report the results of an investigation regarding alleged neglect of client A to the facility administrator within 5 business days of the incident. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Health Care Services for 3 of 4 sampled clients (A, B and C). The facility health care services failed to ensure client A had an annual physical completed and to ensure client C's vision was assessed annually, to ensure clients B and C received annual TB (Tuberculosis) testing, x-ray or symptom screenings, to develop and implement a care plan or high risk health plan to address client A's recurring skin infections, to ensure client C's laboratory monitoring orders were implemented and to ensure client A was evaluated for dental health needs. Findings include: 1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of clients A, B and C, to complete thorough		completed. A review of facility support documents indicated this deficient practice did not affect any additional clients. Through review of facility documentation, the governing body has determined that in addition to Clients A – C, the facility failed to obtain Human rights Committee approval for restrictive programs for two additional clients (D and E). Specifically, the QIDP will obtain Human rights Committee Approval for all restrictive programs for all clients who reside at the facility. A record review located a current annual physical for Client A that was not reproduced for the surveyors. A review of medical records indicated this deficient practice did not affect any additional clients. The facility will obtain current visual assessment for Client C. A review of medical records indicated this deficient practice did not affect any additional clients.	

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	investigations regarding three incidents of alleged neglect regarding clients A, B and C and failed to report the results of an investigation regarding alleged neglect of client A to the facility administrator within 5 business days of the incident. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored clients A, B, C and DC H and DC H's active treatment programs. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility developed discharge summaries of client A, DCs G and H's developmental, behavioral, social and health needs, to ensure clients A and B participated in the development of their ISPs (Individual Support Plans), to ensure client C had a CFA (Comprehensive Functional Assessment) completed and to ensure the facility's HRC (Human Rights Committee) reviewed, approved and monitored clients A, B and C's restrictive programs. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the		The team will assist Clients B and C with obtaining tuberculosis screens. A review of facility medical records indicated this deficient practice did not affect any additional clients. The facility nurse will assure Client C receives all currently recommended lab work and that ongoing labs are drawn as ordered. Although Client A no longer lives in the facility, he facility nurse will be trained regarding the need to develop additional high risk plans for clients as their medical needs change. A review of current diagnostic information and risk plans indicated this deficient practice did not affect additional clients. Client A no longer resides in the facility and an audit conducted by the Operations Team determined that all other clients in the facility had current dental examinations. **PREVENTION:** The investigation team,	

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	facility nursing services ensured client A had an annual physical examination and ensured client C's vision was assessed annually, ensured clients B and C received annual TB (Tuberculosis) testing, x-ray or symptom screenings, to develop and implement a care plan or high risk health plan to address client A's recurring skin infections, to ensure client C's laboratory monitoring orders were implemented and to ensure client A was evaluated for dental health needs. Please see W104. 2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections for 3 of 4 sampled clients. The governing body failed to implement its policy and procedures to prevent neglect of clients A, B and C, to complete thorough investigations regarding three incidents of alleged neglect regarding clients A, B and C and failed to report the results of an investigation regarding alleged neglect of client A to the facility administrator within 5 business days of the incident. Please see W122. 3. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the		comprised of the Program Manager, Quality Assurance Manager, Quality Assurance Coordinator and QIDPs will communicate daily through the course of all investigations –reviewing gathered evidence to determine if the scope of the current investigation needs to be expanded and whether new allegations must be reported and investigated. Additionally at the conclusion of investigation, members of the Operations Team including the Executive Director, Human Resources Specialist, Program Manager, Quality Assurance Manager and Nurse Manager, will conduct a peer review meeting to review the investigation summary and gathered evidence to assure all allegations have been duly reported and investigated. When deficiencies are noted, additional investigations will be initiated as needed. 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	

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	facility met the Condition of Participation: Health Care Services for 3 of 4 sampled clients (A, B and C). The facility health care services failed to ensure client A had an annual physical completed and ensure client C's vision was assessed annually, to ensure clients B and C received annual TB (Tuberculosis) testing, x-ray or symptom screenings, to develop and implement a care plan or high risk health plan to address client A's recurring skin infections, to ensure client C's laboratory monitoring orders were implemented and to ensure client A was evaluated for dental health needs. Please see W318. This federal tag relates to complaint #IN00185435. 9-3-1(a)		Program Manager (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Program Manager 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 Quality Assurance Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The program Managers will provide weekly updates to the Quality Assurance Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.	

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			The QIDP will be trained on the need to complete final Discharge Summaries of clients' developmental, behavioral, social, health and nutritional status upon discharge from the facility. The QIDP will turn in copies of Discharge Summaries to the Program Manager for review and tracking. The QIDP will turn in documentation of person centered planning as it occurs but no less than quarterly to the Program Manager monthly. The Program Manager will in turn follow-up to assure that family members and guardians and the clients themselves are invited and encouraged to participate in the ISP development process. The QIDP will be retrained regarding the need to assure that all relevant assessments are completed within 30 days of admission and reviewed and updated as needed but no less than annually. The Clinical Supervisor and other members of the Operations Team will review facility support documents no less than monthly to assure	

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			appropriate re-assessment occurs as required. A new QIDP has been assigned to the facility and has initiated a process up reviewing and updating all facility support documents including but not limited to assessments. The QIDP will be retrained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs for all clients. The QIDP, facility nurse and Human Rights Committee liaison will each maintain copies of Human rights Committee approval forms to assure the ability to reproduce copies of HRC records for surveyors upon request. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility three times weekly for the next 30 days and twice weekly visits for an additional 60 days. At the conclusion of this period of enhanced administrative	

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			monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include review of Human Rights Committee records to assure appropriate approvals have been obtained. The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to physical evaluations, visual and dental examinations occur within required time frames. Members of the Operations Team (including the Quality Assurance Manager, Program Managers, Nurse Manager, Quality Assurance Coordinator, Training Manager and Executive Director) will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure that examinations including but not limited to physical evaluations take place as required. The Health Services Team will work with The Residential	

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			Manager, QIDP and facility Medical coach to assure that all relevant assessments, including but not limited to visual examinations, are completed for clients within 30 days of admission and as needed but no less than annually thereafter. Members of the Operations Team will follow up with the QIDP no less twice weekly when new clients are admitted to the facility to assure appropriate assessment occurs as required. Prior to admitting new clients, the Program Manager will assist the QIDP with developing a schedule to assure that all necessary assessments occur. Additionally, members of the Operations Team will review medical records no less than monthly to assure all required assessments and follow-up occur as required. The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine appointments and lab tests to assure they occur as recommended. Additionally, the Operations Team will review medical documentation weekly for the next 30 days and twice monthly for the next 60 days to assure labs and appointments occur as recommended and make recommendations to the Health	

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			Services Team as appropriate. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. Additionally the facility nurse will complete a screen for tuberculosis symptoms as part of routine quarterly nursing physical examinations. The QIDP will assure that the nursing team is included in all discussions/decisions relevant to clients' health and safety and modifications will be made to Comprehensive High Risk Plans accordingly. The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans. The Nurse Manager will review all facility risk plan modifications for the next 90 days to assure they contain appropriate detail, and will conduct periodic audits of facility risk plans on an ongoing basis. Members of the Operations Team	

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			will incorporate audits of medical documents into visits to the facility weekly for the next 30 days and twice monthly for the next 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include review of healthcare records and incident and medical appointment documentation to assure appropriate risk plans and nursing supports are in place. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 3 of 4 sampled clients (A, B and C), plus 2 additional clients (DC (Discharged Client) G and DC H), the	W 0104	**CORRECTION:** *The governing body must exercise general policy, budget,*	12/16/2015

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	governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of clients A, B and C, to complete thorough investigations regarding three incidents of alleged neglect regarding clients A, B and C and failed to report the results of an investigation regarding alleged neglect of client A to the facility administrator within 5 business days of the incident. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored clients A, B, C and DC H and DC H's active treatment programs. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility developed discharge summaries of client A, DCs G and H's developmental, behavioral, social and health needs, to ensure clients A and B participated in the development of their ISPs (Individual Support Plans), to ensure client C had a CFA (Comprehensive Functional Assessment) completed and to ensure the facility's HRC (Human Rights Committee)		*and operating direction over the facility.* Specifically, the governing body has facilitated the following: The staff responsible for failing to follow Client A's high risk plan and follow instructions to access emergency medical services for Client A has been terminated. The governing body has established a Quality Assurance Department to assist with and coordinate the investigation process. The Operations Team, comprised of the Program Manager, the Quality Assurance Manager, Quality Assurance Coordinator, Training Manager, Nurse Manager and Executive Director, and the QIDP will directly oversee all investigations. When, during the course of an investigation, additional allegations arise, the governing body will assure that a separate investigation is initiated and completed thoroughly, within required time lines. Oversight will include but not be limited to reconciling conflicting testimony and determining of staff negligence or neglect contributed to the alleged incidents and reconciliation of conflicting testimony.	

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	reviewed, approved and monitored clients A, B and C's restrictive programs. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility nursing services ensured client A had an annual physical examination and ensure client C's vision was assessed annually, ensured clients B and C received annual TB (Tuberculosis) testing, x-ray or symptom screenings, to develop and implement a care plan or high risk health plan to address client A's recurring skin infections, to ensure client C's laboratory monitoring orders were implemented and to ensure client A was evaluated for dental health needs. Findings include: 1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of clients A, B and C, to complete thorough investigations regarding three incidents of alleged neglect regarding clients A, B and C and failed to report the results of an investigation regarding alleged neglect of client A to the facility administrator within 5 business days of the incident. Please see W149.		The Quality Assurance Department will assist with and coordinate the investigation process, including but not limited to assuring results of investigations are reported to the administrator within five working days as required. The QIDP will complete discharge summaries for Client A, and DC Client G and DC Client H. For Clients A and B the QIDP and will be trained regarding the need to bring all elements of the interdisciplinary team including the clients themselves, to assist with the development of individual support plans. A review of facility support documents indicated this deficient practice affected additional clients D and E. Client C's Comprehensive Functional Assessment will be completed. A review of facility support documents indicated this deficient practice did not affect any additional clients.	

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	2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored clients A, B, C and DC H and DC H's active treatment programs. Please see W159. 3. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility developed discharge summaries regarding client A, DCs G and H's developmental, behavioral, social and health needs. Please see W203. 4. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients A and B participated in the development of their ISPs. Please see W209. 5. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure client C had a CFA (Comprehensive Functional Assessment) completed. Please see W259. 6. The governing body failed to exercise general policy, budget and operating		Through review of facility documentation, the governing body has determined that in addition to Clients A – C, the facility failed to obtain Human rights Committee approval for restrictive programs for two additional clients (D and E). Specifically, the QIDP will obtain Human rights Committee Approval for all restrictive programs for all clients who reside at the facility. A record review located a current annual physical for Client A that was not reproduced for the surveyors. A review of medical records indicated this deficient practice did not affect any additional clients. The facility will obtain current visual assessment for Client C. A review of medical records indicated this deficient practice did not affect any additional clients. The team will assist Clients B and C with obtaining tuberculosis screens. A review of facility	

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	direction over the facility to ensure the facility's HRC (Human Rights Committee) reviewed, approved and monitored clients A, B and C's restrictive programs. Please see W262. 7. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure client A had an annual physical completed. Please see W322. 8. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure client C's vision was assessed annually. Please see W323. 9. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility nursing services ensured clients B and C received annual TB testing, x-ray or symptom screenings. Please see W327. 10. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility nursing services developed and implemented a care plan or high risk health plan to address client A's recurring skin infections and to ensure client C's laboratory monitoring orders were implemented. Please see W331.		medical records indicated this deficient practice did not affect any additional clients. The facility nurse will assure Client C receives all currently recommended lab work and that ongoing labs are drawn as ordered. Although Client A no longer lives in the facility, he facility nurse will be trained regarding the need to develop additional high risk plans for clients as their medical needs change. A review of current diagnostic information and risk plans indicated this deficient practice did not affect additional clients. Client A no longer resides in the facility and an audit conducted by the Operations Team determined that all other clients in the facility had current dental examinations. **PREVENTION:** The investigation team, comprised of the Program Manager, Quality Assurance Manager, Quality Assurance Coordinator and QIDPs will communicate daily through the	

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	11. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility nursing services ensured client A was evaluated for dental health needs. Please see W356. This federal tag relates to complaint #IN00185435. 9-3-1(a)		course of all investigations –reviewing gathered evidence to determine if the scope of the current investigation needs to be expanded and whether new allegations must be reported and investigated. Additionally at the conclusion of investigation, members of the Operations Team including the Executive Director, Human Resources Specialist, Program Manager, Quality Assurance Manager and Nurse Manager, will conduct a peer review meeting to review the investigation summary and gathered evidence to assure all allegations have been duly reported and investigated. When deficiencies are noted, additional investigations will be initiated as needed. 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 Program Manager (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all	

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			investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Program Manager 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 Quality Assurance Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The program Managers will provide weekly updates to the Quality Assurance Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members. The QIDP will be trained on the need to complete final Discharge Summaries of clients'	

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			developmental, behavioral, social, health and nutritional status upon discharge from the facility. The QIDP will turn in copies of Discharge Summaries to the Program Manager for review and tracking. The QIDP will turn in documentation of person centered planning as it occurs but no less than quarterly to the Program Manager monthly. The Program Manager will in turn follow-up to assure that family members and guardians and the clients themselves are invited and encouraged to participate in the ISP development process. The QIDP will be retrained regarding the need to assure that all relevant assessments are completed within 30 days of admission and reviewed and updated as needed but no less than annually. The Clinical Supervisor and other members of the Operations Team will review facility support documents no less than monthly to assure appropriate re-assessment occurs as required. A new QIDP has been assigned to the facility and has initiated a process up reviewing and updating all facility	

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			support documents including but not limited to assessments. The QIDP will be retrained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs for all clients. The QIDP, facility nurse and Human Rights Committee liaison will each maintain copies of Human rights Committee approval forms to assure the ability to reproduce copies of HRC records for surveyors upon request. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility three times weekly for the next 30 days and twice weekly visits for an additional 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility.	

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			These administrative documentation reviews will include review of Human Rights Committee records to assure appropriate approvals have been obtained. The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to physical evaluations, visual and dental examinations occur within required time frames. Members of the Operations Team (including the Quality Assurance Manager, Program Managers, Nurse Manager, Quality Assurance Coordinator, Training Manager and Executive Director) will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure that examinations including but not limited to physical evaluations take place as required. The Health Services Team will work with The Residential Manager, QIDP and facility Medical coach to assure that all relevant assessments, including but not limited to visual examinations, are completed for	

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			clients within 30 days of admission and as needed but no less than annually thereafter. Members of the Operations Team will follow up with the QIDP no less twice weekly when new clients are admitted to the facility to assure appropriate assessment occurs as required. Prior to admitting new clients, the Program Manager will assist the QIDP with developing a schedule to assure that all necessary assessments occur. Additionally, members of the Operations Team will review medical records no less than monthly to assure all required assessments and follow-up occur as required. The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine appointments and lab tests to assure they occur as recommended. Additionally, the Operations Team will review medical documentation weekly for the next 30 days and twice monthly for the next 60 days to assure labs and appointments occur as recommended and make recommendations to the Health Services Team as appropriate. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing	

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			gradually the administrative presence in the home to no less than monthly. Additionally the facility nurse will complete a screen for tuberculosis symptoms as part of routine quarterly nursing physical examinations. The QIDP will assure that the nursing team is included in all discussions/decisions relevant to clients' health and safety and modifications will be made to Comprehensive High Risk Plans accordingly. The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans. The Nurse Manager will review all facility risk plan modifications for the next 90 days to assure they contain appropriate detail, and will conduct periodic audits of facility risk plans on an ongoing basis. Members of the Operations Team will incorporate audits of medical documents into visits to the facility weekly for the next 30 days and twice monthly for the next 60 days. At the conclusion of	

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			this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include review of healthcare records and incident and medical appointment documentation to assure appropriate risk plans and nursing supports are in place. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager	
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 3 of 4 sampled clients (A, B and C). The facility failed to implement its policy and procedures to prevent neglect of clients A, B and C, to complete thorough investigations regarding three incidents of alleged	W 0122	**CORRECTION:** *The facility must ensure that specific client protections requirements are met.* Specifically: The staff responsible for failing to	12/16/2015

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	neglect regarding clients A, B and C and failed to report the results of an investigation regarding alleged neglect of client A to the facility administrator within 5 business days of the incident. Findings include: 1. The facility failed to implement its policy and procedures to prevent neglect of clients A, B and C, to complete thorough investigations regarding three incidents of alleged neglect regarding clients A, B and C and failed to report the results of an investigation regarding alleged neglect of client A to the facility administrator within 5 business days of the incident. Please see W149. 2. The facility failed to complete thorough investigations regarding three incidents of alleged neglect regarding clients A, B and C. Please see W154. 3. The facility failed to report the results of an investigation regarding alleged neglect of client A to the facility administrator within 5 business days of the incident. Please see W156. This federal tag relates to complaint #IN00185435. 9-3-2(a)		follow Client A's high risk plan and follow instructions to access emergency medical services for Client A has been terminated. The governing body has established a Quality Assurance Department to assist with and coordinate the investigation process. The Operations Team, comprised of the Program Manager, the Quality Assurance Manager, Quality Assurance Coordinator, Training Manager, Nurse Manager and Executive Director, and the QIDP will directly oversee all investigations. When, during the course of an investigation, additional allegations arise, the governing body will assure that a separate investigation is initiated and completed thoroughly, within required time lines. Oversight will include but not be limited to reconciling conflicting testimony and determining of staff negligence or neglect contributed to the alleged incidents and reconciliation of conflicting testimony. The Quality Assurance Department will assist with and coordinate the investigation process, including but not limited	

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			to assuring results of investigations are reported to the administrator within five working days as required. **PREVENTION:** The investigation team, comprised of the Program Manager, Quality Assurance Manager, Quality Assurance Coordinator and QIDPs will communicate daily through the course of all investigations –reviewing gathered evidence to determine if the scope of the current investigation needs to be expanded and whether new allegations must be reported and investigated. Additionally at the conclusion of investigation, members of the Operations Team including the Executive Director, Human Resources Specialist, Program Manager, Quality Assurance Manager and Nurse Manager, will conduct a peer review meeting to review the investigation summary and gathered evidence to assure all allegations have been duly reported and investigated. When deficiencies are noted, additional investigations will be initiated as needed.	

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			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 Program Manager (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Program Manager 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 Quality Assurance Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The	

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			program Managers will provide weekly updates to the Quality Assurance Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager	
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 observation, record review and interview for 3 of 4 sampled clients (A, B and C), the facility failed to implement its policy and procedures to prevent neglect of clients A, B and C, to complete thorough investigations regarding three incidents of alleged neglect regarding clients A, B and C and failed to report the results of an investigation regarding alleged neglect of client A to the facility administrator within 5 business days of the incident. Findings include:	W 0149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.* Specifically: The staff responsible for failing to follow Client A's high risk plan and follow instructions to access emergency medical services for Client A has been terminated.	12/16/2015

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	The facility's IARs (Incident/Accident Reports), BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/9/15 at 3:00 PM. The review indicated the following: 1. BDDS report dated 10/25/15 indicated, "When staff woke [client A], he did not respond verbally and appeared to be experiencing difficulty breathing. Staff called 911 and EMS (Emergency Medical Services) transported [client A] to the [hospital] ED (Emergency Department) via ambulance. ED staff attempted to stabilize [client A] and in the process he coded 3 times. [Client A] has been admitted to the [hospital] ICU (Intensive Care Unit) with a diagnosis of septic shock and is using a ventilator. [Client A] has late stage renal disease and high risk plans are in place." -BDDS report dated 10/25/15 indicated, "[Client A] was hospitalized on 10/24/15 for treatment of septic shock. While investigating the circumstances of the development of his illness, the investigator determined that [client A] may have experienced an extended period of nausea and vomiting several hours prior to the initiating of treatment for his condition and that [staff #3], who was on		The governing body has established a Quality Assurance Department to assist with and coordinate the investigation process. The Operations Team, comprised of the Program Manager, the Quality Assurance Manager, Quality Assurance Coordinator, Training Manager, Nurse Manager and Executive Director, and the QIDP will directly oversee all investigations. When, during the course of an investigation, additional allegations arise, the governing body will assure that a separate investigation is initiated and completed thoroughly, within required time lines. Oversight will include but not be limited to reconciling conflicting testimony and determining of staff negligence or neglect contributed to the alleged incidents and reconciliation of conflicting testimony. The Quality Assurance Department will assist with and coordinate the investigation process, including but not limited to assuring results of investigations are reported to the administrator within five working days as required.	

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COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

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	duty at the time, allegedly did not report the episode to the nurse on-call per protocol." -Investigative Summary (IS) dated 10/31/15 with addendum dated 11/9/15 indicated the following: -Staff #4's NS (Narrative Statement) undated indicated, "On Saturday, 10/24/15, I clocked in at exactly 8:00 AM and I was told (by the) overnight staff, [staff #3], that client A had defecated on his clothes. Immediately all his soiled clothes that I found in the laundry room were washed and dried. When it was around 9:10 AM, I went to [client A's] room to call him so that he could have his meal before going to dialysis. I called his name as usual but he didn't answer me well (sic) as he used to do. I tried to persuade him to stand from his bed but he couldn't. I immediately call (sic) for colleagues, [staff #5] to pass the information along to the supervisor and the nurse. The nurse came in and his blood sugar and blood pressure were taken which were normal but he was not doing well. Then we quickly called 911 and they came with their officials and took him away with the ambulance to the hospital." -Staff #5's NS undated indicated, "On		**PREVENTION:** The investigation team, comprised of the Program Manager, Quality Assurance Manager, Quality Assurance Coordinator and QIDPs will communicate daily through the course of all investigations –reviewing gathered evidence to determine if the scope of the current investigation needs to be expanded and whether new allegations must be reported and investigated. Additionally at the conclusion of investigation, members of the Operations Team including the Executive Director, Human Resources Specialist, Program Manager, Quality Assurance Manager and Nurse Manager, will conduct a peer review meeting to review the investigation summary and gathered evidence to assure all allegations have been duly reported and investigated. When deficiencies are noted, additional investigations will be initiated as needed. A tracking spreadsheet for incidents requiring investigation,	

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	Saturday morning (10/24/15), when I arrived, the female DSP (Direct Support Professional), [staff #3], was sitting on the couch with her hood up and her feet up in a chair. I then proceeded to clock in for my shift. I went to the kitchen to start breakfast. The male DSP, [staff #4], walked down the hall with some laundry baskets. As I was setting the table, clients were waking up and coming to the kitchen. [Staff #3] was still sitting on the couch with her feet up and a hood on her head. The phone rang and I answered and it was the nurse and she told me she was on the way to the [group home] to observe a medication pass. [Staff #4] was assisting other clients with dressing. He then asked if I could assist with [client A]. As I was going down the hall, [staff #3] said she would get him so I proceeded to serve the other clients breakfast. The supervisor, [RM (Resident Manager) #1], came in the door and I told her that [client A] was not getting up for breakfast. [RM #1] went to look at him. She called me and asked what I thought? I went to his room to assess him and I said to [staff #3] to call 911. She said 'No'. I sat at the table to assist the clients with breakfast. [RM #1] and [staff #3] went back and forth about calling 911. I then took it upon myself to call 911. As I was on the phone with 911, the nurse went to assess [client A]. She said he did		follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Program Manager (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Program Manager 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 Quality Assurance Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The program Managers will provide weekly updates to the Quality Assurance Manager on the status of investigations. Failure to complete thorough investigations	

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	not look well and the nurse said for somebody to call 911 and I said I'm already on the line with them. [Staff #3] then said, '[client A] is okay. It's not that bad'. The nurse then yelled, '[staff #5], tell them to hurry." -Nurse #1's NS undated indicated, "On 10/24/15, I called the [group home] at 8:45 AM to advise them that I was on my way from another site to do an observation. At 9:15 AM, I received a call from the [RM #1] reporting that [client A] did not look well and was not responding when asked to get up and take his medication.. I told her that I was on my way and she should go ahead and call 911. I arrived at 9:30 AM and the EMS (Emergency Medical Services) was not present. [Staff #5] was sitting at the dining table assisting the other consumers while they ate breakfast. [Staff #4] and [staff #3] were coming out of [client A's] bedroom and [RM #1] met me in the dining room. [Client A] was laying crossways on his bed. His feet were on the floor. He was pale and his had face beads of sweat on it. His sheets and clothes were also wet. I leaned over and asked [client A] if he could hear me and he mumbled. He turned his head from the left to the right and looked at me when I asked. I yelled someone call 911 now! I asked [staff #4] and [staff #3] to grab my		within the allowable five business day timeframe will result in progressive corrective action to all applicable team members. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team	

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	bag and to go get [client A's] Glucometer. [Client A's] pulse was very weak, I could not obtain a blood pressure or check his oxygen level with my equipment. [Staff #4] returned with the Glucometer (and) asked [client A] if he could take his blood sugar and I grabbed [client A's] hand and instructed [staff #4] to take it now. [Client A's] sugar was 107. I continued to talk to [client A], however, he was no longer responding to my commands. He was breathing but it was shallow. I positioned myself over top of him and began rubbing his chest firmly with my fist in an attempt to get a response from him. His pupils were pinpoint and fixed. His chest was still rising and I could hear breath sounds. I yelled again and told staff to tell 911 to hurry." Nurse #1's NS undated indicated, "I remained over top of [client A] until EMS responders entered his bedroom at approximately 9:40 AM." Nurse #1's NS undated indicated, "Once [client A] was loaded into the ambulance, I was approached by the team lead and she stated that [staff #3] had told her that [client A] was incontinent of bowel movement after midnight and his clothes had to be discarded. She also stated that [client A] might have vomited, however, this was never confirmed." -RM #1's NS undated indicated, "On			

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	Saturday October, 24 (2015), I went for a pop up visit at [group home] around 8:45 AM. I opened the door, [staff #3] was sitting in the living room, her hoodie covering her head, feet up an (sic) extra chair and binders on her lap (sic). When [staff #3] saw me she put her feet down and I said good morning, she answered 'good morning ma' and I signed in the visit log. [Staff #4] was coming out of the laundry, [clients C and F] were in the living room, [client B] was sitting in (sic) the dining room table, [staff #5] was getting breakfast ready, [clients A and E] were sleeping in their room. I called [staff #3] to come to the medication room so I can do the in-service with her. She started to defense (sic) herself and said the reason I was sitting down it is (sic) just because I am so tired, [client A] had BM (Bowel Movement) all over at (sic) 3:00 AM. And I said [client A or B], because I know [client A] usually go (sic) to the bathroom and I told her (sic) did you contact the nurse... she said no, it was just BM, [RM #1]. I said but it not (sic) [client A's] attitude to [defecate] on himself... in the meantime [staff #5] was calling [staff #4] to get everybody to come have breakfast. [Staff #4] went to [client A's] room and came back asking [staff #3] to come assist because [client A] does not want to wake up. It was about 9:00 AM and [staff #3] came out of			

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	[client A's] room and said he does not want to wake up. I went myself while [staff #4] was still with him begging him to come eat... [client A] was laying in his bed, I said [client A] how are you? He said 'I am fine'. I said can you get up please, he said 'okay, I'll get up'. And I, for him refusing to get up, called [staff #5] into the room. [Staff #5] said 'This guy is dying'! I said, [staff #3] call 911. [Staff #3] said 'No, I am not going to call 911, I do not want to get in trouble. I shout (sic) loudly 'I don't care, call 911'. [Staff #5] got up, got the phone and called 911 (9:10 AM) and I called [nurse #1] (9:15 AM), she said she is on her way. And I called my supervisor. While [staff #5] was still on the phone with 911 I called [nurse #1] again she said I am pulling over [group home] (sic). [Nurse #1] threw away her purse and went to [client A's] room and shouted '[Staff #5], tell them to hurry!" RM #1's NS undated indicated, "After they left, [staff #3] start (sic) explaining to the nurse that [client A] had BM all over. [Nurse #1] said, 'Why you did not notify me (sic)?" -Staff #3's NS undated indicated, "On 10/24/15, I worked 16 hours from 12:00 AM through 4:00 PM. I clocked in and checked on everyone. [Clients B and E] had peed in their beds so I got them cleaned up and did their laundry. Some			

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	hours later, probably about 3:00 AM, I checked on [client A] and he had a BM in bed. There was BM everywhere. I got him to stand up and cleaned up the BM from the bed and the wall and gathered up his clothes. I asked him if he was okay and he said he was okay. I showered him and helped him with deodorant. He was talking and seemed fine. Did you call the nurse? No, he was fine. I didn't think it was an incident." -"The evidence substantiates that [staff #3] failed to notify a ResCare nurse when [client A] experienced an episode of diarrhea, per his CHRHP, during the overnight/early morning hours of 10/24/15. Specifically, by her own admission [staff #3] did not report an episode of fecal incontinence that occurred at approximately 3:00 AM on 10/24/15." -"The evidence substantiates that [staff #3] failed to call 911 immediately when instructed to do so by her supervisor on 10/24/15 resulting in a delay in [client A's] receiving needed emergency medical services. Specifically although she denied refusing to call 911, two witnesses testified that she did not call 911 when asked." -"The evidence does not substantiate that			

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	the team, as (a) whole, failed to recognize an acute decline in the health of [client A] in the 48 hours preceding his hospitalization on 10/24/15." The 10/31/15 IS indicated staff #5 clocked in for her shift on 10/24/15 at 8:01 AM, staff #4 clocked in for his shift on 10/24/15 at 8:02 AM and RM #1 arrived at the group home at 8:45 AM on 10/24/15. The 10/31/15 IS indicated the EMS first responders arrived at the group home at 9:40 AM. The 10/31/15 IS did not indicate documentation of a finding of fact and determination regarding staff #4, staff #5 and RM #1's failure to initiate emergency medical intervention upon verbal report of fecal incontinence and overt changes in client A's mental/physical status. The 10/31/15 IS did not indicate documentation of a date of administrator notification of the findings of the investigation. Client A's record was reviewed on 11/10/15 at 11:08 AM. Client A's CHRHP (Comprehensive High Risk Health Plan) for Hypervolemia (excessive fluid), secondary to kidney failure dated 3/25/15 indicated vomiting and diarrhea should be reported to the nurse. Client A's CHRHP for diabetes			

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	dated 3/25/15 indicated sweating should be reported to the nurse. Client A's CHRHP for diabetes dated 3/25/15 indicated, "Call 911 if 1.) [Client A] appears gravely ill or you are concerned about his immediate health; 2.) Seizure occurs; 3.) Skin in (sic) cold clammy (sweaty) and difficult to arouse." Client A's CHRHP dated 3/25/15 for congestive heart failure indicated the nurse should be notified if client A experienced difficulty breathing while laying flat. Client A's 3/25/15 CHRHP for congestive heart failure indicated, "Call 911 if 1.) [Client A] appears gravely ill or you are concerned about his immediate health; 2.) Shortness of breath; 3.) Difficulty breathing." Nurse #1 was interviewed on 11/10/15 at 2:00 PM. Nurse #1 indicated staff #3 should have notified her regarding client A's 10/24/15 incident of fecal incontinence when it occurred at 3:00 AM. Nurse #1 stated, "[Client A] was sweating. His clothing and bedding were saturated from the sweat." Nurse #1 indicated staff working with client A on 10/24/15 should have called 911 to have EMS arrive at the house before 9:40 AM. 2. IAR dated 8/4/15 indicated, "[Staff #1] was redirecting [client B] from the medication room to the living room.			

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	[Client B] was trying to get on the chair when he fell down and cut his chin on the floor." The 8/4/15 IAR indicated, "Plan of improvement/prevention/resolution (To be completed by QIDP (Qualified Intellectual Disabilities Professional): Staff have been retrained on the safety and welfare of the clients and allowing them to move about as they would like in safe conditions." -BDDS report dated 8/5/15 indicated, "[Client B] had walked from the medication room to the living room and was in the process of sitting down. He fell forward and sustained a half inch laceration on his chin. Staff performed first aid and transported him to the [hospital] ED where the wound was closed with one self-dissolving suture." The 8/5/15 BDDS report indicated, "[Client B] does not have a history of falls and a risk plan is not in place." -Investigation Final Report (IFR) dated 8/8/15 indicated the facility investigated client B's 8/4/15 fall with injury. The 8/8/15 IFR indicated staff #1, staff #2 and TL (Team Leader) #1 were present and on duty in the group home when client B fell on 8/4/15. The IFR indicated the following: -Staff #1's NS dated 8/7/15 indicated,			

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	"[Client B] was in the medication room with the other two staff, [staff #1 and TL #1], on the shift. They were passing medication for the other consumer, [client A]. They called me to come and get [client B] out of the medication room because he was disturbing them. When I get (sic) to the medication room, [client B] was sitting on a chair and I verbally redirected him to the living room. He get off from (sic) the chair and move to the living room. He was about to sit on the couch in the living room when he fell down and hit his chin on the floor." -Staff #2's NS dated 8/7/15 indicated, "I was giving [client A] his medications and [client B] kept coming in (the) medication room. [TL #1] asked [staff #1] if he can get [client B] because he kept touching things and then he set (sic) in the rolling chair and would not get up. [Staff #1] asked [client B] several times and he refused. [Staff #1] rolled him out in the chair. Maybe five or ten minutes later we heard a thud and [client B] came back in the medication room bleeding from the chin. [TL #1] called the nurse and she told her to take him to the hospital." -TL #1's NS dated 8/4/15 indicated, "I, [TL #1], was assisting [staff #2] in doing 9:00 PM (medications), when an issue			

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	occurred that required me to call the nurse for one of the consumers. As I was doing (illegible) I asked [staff #1] if he could keep and (sic) eye on [client B] until we gave him his medication. [Staff #1] proceeded to push [client B] out of the medication (room) in one of the wheeling (sic) chairs. [Staff #1] came back to the medication room about five minutes later and said [client B] had blood all over him. When I asked him what happened, [staff #1] told (me) [client B] had fallen out of chair." The 8/8/15 IFR did not indicate documentation of reconciliation of staff #2, TL #1 and staff #2's statements regarding if client B was pushed in a chair from the medication room to the living room by staff #1 and if client B fell from the rolling chair while being pushed by staff #1 or if he fell while transferring from the rolling chair to the couch. The 8/8/15 IFR did not indicate documentation of a finding of fact or determination if staff #1 was neglectful or mistreated client B by allegedly pushing client B in a rolling chair from the medication room to the living room which resulted in client B requiring medical treatment/sutures to his chin area. Client B's record was reviewed on			

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	11/10/15 at 12:52 PM. Client B's BSP (Behavior Support Plan) dated 11/22/14 indicated, "[Client B] is fully ambulatory with an average gait." Nurse #1 was interviewed on 11/10/15 at 2:00 PM. When asked if client B had a history or pattern of falls or difficulty sitting/walking, Nurse #1 stated, "No." 3. BDDS report dated 6/26/15 indicated, "Staff reported that she (unidentified) observed that [client C] fell in the bathroom when she was assisting him to have his shower. [Client C] fell on his right left (sic) side of his body. Staff quickly assisted [client C] up with the company of the two other staff on the shift. It was observed that he had few scratches on his left side of his back and also on his left thigh. Staff followed the protocol by informing the on-call nurse and the team lead, (sic) Staff was directed by the nurse to give a (sic) first aid and give a pain medication if needed." Client C's record was reviewed on 11/10/15 at 12:11 PM. Client C's Comprehensive High Risk Health Plan (CHRHP) for falls dated 6/23/15 indicated, "3. Utilize shower chair or bath bench during ADL (Activities of Daily Living) and showers/baths. Staff should assist [client C], before, during and after			

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	all showers; 4. Staff to provide at least standby assistance (arms reach) during showering...." Client C's Physician's Orders form dated 11/5/15 indicated, "Ok to use shower chair or tub bench with staff assistance." Observations were conducted at the group home on 11/9/15 from 4:15 PM through 6:15 PM and on 11/10/15 from 6:00 AM through 8:00 AM. The group home did not have a shower chair or tub bench in either of the group home's two bathrooms. RM (Resident Manager) #1 was interviewed on 11/10/15 at 2:15 PM. RM #1 indicated the group home did not have a shower chair or tub bench available for use. The review did not indicate documentation of an investigation regarding client C's 6/25/15 fall to determine if client C's CHRHP for falls was appropriately implemented by staff. AS (Administrative Staff) #1 was interviewed on 11/10/15 at 9:45 AM. AS #1 indicated the facility's abuse and neglect policy should be implemented, investigations of allegations of abuse, neglect and mistreatment should be thorough and the results of investigations			

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	of allegations of abuse, neglect or mistreatment should be reported to the administrator within 5 business days of the alleged incident. AS #1 indicated the facility had substantiated neglect regarding staff #3's failure to notify the facility nurse in a timely manner following his 10/24/15 incident of fecal incontinence at 3:00 AM. The facility's policies and procedures were reviewed on 11/10/15 at 4:26 PM. The facility's Abuse, Neglect, Exploitation and Mistreatment policy dated 2/26/11 indicated the following: - "Program Intervention Neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to implement a support plan, inappropriate application of intervention without a qualified person notification/review." -"Medical Neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide necessary medical attention, proper nutritional support or administering medications as prescribed." -"A full investigation will be conducted by Adept personnel for incident occurring residentially."			

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	The facility's Investigations policy dated 9/14/07 indicated the following: -"The primary purpose of an investigation is to describe and explain factors contributing to an incident and to prevent recurrence." -"10. A thorough investigation final report will be written at the completion of the investigation. The report shall include, but is not limited to the following: (1.) Description of the allegation or incident; (2.) Purpose of the investigation; (3.) Parties providing information; (4.) Summary of information and findings (evidence collected, witnesses interviewed, date of the investigating, name(s) of investigator(s)); (5.) Description and chronology of what happened; (6.) Analysis of the evidence; (7.) Finding of fact and determination as to whether or not the allegations are substantiated, unsubstantiated or inconclusive; (8.) Concerns and recommendations...." This federal tag relates to complaint #IN00185435. 9-3-2(a)			

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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 observation, record review and interview for 3 of 9 allegations of abuse or neglect reviewed, the facility failed to complete thorough investigations regarding three incidents of alleged neglect regarding clients A, B and C. Findings include: The facility's IARs (Incident/Accident Reports), BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/9/15 at 3:00 PM. The review indicated the following: 1. BDDS report dated 10/25/15 indicated, "When staff woke [client A], he did not respond verbally and appeared to be experiencing difficulty breathing. Staff called 911 and EMS (Emergency Medical Services) transported [client A] to the [hospital] ED (Emergency Department) via ambulance. ED staff attempted to stabilize [client A] and in the process he coded 3 times. [Client A] has been admitted to the [hospital] ICU (Intensive Care Unit) with a diagnosis of septic shock and is using a ventilator. [Client A] has late stage renal disease and high risk	W 0154	**CORRECTION:** *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically, the governing body has established a Quality Assurance Department to assist with and coordinate the investigation process. The Operations Team, comprised of the Program Manager, the Quality Assurance Manager, Quality Assurance Coordinator, Training Manager, Nurse Manager and Executive Director, and the QIDP will directly oversee all investigations. When, during the course of an investigation, additional allegations arise, the governing body will assure that a separate investigation is initiated and completed thoroughly, within required time lines. Oversight will include but not be limited to reconciling conflicting testimony and determining of staff negligence or neglect contributed to the alleged incidents and reconciliation of conflicting testimony.	12/16/2015

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	plans are in place." -BDDS report dated 10/25/15 indicated, "[Client A] was hospitalized on 10/24/15 for treatment of septic shock. While investigating the circumstances of the development of his illness, the investigator determined that [client A] may have experienced an extended period of nausea and vomiting several hours prior to the initiating of treatment for his condition and that [staff #3], who was on duty at the time, allegedly did not report the episode to the nurse on-call per protocol." -Investigative Summary (IS) dated 10/31/15 with addendum dated 11/9/15 indicated the following: -Staff #4's NS (Narrative Statement) undated indicated, "On Saturday, 10/24/15, I clocked in at exactly 8:00 AM and I was told (by the) overnight staff, [staff #3], that client A had defecated on his clothes. Immediately all his soiled clothes that I found in the laundry room were washed and dried. When it was around 9:10 AM, I went to [client A's] room to call him so that he could have his meal before going to dialysis. I called his name as usual but he didn't answer me well (sic) as he used to do. I tried to persuade him to stand from his bed but		**PREVENTION:** The investigation team, comprised of the Program Manager, Quality Assurance Manager, Quality Assurance Coordinator and QIDPs will communicate daily through the course of all investigations –reviewing gathered evidence to determine if the scope of the current investigation needs to be expanded and whether new allegations must be reported and investigated. Additionally at the conclusion of investigation, members of the Operations Team including the Executive Director, Human Resources Specialist, Program Manager, Quality Assurance Manager and Nurse Manager, will conduct a peer review meeting to review the investigation summary and gathered evidence to assure all allegations have been duly reported and investigated. When deficiencies are noted, additional investigations will be initiated as needed. A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures	

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	he couldn't. I immediately call (sic) for colleagues, [staff #5] to pass the information along to the supervisor and the nurse. The nurse came in and his blood sugar and blood pressure were taken which were normal but he was not doing well. Then we quickly called 911 and they came with their officials and took him away with the ambulance to the hospital." -Staff #5's NS undated indicated, "On Saturday morning (10/24/15), when I arrived, the female DSP (Direct Support Professional), [staff #3], was sitting on the couch with her hood up and her feet up in a chair. I then proceeded to clock in for my shift. I went to the kitchen to start breakfast. The male DSP, [staff #4], walked down the hall with some laundry baskets. As I was setting the table, clients were waking up and coming to the kitchen. [Staff #3] was still sitting on the couch with her feet up and a hood on her head. The phone rang and I answered and it was the nurse and she told me she was on the way to the [group home] to observe a medication pass. [Staff #4] was assisting other clients with dressing. He then asked if I could assist with [client A]. As I was going down the hall, [staff #3] said she would get him so I proceeded to serve the other clients breakfast. The supervisor, [RM (Resident		will be maintained and distributed daily to facility supervisors and the Operations Team. The Program Manager (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Program Manager 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 Quality Assurance Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The program Managers will provide weekly updates to the Quality Assurance Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in	

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	Manager) #1], came in the door and I told her that [client A] was not getting up for breakfast. [RM #1] went to look at him. She called me and asked what I thought? I went to his room to assess him and I said to [staff #3] to call 911. She said 'No'. I sat at the table to assist the clients with breakfast. [RM #1] and [staff #3] went back and forth about calling 911. I then took it upon myself to call 911. As I was on the phone with 911, the nurse went to assess [client A]. She said he did not look well and the nurse said for somebody to call 911 and I said I'm already on the line with them. [Staff #3] then said, '[client A] is okay. It's not that bad'. The nurse then yelled, '[staff #5], tell them to hurry." -Nurse #1's NS undated indicated, "On 10/24/15, I called the [group home] at 8:45 AM to advise them that I was on my way from another site to do an observation. At 9:15 AM, I received a call from the [RM #1] reporting that [client A] did not look well and was not responding when asked to get up and take his medication.. I told her that I was on my way and she should go ahead and call 911. I arrived at 9:30 AM and the EMS (Emergency Medical Services) was not present. [Staff #5] was sitting at the dining table assisting the other consumers while they ate breakfast. [Staff #4] and		progressive corrective action to all applicable team members. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	

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	[staff #3] were coming out of [client A's] bedroom and [RM #1] met me in the dining room. [Client A] was laying crossways on his bed. His feet were on the floor. He was pale and his face had beads of sweat on it. His sheets and clothes were also wet. I leaned over and asked [client A] if he could hear me and he mumbled. He turned his head from the left to the right and looked at me when I asked. I yelled someone call 911 now! I asked [staff #4] and [staff #3] to grab my bag and to go get [client A's] Glucometer. [Client A's] pulse was very weak, I could not obtain a blood pressure or check his oxygen level with my equipment. [Staff #4] returned with the Glucometer (and) asked [client A] if he could take his blood sugar and I grabbed [client A's] hand and instructed [staff #4] to take it now. [Client A's] sugar was 107. I continued to talk to [client A], however, he was no longer responding to my commands. He was breathing but it was shallow. I positioned myself over top of him and began rubbing his chest firmly with my fist in an attempt to get a response from him. His pupils were pinpoint and fixed. His chest was still rising and I could hear breath sounds. I yelled again and told staff to tell 911 to hurry." Nurse #1's NS undated indicated, "I remained over top of [client A] until EMS responders entered his bedroom at			

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	approximately 9:40 AM." Nurse #1's NS undated indicated, "Once [client A] was loaded into the ambulance, I was approached by the team lead and she stated that [staff #3] had told her that [client A] was incontinent of bowel movement after midnight and his clothes had to be discarded. She also stated that [client A] might have vomited, however, this was never confirmed." -RM #1's NS undated indicated, "On Saturday October, 24 (2015), I went for a pop up visit at [group home] around 8:45 AM. I opened the door, [staff #3] was sitting in the living room, her hoodie covering her head, feet up an (sic) extra chair and binders on her lap (sic). When [staff #3] saw me she put her feet down and I said good morning, she answered 'good morning ma' and I signed in the visit log. [Staff #4] was coming out of the laundry, [clients C and F] were in the living room, [client B] was sitting in (sic) the dining room table, [staff #5] was getting breakfast ready, [clients A and E] were sleeping in their room. I called [staff #3] to come to the medication room so I can do the in-service with her. She started to defense (sic) herself and said the reason I was sitting down it is (sic) just because I am so tired, [client A] had BM (Bowel Movement) all over at (sic) 3:00 AM. And I said [client A or B],			

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	because I know [client A] usually go (sic) to the bathroom and I told her (sic) did you contact the nurse... she said no, it was just BM, [RM #1]. I said but it not (sic) [client A's] attitude to [defecate] on himself... in the meantime [staff #5] was calling [staff #4] to get everybody to come have breakfast. [Staff #4] went to [client A's] room and came back asking [staff #3] to come assist because [client A] does not want to wake up. It was about 9:00 AM and [staff #3] came out of [client A's] room and said he does not want to wake up. I went myself while [staff #4] was still with him begging him to come eat... [client A] was laying in his bed, I said [client A] how are you? He said 'I am fine'. I said can you get up please, he said 'okay, I'll get up'. And I, for him refusing to get up, called [staff #5] into the room. [Staff #5] said 'This guy is dying'! I said, [staff #3] call 911. [Staff #3] said 'No, I am not going to call 911, I do not want to get in trouble. I shout (sic) loudly 'I don't care, call 911'. [Staff #5] got up, got the phone and called 911 (9:10 AM) and I called [nurse #1] (9:15 AM), she said she in on her way. And I called my supervisor. While [staff #5] was still on the phone with 911 I called [nurse #1] again she said I am pulling over [group home] (sic). [Nurse #1] threw away her purse and went to [client A's] room and shouted '[Staff #5],			

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	tell them to hurry!" RM #1's NS undated indicated, "After they left, [staff #3] start (sic) explaining to the nurse that [client A] had BM all over. [Nurse #1] said, 'Why you did not notify me (sic)?" -Staff #3's NS undated indicated, "On 10/24/15, I worked 16 hours from 12:00 AM through 4:00 PM. I clocked in and checked on everyone. [Clients B and E] had peed in their beds so I got them cleaned up and did their laundry. Some hours later, probably about 3:00 AM, I checked on [client A] and he had a BM in bed. There was BM everywhere. I got him to stand up and cleaned up the BM from the bed and the wall and gathered up his clothes. I asked him if he was okay and he said he was okay. I showered him and helped him with deodorant. He was talking and seemed fine. Did you call the nurse? No, he was fine. I didn't think it was an incident." -"The evidence substantiates that [staff #3] failed to notify a ResCare nurse when [client A] experienced an episode of diarrhea, per his CHRHP, during the overnight/early morning hours of 10/24/15. Specifically, by her own admission [staff #3] did not report an episode of fecal incontinence that occurred at approximately 3:00 AM on 10/24/15."			

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-"The evidence substantiates that [staff #3] failed to call 911 immediately when instructed to do so by her supervisor on 10/24/15 resulting in a delay in [client A's] receiving needed emergency medical services. Specifically although she denied refusing to call 911, two witnesses testified that she did not call 911 when asked."

-"The evidence does not substantiate that the team, as (a) whole, failed to recognize an acute decline in the health of [client A] in the 48 hours preceding his hospitalization on 10/24/15."

The 10/31/15 IS indicated staff #5 clocked in for her shift on 10/24/15 at 8:01 AM, staff #4 clocked in for his shift on 10/24/15 at 8:02 AM and RM #1 arrived at the group home at 8:45 AM on 10/24/15. The 10/31/15 IS indicated the EMS first responders arrived at the group home at 9:40 AM. The 10/31/15 IS did not indicate documentation of a finding of fact and determination regarding staff #4, staff #5 and RM #1's failure to initiate emergency medical intervention upon verbal report of fecal incontinence and overt changes in client A's mental/physical status.

Client A's record was reviewed on

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	11/10/15 at 11:08 AM. Client A's CHRHP (Comprehensive High Risk Health Plan) for Hypervolemia (excessive fluid), secondary to kidney failure dated 3/25/15 indicated vomiting and diarrhea should be reported to the nurse. Client A's CHRHP for diabetes dated 3/25/15 indicated sweating should be reported to the nurse. Client A's CHRHP for diabetes dated 3/25/15 indicated, "Call 911 if 1.) [Client A] appears gravely ill or you are concerned about his immediate health; 2.) Seizure occurs; 3.) Skin in (sic) cold clammy (sweaty) and difficult to arouse." Client A's CHRHP dated 3/25/15 for congestive heart failure indicated the nurse should be notified if client A experienced difficulty breathing while laying flat. Client A's 3/25/15 CHRHP for congestive heart failure indicated, "Call 911 if 1.) [Client A] appears gravely ill or you are concerned about his immediate health; 2.) Shortness of breath; 3.) Difficulty breathing." Nurse #1 was interviewed on 11/10/15 at 2:00 PM. Nurse #1 indicated staff #3 should have notified her regarding client A's 10/24/15 incident of fecal incontinence when it occurred at 3:00 AM. Nurse #1 stated, "[Client A] was sweating. His clothing and bedding were saturated from the sweat." Nurse #1			

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	indicated staff working with client A on 10/24/15 should have called 911 to have EMS arrive at the house before 9:40 AM. 2. IAR dated 8/4/15 indicated, "[Staff #1] was redirecting [client B] from the medication room to the living room. [Client B] was trying to get on the chair when he fell down and cut his chin on the floor." The 8/4/15 IAR indicated, "Plan of improvement/prevention/resolution (To be completed by QIDP (Qualified Intellectual Disabilities Professional): Staff have been retrained on the safety and welfare of the clients and allowing them to move about as they would like in safe conditions." -BDDS report dated 8/5/15 indicated, "[Client B] had walked from the medication room to the living room and was in the process of sitting down. He fell forward and sustained a half inch laceration on his chin. Staff performed first aid and transported him to the [hospital] ED where the wound was closed with one self-dissolving suture." The 8/5/15 BDDS reported indicated, "[Client B] does not have a history of falls and a risk plan is not in place." -Investigation Final Report (IFR) dated 8/8/15 indicated the facility investigated client B's 8/4/15 fall with injury. The			

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	8/8/15 IFR indicated staff #1, staff #2 and TL (Team Leader) #1 were present and on duty in the group home when client B fell on 8/4/15. The IFR indicated the following: -Staff #1's NS dated 8/7/15 indicated, "[Client B] was in the medication room with the other two staff, [staff #1 and TL #1], on the shift. They were passing medication for the other consumer, [client A]. They called me to come and get [client B] out of the medication room because he was disturbing them. When I get (sic) to the medication room, [client B] was sitting on a chair and I verbally redirected him to the living room. He get off from (sic) the chair and move to the living room. He was about to sit on the couch in the living room when he fell down and hit his chin on the floor." -Staff #2's NS dated 8/7/15 indicated, "I was giving [client A] his medications and [client B] kept coming in (the) medication room. [TL #1] asked [staff #1] if he can get [client B] because he kept touching things and then he set (sic) in the rolling chair and would not get up. [Staff #1] asked [client B] several times and he refused. [Staff #1] rolled him out in the chair. Maybe five or ten minutes later we heard a thud and [client B] came back in the medication room bleeding			

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	from the chin. [TL #1] called the nurse and she told her to take him to the hospital." -TL #1's NS dated 8/4/15 indicated, "I, [TL #1], was assisting [staff #2] in doing 9:00 PM (medications), when an issue occurred that required me to call the nurse for one of the consumers. As I was doing (illegible) I asked [staff #1] if he could keep and (sic) eye on [client B] until we gave him his medication. [Staff #1] proceeded to push [client B] out of the medication (room) in one of the wheeling chairs. [Staff #1] came back to the medication room about five minutes later and said [client B] had blood all over him. When I asked him what happened, [staff #1] told (me) [client B] had fallen out of chair." The 8/8/15 IFR did not indicate documentation of reconciliation of staff #2, TL #1 and staff #2's statements regarding if client B was pushed in a chair from the medication room to the living room by staff #1 and if client B fell from the rolling chair while being pushed by staff #1 or if he fell while transferring from the rolling chair to the couch. The 8/8/15 IFR did not indicate documentation of a finding of fact or determination if staff #1 was neglectful or mistreated client B by allegedly			

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	pushing client B in a rolling chair from the medication room to the living room which resulted in client B requiring medical treatment/sutures to his chin area. Client B's record was reviewed on 11/10/15 at 12:52 PM. Client B's BSP (Behavior Support Plan) dated 11/22/14 indicated, "[Client B] is fully ambulatory with an average gait." Nurse #1 was interviewed on 11/10/15 at 2:00 PM. When asked if client B had a history or pattern of falls or difficulty sitting/walking, Nurse #1 stated, "No." 3. BDDS report dated 6/26/15 indicated, "Staff reported that she (unidentified) observed that [client C] fell in the bathroom when she was assisting him to have his shower. [Client C] fell on his right left (sic) side of his body. Staff quickly assisted [client C] up with the company of the two other staff on the shift. It was observed that he had few scratches on his left side of his back and also on his left thigh. Staff followed the protocol by informing the on-call nurse and the team lead, (sic) Staff was directed by the nurse to give a (sic) first aid and give a pain medication if needed." Client C's record was reviewed on			

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	11/10/15 at 12:11 PM. Client C's Comprehensive High Risk Health Plan (CHRHP) for falls dated 6/23/15 indicated, "3. Utilize shower chair or bath bench during ADL (Activities of Daily Living) and showers/baths. Staff should assist [client C], before, during and after all showers; 4. Staff to provide at least standby assistance (arms reach) during showering...." Client C's Physician's Orders form dated 11/5/15 indicated, "Ok to use shower chair or tub bench with staff assistance." Observations were conducted at the group home on 11/9/15 from 4:15 PM through 6:15 PM and on 11/10/15 from 6:00 AM through 8:00 AM. The group home did not have a shower chair or tub bench in either of the group home's two bathrooms. RM (Resident Manager) #1 was interviewed on 11/10/15 at 2:15 PM. RM #1 indicated the group home did not have a shower chair or tub bench available for use. The review did not indicate documentation of an investigation regarding client C's 6/25/15 fall to determine if client C's CHRHP for falls was appropriately implemented by staff.			

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	AS (Administrative Staff) #1 was interviewed on 11/10/15 at 9:45 AM. AS #1 indicated investigations of allegations of abuse, neglect and mistreatment should be thorough. This federal tag relates to complaint #IN00185435. 9-3-2(a)			
W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 9 allegations of abuse or neglect reviewed, the facility failed to report the results of an investigation regarding alleged neglect of client A to the facility administrator within 5 business days of the incident. Findings include: The facility's IARs (Incident/Accident Reports), BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/9/15 at 3:00 PM. The review	W 0156	**CORRECTION:** *The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.* Specifically, the governing body has established a Quality Assurance Department to assist with and coordinate the investigation process, including but not limited to assuring results of investigations are reported to the administrator within five working days as required.	12/16/2015

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	indicated the following: 1. BDDS report dated 10/25/15 indicated, "When staff woke [client A], he did not respond verbally and appeared to be experiencing difficulty breathing. Staff called 911 and EMS (Emergency Medical Services) transported [client A] to the [hospital] ED (Emergency Department) via ambulance. ED staff attempted to stabilize [client A] and in the process he coded 3 times. [Client A] has been admitted to the [hospital] ICU (Intensive Care Unit) with a diagnosis of septic shock and is using a ventilator. [Client A] has late stage renal disease and high risk plans are in place." -BDDS report dated 10/25/15 indicated, "[Client A] was hospitalized on 10/24/15 for treatment of septic shock. While investigating the circumstances of the development of his illness, the investigator determined that [client A] may have experienced an extended period of nausea and vomiting several hours prior to the initiating of treatment for his condition and that [staff #3], who was on duty at the time, allegedly did not report the episode to the nurse on-call per protocol." -Investigative Summary (IS) dated 10/31/15 with addendum dated 11/9/15		**PREVENTION:** 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 Program Manager (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they indicate the date and time the administrator was notified of investigation results. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to report the results of investigations within the allowable five business day	

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	indicated the following: -"The evidence substantiates that [staff #3] failed to notify a ResCare nurse when [client A] experienced an episode of diarrhea, per his CHRHP (Comprehensive High Risk Health Plan), during the overnight/early morning hours of 10/24/15. Specifically, by her own admission [staff #3] did not report an episode of fecal incontinence that occurred at approximately 3:00 AM on 10/24/15." -"The evidence substantiates that [staff #3] failed to call 911 immediately when instructed to do so by her supervisor on 10/24/15 resulting in a delay in [client A's] receiving needed emergency medical services. Specifically although she denied refusing to call 911, two witnesses testified that she did not call 911 when asked." The 10/31/15 IS did not indicate documentation of a date of administrator notification of the findings of the investigation. AS (Administrative Staff) #1 was interviewed on 11/10/15 at 9:45 AM. AS #1 indicated the results of investigations of allegations of abuse, neglect or mistreatment should be reported to the		timeframe will result in progressive corrective action to all applicable team members. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Operations Team	

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	administrator within 5 business days of the alleged incident. This federal tag relates to complaint #IN00185435. 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 observation, record review and interview for 3 of 4 sampled clients (A, B and C), plus 2 additional clients (DC (Discharged Client) G and DC H), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients A, B and C's active treatment program by failing to monitor clients A, B and C's formal training objectives for progression/regression of skills. The QIDP failed to integrate, coordinate and monitor clients A, B, C, DC G and DC H's active treatment programs by failing to develop a discharge summary of client A, DCs G and H's developmental, behavioral, social and health needs, to ensure clients A and B	W 0159	**CORRECTION:** *Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.* Specifically, the facility has a new QIDP in place. The QIDP will complete discharge summaries for Client A, and DC Client G and DC Client H. For Clients A and B the QIDP and will be trained regarding the need to bring all elements of the interdisciplinary team including the clients themselves, to assist	12/16/2015

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	participated in the development of their ISPs (Individual Support Plans), to ensure client C had a CFA (Comprehensive Functional Assessment) completed and to ensure the facility's HRC (Human Rights Committee) reviewed, approved and monitored clients A, B and C's restrictive programs. Findings include: 1. Client A's record was reviewed on 11/10/15 at 11:08 AM. Client A's ISP dated 12/18/14 indicated client A had formal training objectives to demonstrate appropriate physical boundaries with staff, help prepare a dish for a meal, identify a side effect of his medication, identify his blood sugar level and combine coins of various denominations to equal one dollar. Client A's record did not indicate documentation of monthly tracking or quarterly review of client A's formal training objectives. 2. Client B's record was reviewed on 11/10/15 at 12:52 PM. Client B's ISP dated 11/22/14 indicated client B had formal training objectives to identify body parts, place a single bite size amount of food in his mouth, will participate in a leisure activity, allow staff to assist him with bathing, identify a quarter and place his hand a specified		with the development of individual support plans. A review of facility support documents indicated this deficient practice affected additional clients D and E. Client C's Comprehensive Functional Assessment will be completed. A review of facility support documents indicated this deficient practice did not affect any additional clients. Through review of facility documentation, the governing body has determined that in addition to Clients A – C, the facility failed to obtain Human rights Committee approval for restrictive programs for two additional clients (D and E). Specifically, the QIDP will obtain Human rights Committee Approval for all restrictive programs for all clients who reside at the facility. **PREVENTION:** The QIDP will be trained on the need to complete final Discharge Summaries of clients' developmental, behavioral, social,	

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	medication card. Client B's record did not indicate documentation of monthly tracking or quarterly review of client B's formal training objectives 3. Client C's record was reviewed on 11/10/15 at 12:11 PM. Client C's ISP dated 8/22/15 indicated client C had formal training objectives to use American Sign Language and a picture book to communicate, identify two quarters to equal fifty cents, brush his teeth, remain on task and identify a side effect of his medication. Client C's record did not indicate documentation of monthly tracking or quarterly review of client C's formal training objectives. 4. The QIDP failed to integrate, coordinate and monitor clients A, DC G and DC H's active treatment programs by failing to develop a discharge summary of client A, DCs G and H's developmental, behavioral, social and health needs. Please see W203. 5. The QIDP failed to integrate, coordinate and monitor clients A and B's active treatment programs by failing to ensure clients A and B participated in the development of their ISPs. Please see		health and nutritional status upon discharge from the facility. The QIDP will turn in copies of Discharge Summaries to the Program Manager for review and tracking. The QIDP will turn in documentation of person centered planning as it occurs but no less than quarterly to the Program Manager monthly. The Program Manager will in turn follow-up to assure that family members and guardians and the clients themselves are invited and encouraged to participate in the ISP development process. The QIDP will be retrained regarding the need to assure that all relevant assessments are completed within 30 days of admission and reviewed and updated as needed but no less than annually. The Clinical Supervisor and other members of the Operations Team will review facility support documents no less than monthly to assure appropriate re-assessment occurs as required. A new QIDP has been assigned to the facility and has initiated a process up reviewing and updating all facility support documents including but	

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	W209. 6. The QIDP failed to integrate, coordinate and monitor client C's active treatment program by failing to ensure client C had a CFA completed. Please see W259. 7. The QIDP failed to integrate, coordinate and monitor clients A, B and C's active treatment programs by failing to ensure the facility's HRC reviewed, approved and monitored clients A, B and C's restrictive programs. Please see W262. 9-3-3(a)		not limited to assessments. The QIDP will be retrained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs for all clients. The QIDP, facility nurse and Human Rights Committee liaison will each maintain copies of Human rights Committee approval forms to assure the ability to reproduce copies of HRC records for surveyors upon request. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility three times weekly for the next 30 days and twice weekly visits for an additional 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility. These administrative	

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			documentation reviews will include review of Human Rights Committee records to assure appropriate approvals have been obtained. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W 0203 Bldg. 00	483.440(b)(5)(i) ADMISSIONS, TRANSFERS, DISCHARGE At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status. Based on record review and interview for 1 of 4 sampled clients (A), plus 2 additional clients (DC (Discharged Client) G and DC H), the facility failed to develop a discharge summary of client A, DCs G and H's developmental, behavioral, social and health needs. Findings include: Interview with AS (Administrative Staff) #1 was conducted on 11/9/15 at 3:00 PM. AS #1 indicated three clients had been discharged from the group home since the last annual survey (10/3/14). AS #1 indicated client A had been discharged upon being admitted to the hospital for	W 0203	**CORRECTION:** *At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status.* Specifically, the QIDP will complete discharge summaries for Client A, and DC Client G and DC Client H. **PREVENTION:** The QIDP will be trained on the need to complete final Discharge Summaries of clients'	12/16/2015

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	longer than 15 days. AS #1 indicated client A had been admitted to the hospital on 10/24/15 and continued in the ICU (Intensive Care Unit) through the date of review. AS #1 indicated DCs G and H had been discharged to waiver homes. AS #1 did not specify the dates of DCs G and H's discharge dates. 1. Client A's record was reviewed on 11/10/15 at 11:08 AM. Client A's record indicated he had been admitted to the hospital on 10/24/15 and had not been released from the hospital through the time of review. Client A's record did not indicate documentation of a discharge summary of client A's developmental, behavioral, social or health needs. AS #1 was interviewed on 11/10/15 at 9:45 AM. AS #1 indicated he would provide discharge summaries for clients A, DCs G and H. AS #1 did not provide additional documentation of discharge summaries for clients A, DCs G or H. 9-3-4(a)		developmental, behavioral, social, health and nutritional status upon discharge from the facility. The QIDP will turn in copies of Discharge Summaries to the Program Manager for review and tracking. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W 0209 Bldg. 00	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.			

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	Based on record review and interview for 2 of 4 sampled clients (A and B), the facility failed to ensure clients A and B participated in the development of their ISPs (Individual Support Plans). Findings include: 1. Client A's record was reviewed on 11/10/15 at 11:08 AM. Client A's ISP dated 12/18/14 indicated client A was an emancipated adult with a HCR (Health Care Representative). Client A's ISP or record did not indicate documentation of client A or his HCR's signature or participation in the development of his ISP. 2. Client B's record was reviewed on 11/10/15 at 12:52 PM. Client B's ISP dated 11/22/14 indicated client B was an emancipated adult with a HCR. Client B's ISP or record did not indicate documentation of client B or his HCR's signature or participation in the development of his ISP. AS (Administrative Staff) #1 was interviewed on 11/10/15 at 9:45 AM. AS #1 indicated clients A and B should participate in the development of their ISPs. 9-3-4(a)	W 0209	**CORRECTION:** *Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.* Specifically for Clients A and B the QIDP and will be trained regarding the need to bring all elements of the interdisciplinary team including the clients themselves, to assist with the development of individual support plans. A review of facility support documents indicated this deficient practice affected additional clients D and E. **PERVENTION:** The QIDP will turn in documentation of person centered planning as it occurs but no less than quarterly to the Program Manager monthly. The Program Manager will in turn follow-up to assure that family members and guardians and the clients themselves are invited and encouraged to participate in the ISP development process. **RESPONSIBLE PARTIES:**	12/16/2015

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W 0259 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 4 sampled clients (C), the facility failed to ensure client C had a CFA (Comprehensive Functional Assessment) completed. Findings include: Client C's record was reviewed on 11/10/15 at 12:11 PM. Client C's record did not indicate documentation of a CFA. Client C's Physician's Orders dated 11/5/15 indicated client C was admitted to the facility on 3/21/06. AS (Administrative Staff) #1 was interviewed on 11/10/15 at 9:45 AM. AS #1 indicated client C's CFA should be reviewed annually. 9-3-4(a)	W 0259	QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team **CORRECTION:** At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Specifically, Client C's Comprehensive Functional Assessment will be completed. A review of facility support documents indicated this deficient practice did not affect any additional clients. **PREVENTION:** The QIDP will be retrained regarding the need to assure that all relevant assessments are completed within 30 days of admission and reviewed and updated as needed but no less than annually. The Clinical Supervisor and other members of	12/16/2015

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			the Operations Team will review facility support documents no less than monthly to assure appropriate re-assessment occurs as required. A new QIDP has been assigned to the facility and has initiated a process up reviewing and updating all facility support documents including but not limited to assessments. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
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 3 of 4 sampled clients (A, B and C), the facility's HRC (Human Rights Committee) failed to review, approve and monitor clients A, B and C's restrictive programs. Findings include: 1. Client A's record was reviewed on 11/10/15 at 11:08 AM. Client A's BSP	W 0262	**CORRECTION:** *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.* Through review of facility documentation, the governing body has determined that in	12/16/2015

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	(Behavior Support Plan) dated 12/18/14 indicated client A received Risperdal 1 milligram tablet IED (Intermittent Explosive Disorder), Lexapro 20 milligram tablet (IED/Depression) and Ativan 1 milligram (Anxiety). Client A's record did not indicate documentation of HRC review, approval or monitoring regarding client A's use of Risperdal, Lexapro or Ativan for behavior management. 2. Client B's record was reviewed on 11/10/15 at 12:52 PM. Client B's POs (Physician's Orders) dated 11/5/15 indicated client B received Diazepam 10 milligram tablet PRN (As Needed) (sedative) for pre-sedation before medical appointments and Invega 3 milligram (Impulse Control). Client B's record did not indicate documentation of HRC review, approval or monitoring regarding client B's use of Invega or Diazepam for behavior management. 3. Client C's record was reviewed on 11/10/15 at 12:11 PM. Client C's BSP dated 8/23/15 indicated client C received Lithium Carbonate 300 milligrams (aggression), Olanzapine 35 milligrams (psychosis), Seroquel 200 milligrams (aggression) and Sertraline 100 milligrams (depression). Client C's record did not indicate documentation of HRC		addition to Clients A – C, this deficient practice affected two additional clients (D and E). Specifically, the QIDP will obtain Human rights Committee Approval for all restrictive programs for all clients who reside at the facility. **PREVENTION:** The QIDP will be retrained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs for all clients. The QIDP, facility nurse and Human Rights Committee liaison will each maintain copies of Human rights Committee approval forms to assure the ability to reproduce copies of HRC records for surveyors upon request. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility three times weekly for the next 30 days and twice weekly	

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	review, approval or monitoring regarding client C's use of Lithium Carbonate, Olanzapine, Seroquel, or Sertraline for behavior management. AS (Administrative Staff) #1 was interviewed on 11/10/15 at 9:45 AM. AS indicated the HRC should review, approve and monitor clients A, B and C's use of psychotropic medications used for behavior management. 9-3-4(a)		visits for an additional 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include review of Human Rights Committee records to assure appropriate approvals have been obtained. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W 0318 Bldg. 00	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Health Care Services for 3 of 4 sampled clients (A, B and C). The facility health care services failed to ensure client A had an annual physical completed and ensure client C's vision was assessed annually, to ensure clients B and C received annual TB (Tuberculosis) testing, x-ray or symptom screenings, to develop and implement a care plan or	W 0318	**CORRECTION:** *The facility must ensure that specific health care services requirements are met.* Specifically: A record review located a current annual physical for Client A that was not reproduced for the	12/16/2015

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	high risk health plan to address client A's recurring skin infections, to ensure client C's laboratory monitoring orders were implemented and to ensure client A was evaluated for dental health needs. Findings include: 1. The facility health care services failed to ensure client A had an annual physical completed. Please see W322. 2. The facility health care services failed to ensure client C's vision was assessed annually. Please see W323. 3. The facility health care services failed to ensure clients B and C received annual TB testing, x-ray or symptom screenings. Please see W327. 4. The facility health care services failed to develop and implement a care plan or high risk health plan to address client A's recurring skin infections. The facility nursing services failed to ensure client C's laboratory monitoring orders were implemented. Please see W331. 5. The facility health care services failed to ensure client A was evaluated for dental health needs. Please see W356. This federal tag relates to complaint		surveyors. A review of medical records indicated this deficient practice did not affect any additional clients. The facility will obtain current visual assessment for Client C. A review of medical records indicated this deficient practice did not affect any additional clients. The team will assist Clients B and C with obtaining tuberculosis screens. A review of facility medical records indicated this deficient practice did not affect any additional clients. The facility nurse will assure Client C receives all currently recommended lab work and that ongoing labs are drawn as ordered. Although Client A no longer lives in the facility, he facility nurse will be trained regarding the need to develop additional high risk plans for clients as their medical needs change. A review of current diagnostic information and risk plans indicated this deficient practice did not affect additional clients.	

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	#IN00185435. 9-3-6(a)		Client A no longer resides in the facility and an audit conducted by the Operations Team determined that all other clients in the facility had current dental examinations. **PREVENTION:** The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to physical evaluations, visual and dental examinations occur within required time frames. Members of the Operations Team (including the Quality Assurance Manager, Program Managers, Nurse Manager, Quality Assurance Coordinator, Training Manager and Executive Director) will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure that examinations including but not limited to physical evaluations take place as required. The Health Services Team will work with The Residential Manager, QIDP and facility	

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			Medical coach to assure that all relevant assessments, including but not limited to visual examinations, are completed for clients within 30 days of admission and as needed but no less than annually thereafter. Members of the Operations Team will follow up with the QIDP no less twice weekly when new clients are admitted to the facility to assure appropriate assessment occurs as required. Prior to admitting new clients, the Program Manager will assist the QIDP with developing a schedule to assure that all necessary assessments occur. Additionally, members of the Operations Team will review medical records no less than monthly to assure all required assessments and follow-up occur as required. The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine appointments and lab tests to assure they occur as recommended. Additionally, the Operations Team will review medical documentation weekly for the next 30 days and twice monthly for the next 60 days to assure labs and appointments occur as recommended and make recommendations to the Health Services Team as appropriate.	

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			After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. Additionally the facility nurse will complete a screen for tuberculosis symptoms as part of routine quarterly nursing physical examinations. The QIDP will assure that the nursing team is included in all discussions/decisions relevant to clients' health and safety and modifications will be made to Comprehensive High Risk Plans accordingly. The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans. The Nurse Manager will review all facility risk plan modifications for the next 90 days to assure they contain appropriate detail, and will conduct periodic audits of facility risk plans on an ongoing basis. Members of the Operations Team will incorporate audits of medical	

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			documents into visits to the facility weekly for the next 30 days and twice monthly for the next 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include review of healthcare records and incident and medical appointment documentation to assure appropriate risk plans and nursing supports are in place. **RESPONSIBLE PARTIES:** QIDP, Health Services Team, Operations Team	
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 1 of 4 sampled clients (A), the facility nursing services failed to ensure client A had an annual physical completed. Findings include: Client A's record was reviewed on 11/10/15 at 11:08 AM. Client A's record did not indicate documentation of an	W 0322	**CORRECTION:** The facility must provide or obtain preventive and general medical care. Specifically, a record review located a current annual physical for Client A that was not reproduced for the surveyors. A review of medical records indicated this deficient practice did not affect any	12/16/2015

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	annual physical examination. Nurse #1 was interviewed on 11/10/15 at 2:00 PM. Nurse #1 indicated client A should have an annual physical examination. Nurse #1 indicated she would attempt to locate documentation of client A's annual physical. Nurse #1 did not provide additional documentation regarding client A's physical. 9-3-6(a)		additional clients. **PREVENTION:** The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to physical evaluations, occur within required time frames. Members of the Operations Team (including the Quality Assurance Manager, Program Managers, Nurse Manager, Quality Assurance Coordinator, Training Manager and Executive Director) will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure that examinations including but not limited to physical evaluations take place as required. **RESPONSIBLE PARTIES:** Health Services Team, QIDP, Residential Manager, Team Leader, Direct Support Staff, 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			

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	minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 4 sampled clients (C), the facility nursing services failed to ensure client C's vision was assessed annually. Findings include: Client C's record was reviewed on 11/10/15 at 12:11 PM. Client C's visual care progress note dated 8/23/13 indicated client C should return in 2 years for a follow up examination. Client C's record did not indicate documentation of additional vision examinations since the 8/23/13 exam. Nurse #1 was interviewed on 11/10/15 at 2:00 PM. Nurse #1 indicated client C's 8/23/13 vision care recommendations should be followed. Nurse #1 indicated she would attempt to locate documentation of client C's vision examination. Nurse #1 did not provide additional documentation regarding client C's recommended vision examination. 9-3-6(a)	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, the facility will obtain current visual assessment for Client C. A review of medical records indicated this deficient practice did not affect any additional clients. **PREVENTION:** The Health Services Team will work with The Residential Manager, QIDP and facility Medical coach to assure that all relevant assessments, including but not limited to visual examinations, are completed for clients within 30 days of admission and as needed but no less than annually thereafter. Members of the Operations Team (including the Quality Assurance Manager, Program Managers, Nurse Manager, Quality Assurance Coordinator, Training Manager and Executive Director) will follow up with the QIDP no less twice weekly when new clients are admitted to the facility	12/16/2015

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			to assure appropriate assessment occurs as required. Prior to admitting new clients, the Program Manager will assist the QIDP with developing a schedule to assure that all necessary assessments occur. Additionally, members of the Operations Team will review medical records no less than monthly to assure all required assessments and follow-up occur as required. **RESPONSIBLE PARTIES:** Health Services Team, QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W 0327 Bldg. 00	483.460(a)(3)(iv) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. 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 annual TB (Tuberculosis) testing, x-ray or symptom screenings. Findings include:	W 0327	**CORRECTION:** *The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate*	12/16/2015

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	1. Client B's record was reviewed on 11/10/15 at 11:08 AM. Client B's TB testing form dated 10/6/14 indicated client B had his TB test completed on 10/6/14. Client B's record did not indicate additional documentation of annual TB testing, x-ray or symptom screening since 10/6/14. 2. Client C's record was reviewed on 11/10/15 at 12:11 PM. Client C's TB testing form dated 8/11/14 indicated client C had his TB test completed on 8/11/14. Client C's record did not indicate additional documentation of annual TB testing, x-ray or symptom screening since 8/11/14. Nurse #1 was interviewed on 11/10/15 at 2:00 PM. Nurse #1 indicated clients B and C should have annual TB testing completed. 9-3-6(a)		*to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both.* Specifically, the team will assist Clients B and C with obtaining tuberculosis screens. A review of facility medical records indicated this deficient practice did not affect any additional clients. **PREVENTION:** The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine appointments and lab tests to assure they occur as recommended. Additionally, the Operations Team (including the Quality Assurance Manager, Program Managers, Nurse Manager, Quality Assurance Coordinator, Training Manager and Executive Director) will review medical documentation weekly for the next 30 days and twice monthly for the next 60 days to assure labs and appointments occur as recommended and make recommendations to the Health Services Team as appropriate. After three months the	

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			administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. Additionally the facility nurse will complete a screen for tuberculosis symptoms as part of routine quarterly nursing physical examinations. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team	
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 2 of 4 sampled clients (A and C), the facility nursing services failed to develop and implement a care plan or high risk health plan to address client A's recurring skin infections. The facility nursing services failed to ensure client C's laboratory monitoring orders were implemented. Findings include: 1. The facility's IARs (Incident/Accident	W 0331	**CORRECTION:** *The facility must provide clients with nursing services in accordance with their needs.* Specifically: The facility nurse will be retrained regarding the need to develop risk plans for all relevant medical conditions. Specifically, the facility nurse will assure Client C receives all currently recommended lab work and that ongoing labs are drawn as ordered. Although Client A no longer lives in the facility, he	12/16/2015

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	15G449	A. BUILDING 00 B. WING	11/16/2015

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	Reports), BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/9/15 at 3:00 PM. The review indicated the following: -BDDS report dated 6/6/15 indicated, "[Client A] was taken to [medical clinic] after workshop called and made house staff aware that he was crying and complaining of pain in his left arm were (sic) his dialysis (sic) port is located. Staff took [client A] to [medical clinic] fist (sic) and then were told to transport him to [hospital] ER (Emergency Room). The diagnosis was cellulitis of the skin and they prescribed antibiotics and said to follow up with his primary care doctor next week. [Client A] will see his primary care doctor June 15, 2015 at 9:30 AM. Staff will continue to provide emotional and physical support to [client A] and give medication to resolve (the) infection of his left arm as prescribed and as scheduled daily until finished. Staff will also become more aware of his dialysis (sic) port daily to ensure that an infection doesn't reoccur." -BDDS report dated 9/30/15 indicated, "[Client A] was released from the hospital where he had been treated to (sic) a bacterial infection at the site of his Arteriovenous fistula (dialysis port) on		facility nurse will be trained regarding the need to develop additional high risk plans for clients as their medical needs change. A review of current diagnostic information and risk plans indicated this deficient practice did not affect additional clients. **PERVENTION:** The QIDP will assure that the nursing team is included in all discussions/decisions relevant to clients' health and safety and modifications will be made to Comprehensive High Risk Plans accordingly. The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team (including the Quality Assurance Manager, Program Managers, Nurse Manager, Quality Assurance Coordinator, Training Manager and Executive Director) weekly to discuss health and safety issues including but not limited to needed updates to risk plans. The Nurse Manager will review all facility risk plan modifications for the next 90 days to assure they contain appropriate detail, and will conduct periodic audits of facility risk plans on an ongoing basis.	

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	9/24/15 (previously reported incident). On 9/29/15, [client A] experienced nausea and vomiting while eating lunch and the ResCare nurse advised staff to transport him to the [hospital] ED (Emergency Department) for evaluation. After initial tests, he was admitted to the hospital for observation and treatment of an unspecified viral infection." BDDS report dated 10/25/15 indicated, "When staff woke [client A], he did not respond verbally and appeared to be experiencing difficulty breathing. Staff called 911 and EMS (Emergency Medical Services) transported [client A] to the [hospital] ED via ambulance. ED staff attempted to stabilize [client A] and in the process he coded 3 times. [Client A] has been admitted to the [hospital] ICU (Intensive Care Unit) with a diagnosis of septic shock and is using a ventilator. [Client A] has late stage renal disease and high risk plans are in place." -BDDS report dated 10/25/15 indicated, "[Client A] was hospitalized on 10/24/15 for treatment of septic shock. While investigating the circumstances of the development of his illness, the investigator determined that [client A] may have experienced an extended period of nausea and vomiting several hours prior to the initiating of treatment for his		Members of the Operations Team will incorporate audits of support documents into visits to the facility weekly for the next 30 days and twice monthly for the next 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include review of healthcare records and incident and medical appointment documentation to assure appropriate risk plans and nursing supports are in place. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team	

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	condition and that [staff #3], who was on duty at the time, allegedly did not report the episode to the nurse on-call per protocol." Client A's record was reviewed on 11/10/15 at 11:08 AM. Client A's ER hospital forms dated 1/2/15 indicated client was evaluated and admitted to the hospital on 1/2/15 and diagnosed with Sepsis. Client A's Direct Support Team Communication Notes dated 10/7/15 indicated, "Please apply Bacitracin ointment (anti-septic) to [client A's] wrist after showers." Client A's Physician's Orders form dated 10/1/15 indicated client A's skin should be monitored weekly. Client A's record did not indicate documentation specifically addressing how staff should monitor client A's dialysis port, for sepsis and for viral and/or recurring skin infections. Nurse #1 was interviewed on 11/10/15 at 2:00 PM. Nurse #1 indicated client A did not have a specific risk plan identifying signs/symptoms related to recurring skin infections and viral infections regarding client A's dialysis port. Nurse #1 indicated client A's arm was covered with a clear plastic wrap with the port and surrounding area visible. 2. Client C's record was reviewed on			

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	11/10/15 at 12:11 PM. Client C's Physician's Orders form dated 11/5/15 indicated client C should have his CBC (Complete Blood Count) monitored every 2 months. Client C's record indicated client C had his CBC tested on 2/15 and 7/15. Client C's record did not indicate documentation of CBC laboratory testing every 2 months. Nurse #1 was interviewed on 11/10/15 at 2:00 PM. Nurse #1 indicated client C's laboratory orders should be implemented. This federal tag relates to complaint #IN00185435. 9-3-6(a)			
W 0356 Bldg. 00	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Based on record review and interview for 1 of 4 sampled clients (A), the facility nursing services failed to ensure client A was evaluated for dental health needs. Findings include:	W 0356	**CORRECTION:** *The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental*	12/16/2015

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	Client A's record was reviewed on 11/10/15 at 11:08 AM. Client A's record did not indicate documentation of a dental examination/assessment. Nurse #1 was interviewed on 11/10/15 at 2:00 PM. Nurse #1 indicated client A should have routine dental examinations/assessment for the maintenance of his dental health. 9-3-6(a)		*health.* Specifically, Client A no longer resides in the facility and an audit conducted by the Operations Team determined that this deficient practice did not affect additional clients **PREVENTION:** The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine dental appointments and follow-ups to assure they occur as recommended. Members of the Operations Team (including the Quality Assurance Manager, Program Managers, Nurse Manager, Quality Assurance Coordinator, Training Manager and Executive Director) will review medical documentation weekly for the next 30 days and twice monthly for the next 60 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. This administrative support will include review of medical documentation to arrange for appropriate follow-up as needed. **RESPONSIBLE**	

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			PARTIES: QIDP, Residential Manager, Team Lead, Direct Support Staff, Health Services Team, Operations Team	