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	01/12/2018

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

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W 0000 Bldg. 00	This visit was for a pre-determined full annual recertification and state licensure survey. This visit was done in conjunction with the PCR (Post Certification Revisit) to the investigation of complaint #IN00244442 completed on 11/17/17. Dates of Survey: 1/8/18, 1/9/18, 1/10/18, 1/11/18 and 1/12/18. Facility Number: 000963 Provider Number: 15G449 AIMS Number: 100244740 These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/25/18.	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. Based on observation, record review and interview, the facility failed to meet the	W 0102	**CORRECTION:** *The facility must ensure that*	02/07/2018

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

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	Condition of Participation: Governing Body for 3 of 3 sampled clients (A, B and C), plus 3 additional clients (D, E and F). The governing body failed to provide general policy, budget and operating direction over the facility to ensure the Operations Team systemically implemented the facility's Plan of Correction, to ensure client E's record contained his medical and health care documentation, to ensure clients A, B, C, D and F's personal rights to retain and use their personal belongings were protected regarding client E's behavior, to ensure clients A, B and C's personal finances were accounted for, to ensure the facility implemented its written policy and procedures to ensure an injury of unknown origin was immediately reported to the facility administrator regarding client A. The governing body failed to implement its written policy and procedures to prevent abuse and develop and implement effective corrective measures to address client E's ongoing verbal and physically aggressive behaviors (yelling, threats, biting, head butting and attempts at biting and head butting, theft/attempted theft of clients personal belongings) and verbal and physical disruption (jumping, screaming and entering other clients rooms during overnight hours to attempt to fight clients or steal their personal		*specific governing body and management requirements are met.* Specifically: The interdisciplinary team has assembled a comprehensive medical record for client E. A review of facility documentation indicated that this deficient practice did not affect other clients. All staff have been trained on expectations for one to one observation of Client E, including but not limited to preventing client E from accessing his housemate's belongings. The Residential Manager will assure one to one staffing is scheduled on all shifts and will provide the Program Manager and Operations Manager with a one to one specific schedule detailing who will be on duty to handle one to one responsibilities. Supervisory staff from in and outside of the facility will fill any gaps in coverage. Additionally, the interdisciplinary team has assisted Client A with placing a lock on his door. Fill-in staff will receive client specific training for all clients prior to working at the facility.	

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	belongings) in the home creating an emotionally intimidating and hostile environment (an environment that is difficult or uncomfortable) for clients B, C, D and F, to ensure an injury of unknown origin was immediately reported to the facility administrator, to ensure the facility developed and implemented effective corrective measures to address client E's ongoing verbal and physically aggressive behaviors (yelling, threats, biting, head butting and attempts at biting and head butting, theft/attempted theft of clients personal belongings) and verbal and physical disruption (jumping, screaming and entering other clients rooms during overnight hours to attempt to fight clients or steal their personal belongings) in the home creating an emotionally intimidating and hostile environment (an environment that is difficult or uncomfortable) for clients A, B, C, D and F, to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored clients A, B, C, D, E and F's active treatment programs by failing to provide sufficient direct care staff to implement client E's active treatment program and to manage his nighttime disruptive behaviors or implement his 1:1 staff to client ratio supervision as described in his BSP (Behavior Support Plan) and to ensure the agency owned and operated day		Personal financial ledgers for all clients will be updated by the Residential Manager and reviewed by the Area Supervisor and certified as accurate per facility protocol. The Residential Manager will receive detailed training and will maintain an up to date ledger to track purchases for all clients. All staff will assure that clients provide receipts for purchases as appropriate and the Residential Manager will maintain copies of receipts for purchases recorded on the ledgers. All facility supervisory and direct support staff will be retrained to report suspected abuse, neglect, mistreatment and exploitation, -including but not limited to injuries of undetermined origin. All staff have been trained on expectations for one to one observation of Client E, including but not limited to preventing client E from engaging in aggressive behavior including yelling, threats, biting, head butting and attempts at biting, head butting and accessing his housemate's belongings. The house manager will assure one to one staffing is scheduled on all shifts and will provide the Operations Manager	

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	service provider for clients A, B, C, D, E and F had current copies of their ISPs (Individual Support Plans), BSPs (Behavior Support Plans) or current HRHPs (High Risk Health Plans), to provide sufficient direct care staff to implement client E's active treatment program and to manage his nighttime disruptive behaviors or implement his 1:1 staff to client ratio supervision as described in his BSP (Behavior Support Plan), to ensure the agency owned and operated day service provider for clients A, B, C, D, E and F had current copies of their ISPs (Individual Support Plans). BSPs (Behavior Support Plans) or current HRHPs (High Risk Health Plans), to ensure client E participated in his day service's active treatment program, to ensure client D had an annual physical examination, to ensure clients A, B, C, D and E had routine and recommended vision assessments and services, to monitor and proactively address client E's chronic insomnia and day time lethargy, to ensure staff working with clients A, B, C, D, E and F were trained regarding their individual High Risk Health Plans, to ensure clients A, B, D, E and F's dental recommendations were implemented and clients received routine dental examinations, to ensure staff administered client E's medication without error and to conduct quarterly evacuation drills for each shift of		with a one to one specific schedule detailing who will be on duty to handle one to one responsibilities. Supervisory staff from in and outside of the facility will fill any gaps in coverage. Additionally, the interdisciplinary team has assisted Client A with placing a lock on his door. Fill-in staff will receive client specific training for all clients prior to working at the facility, including but not limited to client E's enhanced supervision protocols. The governing body has directed the facility to modify the staffing matrix to assure client E has one to one staffing while awake, including on the overnight shift when direct support personnel are unavailable to provide coverage as described above, salaried supervisory staff will fill in, providing direct support as needed. Staff assigned to work with client E have been trained on active treatment expectations, per client E's plan. The facility's contracted day service provider has received current copies of all clients' current Individual Support Plans and Behavior Support Plans.	

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	personnel for clients A, B, C, D, E and F. 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 3 sampled clients (A, B and C), plus 3 additional clients (D, E and F). The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Facility Staffing for 3 of 3 sampled clients (A, B and C), plus 3 additional clients (D, E and F). 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 3 sampled clients (A, B and C), plus 3 additional clients (D, E and F). Findings include: 1. The governing body failed to provide general policy, budget and operating direction over the facility to ensure the Operations Team systemically implemented		The facility is providing sufficient staff to assure client E may attend day service. Through observation the governing body has determined that this deficient practice did not affect other individuals. Client D has received a physical examination from his primary care physician. Through a review of facility medical records, the governing body has determined that all clients who reside in the facility have current annual physical examinations. All clients who reside in the facility have received current vision assessments. The interdisciplinary team has developed a comprehensive high risk plan to monitor and address client E's insomnia. All staff will be trained on implementation of the plan. Additionally, client E has an appointment with his new attending psychiatrist on 2/5/18 to review his current psychotropic medication regime to determine if adverse interactions could be impacting client E's ability to sleep	

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	the facility's Plan of Correction, to ensure client E's record contained his medical and health care documentation, to ensure clients A, B, C, D and F's personal rights to retain and use their personal belongings were protected regarding client E's behavior, to ensure clients A, B and C's personal finances were accounted for, to ensure the facility implemented its written policy and procedures to ensure an injury of unknown origin was immediately reported to the facility administrator regarding client A. The governing body failed to implement its written policy and procedures to prevent abuse and develop and implement effective corrective measures to address client E's ongoing verbal and physically aggressive behaviors (yelling, threats, biting, head butting and attempts at biting and head butting, theft/attempted theft of clients personal belongings) and verbal and physical disruption (jumping, screaming and entering other clients rooms during overnight hours to attempt to fight clients or steal their personal belongings) in the home creating an emotionally intimidating and hostile environment (an environment that is difficult or uncomfortable) for clients B, C, D and F, to ensure an injury of unknown origin was immediately reported to the facility administrator, to ensure the facility developed and implemented effective		through the night consistently. All facility staff have been retrained on implementation of high risk plans and the plans are stored in a manner to provide staff with easy access to review when needed. The team has scheduled comprehensive dental examinations for all clients who reside at the facility at the earliest available appointments. All facility staff have been retrained to on proper measurement of liquid medication, prior to administration. Although this deficient practice did not affect additional clients, the facility nurse will review agency medication and treatment administration protocols with all staff. The facility has conducted additional evacuation drills on each shift during the current quarter. **Root Cause Analysis of why**	

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	corrective measures to address client E's ongoing verbal and physically aggressive behaviors (yelling, threats, biting, head butting and attempts at biting and head butting, theft/attempted theft of clients personal belongings) and verbal and physical disruption (jumping, screaming and entering other clients rooms during overnight hours to attempt to fight clients or steal their personal belongings) in the home creating an emotionally intimidating and hostile environment (an environment that is difficult or uncomfortable) for clients A, B, C, D and F, to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored clients A, B, C, D, E and F's active treatment programs by failing to provide sufficient direct care staff to implement client E's active treatment program and to manage his nighttime disruptive behaviors or implement his 1:1 staff to client ratio supervision as described in his BSP (Behavior Support Plan) and to ensure the agency owned and operated day service provider for clients A, B, C, D, E and F had current copies of their ISPs (Individual Support Plans), BSPs (Behavior Support Plans) or current HRHPs (High Risk Health Plans), to provide sufficient direct care staff to implement client E's active treatment program and to manage his nighttime disruptive behaviors or implement		**corrections implemented after the 11/17/17 survey have failed.** ·The governing body failed to assure appropriate staffing was in place in the home to support a recently admitted aggressive client with adjusting to his new environment. ·The governing body failed to properly prepare administrative monitors to provide appropriate oversight and guidance to facility staff. ·The governing body failed to provide sufficient oversight to facility nursing staff. **PERVENTION:** The Facility Nurse and QIDP have been retrained on the need to assemble a comprehensive medical record at the time clients are admitted and to update the record as assessments are completed. When new clients are admitted to the facility, the Nurse Manager and QIDP manager will conduct weekly document reviews to assure records are assembled as required. Supervisory staff will review all facility documentation to assure	

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	his 1:1 staff to client ratio supervision as described in his BSP (Behavior Support Plan), to ensure the agency owned and operated day service provider for clients A, B, C, D, E and F had current copies of their ISPs (Individual Support Plans). BSPs (Behavior Support Plans) or current HRHPs (High Risk Health Plans), to ensure client E participated in his day service's active treatment program, to ensure client D had an annual physical examination, to ensure clients A, B, C, D and E had routine and recommended vision assessments and services, to monitor and proactively address client E's chronic insomnia and day time lethargy, to ensure staff working with clients A, B, C, D, E and F were trained regarding their individual High Risk Health Plans, to ensure clients A, B, D, E and F's dental recommendations were implemented and clients received routine dental examinations, to ensure staff administered client E's medication without error and to conduct quarterly evacuation drills for each shift of personnel for clients A, B, C, D, E and F. 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 3 sampled clients		incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to the administrator. The QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to accurately report allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, the governing body will administer written corrective action up to and including termination of employment. When incidents occur, The QIDP Manager will guide the QIDP through the investigation and corrective measure implementation process, providing follow-up as needed but no less than daily. Additionally, the Quality Assurance Manager and QIDP Manager will follow-up with administrative level program staff (Program Manager and Operations Manager)	

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	(A, B and C), plus 3 additional clients (D, E and F). Please see W122. 3. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Facility Staffing for 3 of 3 sampled clients (A, B and C), plus 3 additional clients (D, E and F). Please see W158. 4. 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 3 sampled clients (A, B and C), plus 3 additional clients (D, E and F). Please see W318. 9-3-1(a)		The QIDP has been retrained on the need to provide current support documents to day service providers and families to assure continuity in each client's active treatment program. Members of the Operations Team comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, and Nurse Manager) will review Day service observation checklists, document receipts and e-mail properties to assure day service staff and families have been provided with copies of current support documents. The Residential Manager and Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. Professional staff will be retrained regarding the need to conduct evacuation drills on each shift for all staff each quarter. The Operations Team will review all facility evacuation drill reports and follow up with professional staff as needed to assure drills occur as scheduled. Program Manager will track evacuation drill compliance and follow up with facility professional staff and the agency	

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			Safety Committee accordingly. The nurse formerly assigned to the facility has been placed on administrative leave pending a full review of her work product to determine necessary corrective measures and appropriate performance action, and a new nurse has been assigned to the facility. The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to physical examinations occur no less than annually. The QIDP will work with the facility nurse will coordinate training with the facility direct support medical coach and Residential Manager to assure that all medical assessments and evaluations occur as required. The QIDP will coordinate with the facility nurse and facility direct support staff and supervisors to facilitate ongoing training toward competency in implementation of	

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			high risk plans. The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to including but not limited to proper implementation of behavior supports and high risk plans, as well as assuring sufficient staff are present, filling in gaps in staffing as needed. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger and Registered Nurse) will review facility support documents and perform visual assessments of the facility no less than daily for the next 30 days, and after 30 days, will conduct administrative observations no less than three times weekly until all staff demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional	

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			Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight	

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			shift no less than twice monthly –more frequently if training issues or problems are discovered. Administrative support at the home will include: ·Assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring adequate direct support staff are on duty to meet the needs of all clients. ·Assuring a complete and accurate accounting of client finances is present. ·Assuring corrective measures are developed after substantiated incidents and implemented effectively. ·Assuring client E attends day programming with appropriate staffing in place. ·Assuring that routine medical assessments, including but not limited to annual physical and visual examinations, occur as required. ·Assuring that routine dental evaluations and recommended dental follow-up occur as required. ·Assuring Medications are administered without error. ·Assuring evacuation drills occur as required.	

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			Preventative measures to be implemented based on Root Cause Analysis of why corrections implemented after the 11/17/17 survey have failed. The Residential Manager has been directed to provide the Program Manager and Operations Manager with copies of a specific schedule listing client E's assigned one to one staff. The Operations Manager will review all requests for staffing reductions, with emphasis on safety considerations, prior to approving implementation. The Quality Assurance Manager and QIDP Manager or other designated Quality Assurance staff will perform spot checks of attendance records to assure ongoing compliance. If deficiencies are noted, the QA staff will notify the Program Manager, Operations Manager and Executive Director to assure prompt corrective action. Prior to each schedule period, the Operations Team will follow-up verbally and via email to assure that appropriate coverage has been arranged.	

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			Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: ·The role of the administrative monitor is not simply to observe & Report. ·When opportunities for training are observed, the monitor must step in and provide the training and document it. ·If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. ·Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training as needed. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Additional Preventative Healthcare	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			Services Measures: 1.Nursing caseloads have been reduced to 3-4 SGL homes per nurse. 2.The Nurse Manager will no longer be responsible for a caseload. 3.The Nurse Manager will do side by side audits of SGL home with the assigned nurse weekly. 4.Copies of Nurse Manager Audits will be provided to the Executive Director and Regional Director (Area Manager) for review. 5.The Executive Director and Regional Director will meet with the Nurse Manager weekly to review concerns raised through audits, incident reports or other concerns brought to management attention. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director	
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 3 sampled clients (A, B	W 0104	The interdisciplinary team has assembled a comprehensive medical record for client E. A	02/07/2018

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	and C), plus 3 additional clients (D, E and F), the governing body failed to provide general policy, budget and operating direction over the facility to ensure the Operations Team systemically implemented the facility's Plan of Correction, to ensure client E's record contained his medical and health care documentation, to ensure clients A, B, C, D and F's personal rights to retain and use their personal belongings were protected regarding client E's behavior, to ensure clients A, B and C's personal finances were accounted for, to ensure the facility implemented its written policy and procedures to ensure an injury of unknown origin was immediately reported to the facility administrator regarding client A. The governing body failed to implement its written policy and procedures to prevent abuse and develop and implement effective corrective measures to address client E's ongoing verbal and physically aggressive behaviors (yelling, threats, biting, head butting and attempts at biting and head butting, theft/attempted theft of clients personal belongings) and verbal and physical disruption (jumping, screaming and entering other clients rooms during overnight hours to attempt to fight clients or steal their personal belongings) in the home creating an emotionally intimidating and hostile environment (an environment that is difficult		review of facility documentation indicated that this deficient practice did not affect other clients. All staff have been trained on expectations for one to one observation of Client E, including but not limited to preventing client E from accessing his housemate's belongings. The Residential Manager will assure one to one staffing is scheduled on all shifts and will provide the Program Manager and Operations Manager with a one to one specific schedule detailing who will be on duty to handle one to one responsibilities. Supervisory staff from in and outside of the facility will fill any gaps in coverage. Additionally, the interdisciplinary team has assisted Client A with placing a lock on his door. Fill-in staff will receive client specific training for all clients prior to working at the facility. Personal financial ledgers for all clients will be updated by the Residential Manager and reviewed by the Area Supervisor and certified as accurate per facility protocol. The Residential Manager will receive detailed training and will maintain an up to date ledger to track purchases for all clients.	

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	or uncomfortable) for clients B, C, D and F, to ensure an injury of unknown origin was immediately reported to the facility administrator, to ensure the facility developed and implemented effective corrective measures to address client E's ongoing verbal and physically aggressive behaviors (yelling, threats, biting, head butting and attempts at biting and head butting, theft/attempted theft of clients personal belongings) and verbal and physical disruption (jumping, screaming and entering other clients rooms during overnight hours to attempt to fight clients or steal their personal belongings) in the home creating an emotionally intimidating and hostile environment (an environment that is difficult or uncomfortable) for clients A, B, C, D and F, to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored clients A, B, C, D, E and F's active treatment programs by failing to provide sufficient direct care staff to implement client E's active treatment program and to manage his nighttime disruptive behaviors or implement his 1:1 staff to client ratio supervision as described in his BSP (Behavior Support Plan) and to ensure the agency owned and operated day service provider for clients A, B, C, D, E and F had current copies of their ISPs (Individual Support Plans), BSPs (Behavior		All staff will assure that clients provide receipts for purchases as appropriate and the Residential Manager will maintain copies of receipts for purchases recorded on the ledgers. All facility supervisory and direct support staff will be retrained to report suspected abuse, neglect, mistreatment and exploitation, -including but not limited to injuries of undetermined origin. All staff have been trained on expectations for one to one observation of Client E, including but not limited to preventing client E from engaging in aggressive behavior including yelling, threats, biting, head butting and attempts at biting, head butting and accessing his housemate's belongings. The house manager will assure one to one staffing is scheduled on all shifts and will provide the Operations Manager with a one to one specific schedule detailing who will be on duty to handle one to one responsibilities. Supervisory staff from in and outside of the facility will fill any gaps in coverage. Additionally, the interdisciplinary team has assisted Client A with placing a lock on his door. Fill-in staff will receive client	

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	Support Plans) or current HRHPs (High Risk Health Plans), to provide sufficient direct care staff to implement client E's active treatment program and to manage his nighttime disruptive behaviors or implement his 1:1 staff to client ratio supervision as described in his BSP (Behavior Support Plan), to ensure the agency owned and operated day service provider for clients A, B, C, D, E and F had current copies of their ISPs (Individual Support Plans). BSPs (Behavior Support Plans) or current HRHPs (High Risk Health Plans), to ensure client E participated in his day service's active treatment program, to ensure client D had an annual physical examination, to ensure clients A, B, C, D and E had routine and recommended vision assessments and services, to monitor and proactively address client E's chronic insomnia and day time lethargy, to ensure staff working with clients A, B, C, D, E and F were trained regarding their individual High Risk Health Plans, to ensure clients A, B, D, E and F's dental recommendations were implemented and clients received routine dental examinations, to ensure staff administered client E's medication without error and to conduct quarterly evacuation drills for each shift of personnel for clients A, B, C, D, E and F. Findings include:		specific training for all clients prior to working at the facility, including but not limited to client E's enhanced supervision protocols. The governing body has directed the facility to modify the staffing matrix to assure client E has one to one staffing while awake, including on the overnight shift when direct support personnel are unavailable to provide coverage as described above, salaried supervisory staff will fill in, providing direct support as needed. Staff assigned to work with client E have been trained on active treatment expectations, per client E's plan. The facility's contracted day service provider has received current copies of all clients' current Individual Support Plans and Behavior Support Plans. The facility is providing sufficient staff to assure client E may attend day service. Through observation the governing body has determined that this deficient practice did not affect other individuals.	

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	1. The facility Plan of Correction dated 12/17/17 was reviewed on 1/8/18 at 10:00 AM. The facility's Plan of Correction dated 12/17/17 indicated, "The Nurse Manager with the assistance of the remainder of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) will conduct a comprehensive review of facility medical and training records to: 1. Assure chronic healthcare conditions are properly monitored by facility nursing. 2. Assure comprehensive High Risk Plans address all clients ' chronic healthcare conditions. 3. Assure staff are trained and demonstrate competency in caring for chronic health conditions and implementing high risk plans. 4. Assure facility nursing has monitored clients ' medical condition and informed clients ' doctors regarding emerging medical conditions including but not limited to blood pressure and weight gain/loss. 5. Assure routine and preventative		Client D has received a physical examination from his primary care physician. Through a review of facility medical records, the governing body has determined that all clients who reside in the facility have current annual physical examinations. All clients who reside in the facility have received current vision assessments. The interdisciplinary team has developed a comprehensive high risk plan to monitor and address client E's insomnia. All staff will be trained on implementation of the plan. Additionally, client E has an appointment with his new attending psychiatrist on 2/5/18 to review his current psychotropic medication regime to determine if adverse interactions could be impacting client E's ability to sleep through the night consistently. All facility staff have been retrained on implementation of high risk plans and the plans are stored in a manner to provide staff with easy access to review when	

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	healthcare occurs as required." -The facility Plans of Correction dated 12/17/17 indicated, "The facility must provide or obtain preventive and general medical care. Specifically, through a review of facility medical records, the governing body has determined this deficient practice affected one additional client and the team will obtain an annual physical examination for the affected client. PREVENTION: The facility nurse and Residential Manager will be retrained regarding the need to obtain and preventative and general medical care including but not limited to annual physical examinations. The Nurse Manager/RN will provide direct assistance with provision of the facility ' s healthcare needs directly until the facility demonstrates competency. The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to physical examinations occur no less than annually. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, and Nurse		needed. The team has scheduled comprehensive dental examinations for all clients who reside at the facility at the earliest available appointments. All facility staff have been retrained to on proper measurement of liquid medication, prior to administration. Although this deficient practice did not affect additional clients, the facility nurse will review agency medication and treatment administration protocols with all staff. The facility has conducted additional evacuation drills on each shift during the current quarter. **Root Cause Analysis of why corrections implemented after the 11/17/17 survey have failed.** ·The governing body failed to assure appropriate staffing was in place in the home to support a recently admitted aggressive client with adjusting to his new	

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	Manager) as well as the QIDP will incorporate medical chart reviews into a period of intensive administrative oversight at the facility -weekly until the team demonstrates competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. At that time, the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than twice monthly to assure that routine medical assessments, including but not limited to annual physical examinations, occur as required." -The facility Plans of Correction dated 12/17/17 indicated, "Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. Specifically: The Nurse Manager with the assistance of the remainder of the Operations Team (comprised of the		environment. ·The governing body failed to properly prepare administrative monitors to provide appropriate oversight and guidance to facility staff. ·The governing body failed to provide sufficient oversight to facility nursing staff. **PERVENTION:** The Facility Nurse and QIDP have been retrained on the need to assemble a comprehensive medical record at the time clients are admitted and to update the record as assessments are completed. When new clients are admitted to the facility, the Nurse Manager and QIDP manager will conduct weekly document reviews to assure records are assembled as required. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to the administrator. The QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for	

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	Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) will conduct a comprehensive review of facility medical and training records to assure staff are trained and demonstrate competency in caring for chronic health conditions and implementing high risk plans." Nurse Manager (NM) #1 was interviewed on 1/8/18 at 1:45 PM. NM #1 indicated clients A, B, C, D, E and F's High Risk Health Plans had been updated by LPN #1. NM #1 was interviewed on 1/8/18 at 1:59 PM. NM #1 indicated the updated High Risk Health Plans would be provided via email. NM #1 provided clients A, B, C, D, E and F's High Risk Health Plans via email on 1/8/18 at 2:34 PM. Review of the attached risk plans indicated the following: -Client A's High Risk Health Plans regarding Allergies, Anemia, Prostate Cancer, Seizures, Choking, Skin Infection and Respiratory Infection were reviewed/revised on 11/17/17.		reporting to outside agencies, to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to accurately report allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, the governing body will administer written corrective action up to and including termination of employment. When incidents occur, The QIDP Manager will guide the QIDP through the investigation and corrective measure implementation process, providing follow-up as needed but no less than daily. Additionally, the Quality Assurance Manager and QIDP Manager will follow-up with administrative level program staff (Program Manager and Operations Manager) The QIDP has been retrained on the need to provide current support documents to day service providers and families to assure continuity in each client's active treatment program. Members of the Operations Team comprised of the Executive Director, Operations Managers, Program Managers,	

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	-Client B's High Risk Health Plans regarding Skin Infection were reviewed/revised on 11/17/17. -Client C's High Risk Health Plans regarding Respiratory Infection, Skin Infection and Choking Potential were reviewed/revised on 11/17/17. -Client D's High Risk Health Plans regarding Hypokalemia (low blood platelets), Choking, Skin Breakdown, Constipation or Bleeding were reviewed/revised on 11/17/17. -Client E's High Risk Health Plan regarding Skin Infection were reviewed/revised on 11/17/17. -Client F's High Risk Health Plans regarding Choking, Dermatitis, Hyponatremia (not enough salt in body fluids), Skin Breakdown, Respiratory Infection, Seizures and Hyperlipidemia were reviewed/revised on 11/17/17. Staff #2 was interviewed on 1/8/18 at 4:45 PM. Staff #2 indicated she worked the evening shift from 2 PM-10 PM and on weekends from 8 AM -12 PM. When asked if she had received any recent retraining regarding client high risk plans,		Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, and Nurse Manager) will review Day service observation checklists, document receipts and e-mail properties to assure day service staff and families have been provided with copies of current support documents. The Residential Manager and Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. Professional staff will be retrained regarding the need to conduct evacuation drills on each shift for all staff each quarter. The Operations Team will review all facility evacuation drill reports and follow up with professional staff as needed to assure drills occur as scheduled. Program Manager will track evacuation drill compliance and follow up with facility professional staff and the agency Safety Committee accordingly. The nurse formerly assigned to the facility has been placed on administrative leave pending a full review of her work product to determine necessary corrective	

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	staff #2 stated, "No." Staff #2 stated she "remembers signing some training but nothing at the home with [LPN (Licensed Practical Nurse) #1]." MC (Med Coach) #1 was interviewed on 1/8/18 at 5 PM. When asked to describe clients A, B, C, D, E and F's High Risk Health Plans and BSP (Behavior Support Plans), MC #1 stated, "Don't think [client C] has one. [Clients A, D and F] not had house training on them." MC #1 indicated she had received some client specific training for the home but was uncertain whom she had been trained on. MC #1 indicated client A had skin picking behaviors. MC #1 indicated client F was on a fluid restriction. MC #1 indicated client D had incontinence issues, stole food and should be monitored when he ate. MC #1 did not demonstrate retention or knowledge of client C's choking risk plan, client B's seizure risk plan, client A's allergy and sinusitis risk plan or client D's constipation and Thrombocytopenia (low blood platelet) risk plans. Staff #1 was interviewed on 1/8/18 at 5:15 PM. Staff #1 indicated he started working at the home on 12/26/17 and worked the 4 PM -12 AM shift during weekdays. When asked to describe clients A, B, C, D, E and F's High Risk Health Plans and BSP, staff		measures and appropriate performance action, and a new nurse has been assigned to the facility. The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to physical examinations occur no less than annually. The QIDP will work with the facility nurse will coordinate training with the facility direct support medical coach and Residential Manager to assure that all medical assessments and evaluations occur as required. The QIDP will coordinate with the facility nurse and facility direct support staff and supervisors to facilitate ongoing training toward competency in implementation of high risk plans. The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist	

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	#1 stated, "Don't know about risk plans. [Client C] was on leave when I started and just came back this week so only worked with him for about one week. [Clients B and C] were both gone and just recently came back. [Client D] has to be watched for choking and will eat fast. He has to have help getting in and out of the shower." Staff #1 did not demonstrate retention or knowledge of client C's choking risk plan, client B's seizure risk plan, client A's allergy and sinusitis risk plan or client D's constipation and Thrombocytopenia (low blood platelet) risk plans. Client B's day services record was reviewed on 1/9/18 at 9:24 AM. Client B's day service record indicated client B had a High Risk Health Plan dated 8/22/17 regarding seizures. Client B's record did not indicate documentation of client B's updated/revised 11/17/17 High Risk Health Plan regarding seizures. Client C's day services record was reviewed on 1/9/18 at 9:20 AM. Client C's High Risk Plans included Respiratory Infection, Skin Infection, Choking Potential all dated 8/21/17. Client C's day services record did not indicate documentation of client C's updated/revised 11/17/17 High Risk Health		with and monitor skills training including but not limited to including but not limited to proper implementation of behavior supports and high risk plans, as well as assuring sufficient staff are present, filling in gaps in staffing as needed. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger and Registered Nurse) will review facility support documents and perform visual assessments of the facility no less than daily for the next 30 days, and after 30 days, will conduct administrative observations no less than three times weekly until all staff demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	Plans regarding Respiratory Infection, Skin Infection and Choking Potential. Client D's day services record was reviewed on 1/9/18 at 9:28 AM. Client D's day services record indicated client D's ISP was dated 11/22/16, BSP was dated 11/22/16 and High Risk Health Plans regarding Skin Integrity, Constipation and Choking were all dated 4/8/16. Client D's day services record did not indicate documentation of client D's ISP dated 11/2/17, BSP dated 11/22/17 or High Risk Health Plans regarding Hypokalemia (low blood platelets), Choking, Skin Breakdown, Constipation or Bleeding all dated 11/17/17. Client E's day services record was reviewed on 1/9/18 at 9 AM. Client E's day services record indicated client E's ISP was dated 8/2/16, BSP was dated 8/2/16 and did not include any High Risk Health Plans. Client E's day services record did not indicate documentation of client E's ISP dated 11/17/17, BSP dated 12/14/17 or High Risk Health Plan regarding Skin Infection dated 11/17/17. Client F's day services record was reviewed on 1/9/18 at 9:26 AM. Client F's day services record indicated client F's High Risk Health Plans regarding Hyperlipidemia,		and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered. Administrative support at the home will include:	

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	01/12/2018

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

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	Hyponatremia, Dermatitis, Choking, Seizures, Respiratory Infection and Skin Breakdown were all dated 8/22/17. Day Services training logs were reviewed on 1/9/18 at 9:30 AM. The review did not indicate documentation of staff training regarding clients B, C, D, E or F's updated/most current High Risk Health Plans dated 11/17/17 by LPN #1. DSM #1 was interviewed on 1/9/18 at 9:31 AM. DSM #1 indicated there was not documentation of fluid tracking for December 2017 or January 2018 regarding client F's fluid restriction/intake. DSM #1 indicated LPN #1 had not provided training for day services staff regarding clients B, C, D, E or F's updated/most current High Risk Health Plans dated 11/17/17. Client A's group home record was reviewed on 1/9/18 at 12:01 PM. Client A's High Risk Health Plans regarding Allergies, Anemia, Prostate Cancer, Seizures, Choking, Skin Infection and Respiratory Infection were all dated 10/18/16. Client A's record did not indicate documentation of updated/revised High Risk Health Plans since 10/18/16. Client B's group home record was reviewed		·Assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring adequate direct support staff are on duty to meet the needs of all clients. ·Assuring a complete and accurate accounting of client finances is present. ·Assuring corrective measures are developed after substantiated incidents and implemented effectively. ·Assuring client E attends day programming with appropriate staffing in place. ·Assuring that routine medical assessments, including but not limited to annual physical and visual examinations, occur as required. ·Assuring that routine dental evaluations and recommended dental follow-up occur as required. ·Assuring Medications are administered without error. ·Assuring evacuation drills occur as required. **Preventative measures to be implemented based on Root Cause Analysis of why corrections implemented after the 11/17/17 survey have failed.**	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	on 1/9/18 at 10:48 AM. Client B's Record of Visit form dated 11/28/17 indicated he was evaluated and treated for a human bite wound. Client B's Record of Visit form dated 12/11/17 indicated client B was evaluated and treated for a human bite wound. Client B's record did not indicate documentation of client B's 11/17/17 High Risk Health Plan regarding Skin Infection. Client C's group home record was reviewed on 1/9/18 at 10:19 AM. Client C's record did not indicate documentation of client C's updated/revised 11/17/17 High Risk Health Plans regarding Respiratory Infection, Skin Infection and Choking Potential. Client D's group home record was reviewed on 1/9/18 at 11:22 AM. Client D's record did not indicate documentation of client D's ISP dated 11/2/17, BSP dated 11/22/17 or High Risk Health Plans regarding Hypokalemia (low blood platelets), Choking, Skin Breakdown, Constipation or Bleeding all dated 11/17/17. Client E's group home record was reviewed on 1/9/18 at 12:24 PM. Client E's record did not indicate documentation of client E's High Risk Health Plan regarding Skin Infection dated 11/17/17.		The Residential Manager has been directed to provide the Program Manager and Operations Manager with copies of a specific schedule listing client E's assigned one to one staff. The Operations Manager will review all requests for staffing reductions, with emphasis on safety considerations, prior to approving implementation. The Quality Assurance Manager and QIDP Manager or other designated Quality Assurance staff will perform spot checks of attendance records to assure ongoing compliance. If deficiencies are noted, the QA staff will notify the Program Manager, Operations Manager and Executive Director to assure prompt corrective action. Prior to each schedule period, the Operations Team will follow-up verbally and via email to assure that appropriate coverage has been arranged. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: ·The role of the administrative monitor is not simply to observe &	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

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	Client F's group home record was reviewed on 1/9/18 at 11:47 AM. Client F's record did not indicate documentation of client F's High Risk Health Plans regarding Choking, Dermatitis, Hyponatremia (not enough salt in body fluids), Skin Breakdown, Respiratory Infection, Seizures and Hyperlipidemia all dated 11/17/17. QIDP (Qualified Intellectual Disabilities Professional) #1, AS (Area Supervisor) #1, HM (Home Manager) #1 and LPN (Licensed Practical Nurse) #1 were interviewed on 1/9/18 at 1:07 PM. QIDP #1 indicated the day services should have current copies of ISP's, BSP's and High Risk Health Plans. When asked to provide documentation of staff training regarding updated/current High Risk Health Plans, LPN #1 indicated clients A, B, C, D, E and F's charts at the group home and at day services should contain the 11/17/17 updated High Risk Health Plans. LPN #1 indicated all staff working with clients A, B, C, D, E and F should be trained regarding clients A, B, C, D, E and F's High Risk Health Plans. LPN #1 stated, "Yes, the in-service paper should be here (looking through the home's MAR). Can't find it. I will have to get back to you." LPN #1		Report. ·When opportunities for training are observed, the monitor must step in and provide the training and document it. ·If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. ·Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training as needed. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Additional Preventative Healthcare Services Measures: 1.Nursing caseloads have been reduced to 3-4 SGL homes per nurse. 2.The Nurse Manager will no longer be responsible for a caseload. 3.The Nurse Manager will do	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	stated, "Yes, I did an in-service on High Risk Plans and updated the risk plans." LPN #1 indicated she had not conduct retraining on high risk health plans with day services staff. No additional documentation of staff training was provided by LPN #1. HM #1 indicated client B's 11/28/17 and 12/11/17 bite wounds were a result of client E biting him. HM #1 indicated clients B and E were roommates. QIDP #1 indicated staff working in the home had been retrained on implementation of client E's 1 to 1 ratio staff supervision following the 1/2/18 IDT. QIDP #1 indicated staff should be implementing one to one ratio supervision during the day and completing 15 minute checks during sleep. When asked to clarify client E's 15 minute checks during sleeping hours in contrast to client E's 12/14/17 BSP protocol indicating 1 to 1 ratio should continue being implemented during the overnight/sleeping hours, QIDP #1 stated, "We discussed that and thought he probably needed the one to one ratio supervision over night but there were staffing concerns." QIDP #1 indicated the facility did not have enough overnight staff available to implement one to one ratio staff supervision as described in his 12/14/17 BSP regarding client E assessed supervision needs. QIDP #1 indicated clients B and E were roommates. QIDP #1		side by side audits of SGL home with the assigned nurse weekly. 4.Copies of Nurse Manager Audits will be provided to the Executive Director and Regional Director (Area Manager) for review. 5.The Executive Director and Regional Director will meet with the Nurse Manager weekly to review concerns raised through audits, incident reports or other concerns brought to management attention. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	indicated the day services should participate in client E's 12/11/17 and 1/2/18 IDT meetings and the recommendations should have been communicated with the day services regarding client E's one to one ratio supervision. QIDP #1 indicated the day services should be tracking client F's fluid intake as described in his fluid restriction High Risk Health Plan. QIDP #1 indicated there should be two staff on duty in the home to implement client E's one to one ratio supervision. 2. The governing body failed to provide general policy, budget and operating direction over the facility to ensure client E's record contained his medical and health care documentation. Please see W111. 3. The governing body failed to provide general policy, budget and operating direction over the facility to ensure clients A, B, C, D and F's personal rights to retain and use their personal belongings were protected regarding client E's behavior. Please see W137. 4. The governing body failed to provide general policy, budget and operating direction over the facility to ensure clients A, B and C's personal finances were accounted for. Please see W140.			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	5. The governing body failed to provide general policy, budget and operating direction over the facility to ensure the facility implemented its written policy and procedures to ensure an injury of unknown origin was immediately reported to the facility administrator regarding client A. The governing body failed to implement its written policy and procedures to prevent abuse and develop and implement effective corrective measures to address client E's ongoing verbal and physically aggressive behaviors (yelling, threats, biting, head butting and attempts at biting and head butting, theft/attempted theft of clients personal belongings) and verbal and physical disruption (jumping, screaming and entering other clients rooms during overnight hours to attempt to fight clients or steal their personal belongings) in the home creating an emotionally intimidating and hostile environment (an environment that is difficult or uncomfortable) for clients B, C, D and F. Please see W149. 6. The governing body failed to provide general policy, budget and operating direction over the facility to ensure an injury of unknown origin was immediately reported to the facility administrator regarding client A. Please see W153.			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	7. The governing body failed to provide general policy, budget and operating direction over the facility to ensure the facility developed and implemented effective corrective measures to address client E's ongoing verbal and physically aggressive behaviors (yelling, threats, biting, head butting and attempts at biting and head butting, theft/attempted theft of clients personal belongings) and verbal and physical disruption (jumping, screaming and entering other clients rooms during overnight hours to attempt to fight clients or steal their personal belongings) in the home creating an emotionally intimidating and hostile environment (an environment that is difficult or uncomfortable) for clients A, B, C, D and F. Please see W157. 8. The governing body failed to provide general policy, budget and operating direction over the facility by failing to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored clients A, B, C, D, E and F's active treatment programs by failing to provide sufficient direct care staff to implement client E's active treatment program and to manage his nighttime disruptive behaviors or implement his 1:1 staff to client ratio supervision as described			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	in his BSP (Behavior Support Plan) and to ensure the agency owned and operated day service provider for clients A, B, C, D, E and F had current copies of their ISPs (Individual Support Plans), BSPs (Behavior Support Plans) or current HRHPs (High Risk Health Plans). Please see W159. 9. The governing body failed to provide general policy, budget and operating direction over the facility to provide sufficient direct care staff to implement client E's active treatment program and to manage his nighttime disruptive behaviors or implement his 1:1 staff to client ratio supervision as described in his BSP (Behavior Support Plan). Please see W186. 10. The governing body failed to provide general policy, budget and operating direction over the facility to ensure the agency owned and operated day service provider for clients A, B, C, D, E and F had current copies of their ISPs (Individual Support Plans), BSPs (Behavior Support Plans) or current HRHPs (High Risk Health Plans). Please see W248. 11. The governing body failed to provide general policy, budget and operating direction over the facility to ensure client E participated in his day service's active			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

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	treatment program. Please see W249. 12. The governing body failed to provide general policy, budget and operating direction over the facility to ensure client D had an annual physical examination. Please see W322. 13. The governing body failed to provide general policy, budget and operating direction over the facility to ensure clients A, B, C, D and E had routine and recommended vision assessments and services. Please see W323. 14. The governing body failed to provide general policy, budget and operating direction over the facility to monitor and proactively address client E's chronic insomnia and day time lethargy. Please see W331. 15. The governing body failed to provide general policy, budget and operating direction over the facility to ensure staff working with clients A, B, C, D, E and F were trained regarding their individual High Risk Health Plans. Please see W342. 16. The governing body failed to provide general policy, budget and operating direction over the facility to ensure clients A,			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	B, D, E and F's dental recommendations were implemented and clients received routine dental examinations. Please see W356. 17. The governing body failed to provide general policy, budget and operating direction over the facility to ensure staff administered client C's medication without error. Please see W369. 18. The governing body failed to provide general policy, budget and operating direction over the facility to conduct quarterly evacuation drills for each shift of personnel for clients A, B, C, D, E and F. Please see W440. 9-3-1(a)			
W 0111 Bldg. 00	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. Based on record review and interview for 1 additional client (E), the facility failed to ensure client E's record contained his medical and health care documentation.	W 0111	**CORRECTION:** *The facility must develop and maintain a record keeping system that documents the client's health care, active treatment, social*	02/07/2018

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	01/12/2018

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	Findings include: HM (Home Manager) #1 was interviewed on 1/9/18 at 10:15 AM. HM #1 indicated client E did not have a medical chart available for review. LPN (Licensed Practical Nurse) #1 was interviewed on 1/9/18 at 12:48 PM. LPN #1 provided a chart for client E. LPN #1 indicated client E's chart did not have his physical, vision examination, dental examination or other information related to his medical status. LPN #1 indicated she would check her personal files to locate additional documentation of client E's physical, vision, dental and recent medical visits. Client E's record was reviewed on 1/9/18 at 12:48 PM. Client E's chart contained a copy of his physicians orders dated December 2017. The chart did not contain additional medical documentation regarding client E's medical status. 9-3-1(a)		*information, and protection of the client's rights.* Specifically, the interdisciplinary team has assembled a comprehensive medical record for client E. A review of facility documentation indicated that this deficient practice did not affect other clients. **PERVENTION:** The Facility Nurse and QIDP have been retrained on the need to assemble a comprehensive medical record at the time clients are admitted and to update the record as assessments are completed. When new clients are admitted to the facility, the Nurse Manager and QIDP manager will conduct weekly document reviews to assure records are assembled as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director	
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client			

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	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 3 sampled clients (A, B and C), plus 3 additional clients (D, E and F). The facility failed to ensure clients A, B, C, D and F's personal rights to retain and use their personal belongings were protected regarding client E's behavior, to ensure clients A, B and C's personal finances were accounted for and to implement its written policy and procedures to ensure an injury of unknown origin was immediately reported to the facility administrator regarding client A. The facility failed to implement its written policy and procedures to prevent abuse and develop and implement effective corrective measures to address client E's ongoing verbal and physically aggressive behaviors (yelling, threats, biting, head butting and attempts at biting and head butting, theft/attempted theft of clients personal belongings) and verbal and physical disruption (jumping, screaming and entering other clients rooms during overnight hours to attempt to fight clients or steal their personal belongings) in the home creating an emotionally intimidating and hostile environment (an environment that is difficult or uncomfortable) for clients B, C, D and F.	W 0122	**CORRECTION:** *The facility must ensure that specific client protections requirements are met.* Specifically, the governing body facilitated the following: All staff have been trained on expectations for one to one observation of Client E, including but not limited to preventing client E from accessing his housemate's belongings. The Residential Manager will assure one to one staffing is scheduled on all shifts and will provide the Program Manager and Operations Manager with a one to one specific schedule detailing who will be on duty to handle one to one responsibilities. Supervisory staff from in and outside of the facility will fill any gaps in coverage. Additionally, the interdisciplinary team has assisted Client A with placing a lock on his door. Fill-in staff will receive client specific training for all clients prior to working at the facility. All facility supervisory and direct support staff will be retrained to report suspected abuse, neglect, mistreatment and exploitation, -including but not limited to	02/07/2018

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

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	Findings include: 1. The facility failed to ensure clients A, B, C, D and F's personal rights to retain and use their personal belongings were protected regarding client E's behavior. Please see W137. 2. The facility failed to ensure clients A, B and C's personal finances were accounted for. Please see W140. 3. The facility failed to implement its written policy and procedures to ensure an injury of unknown origin was immediately reported to the facility administrator regarding client A. The facility failed to implement its written policy and procedures to prevent abuse and develop and implement effective corrective measures to address client E's ongoing verbal and physically aggressive behaviors (yelling, threats, biting, head butting and attempts at biting and head butting, theft/attempted theft of clients personal belongings) and verbal and physical disruption (jumping, screaming and entering other clients rooms during overnight hours to attempt to fight clients or steal their personal belongings) in the home creating an emotionally intimidating and hostile environment (an environment that is difficult		injuries of undetermined origin. All staff have been trained on expectations for one to one observation of Client E, including but not limited to preventing client E from engaging in aggressive behavior including yelling, threats, biting, head butting and attempts at biting, head butting and accessing his housemate's belongings. The house manager will assure one to one staffing is scheduled on all shifts and will provide the Operations Manager with a one to one specific schedule detailing who will be on duty to handle one to one responsibilities. Supervisory staff from in and outside of the facility will fill any gaps in coverage. Additionally, the interdisciplinary team has assisted Client A with placing a lock on his door. Fill-in staff will receive client specific training for all clients prior to working at the facility, including but not limited to client E's enhanced supervision protocols. **PERVENTION:** Supervisory staff will review all facility documentation to assure incidents are reported as required.	

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	01/12/2018

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

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	or uncomfortable) for clients B, C, D and F. Please see W149. 4. The facility failed to ensure an injury of unknown origin was immediately reported to the facility administrator regarding client A. Please see W153. 5. The facility failed to develop and implement effective corrective measures to address client E's ongoing verbal and physically aggressive behaviors (yelling, threats, biting, head butting and attempts at biting and head butting, theft/attempted theft of clients personal belongings) and verbal and physical disruption (jumping, screaming and entering other clients rooms during overnight hours to attempt to fight clients or steal their personal belongings) in the home creating an emotionally intimidating and hostile environment (an environment that is difficult or uncomfortable) for clients A, B, C, D and F. Please see W157. 9-3-2(a)		Additionally, internal and day service incident reports will be sent via electronic fax directly to the administrator. The QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to accurately report allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, the governing body will administer written corrective action up to and including termination of employment. When incidents occur, The QIDP Manager will guide the QIDP through the investigation and corrective measure implementation process, providing follow-up as needed but no less than daily. Additionally, the Quality Assurance Manager and QIDP Manager will follow-up with administrative level program staff (Program Manager and Operations Manager) The Residential Manager and Area	

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	01/12/2018

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

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			Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger and Registered Nurse) will review facility support documents and perform visual assessments of the facility no less than daily for the next 30 days, and after 30 days, will conduct administrative observations no less than three times weekly until all staff demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: ·The role of the administrative monitor is not simply to observe & Report. ·When opportunities for training are observed, the monitor must step in and provide the training and document it.	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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

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			·If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. ·Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training as needed. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include: ·Assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring adequate direct support staff are on duty to meet the needs of all clients. ·Assuring corrective measures are developed after substantiated incidents and implemented effectively.	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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

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			The Quality Assurance Manager and QIDP Manager or other designated Quality Assurance staff will perform spot checks of attendance records to assure ongoing compliance. If deficiencies are noted, the QA staff will notify the Program Manager, Operations Manager and Executive Director to assure prompt corrective action. Prior to each schedule period, the Operations Team will follow-up verbally and via email to assure that appropriate coverage has been arranged. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director	
W 0137 Bldg. 00	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on record review and interview for 3 of 3 sampled clients (A, B and C), plus 2 additional clients (D and F), the facility failed to ensure clients A, B, C, D and F's personal rights to retain and use their	W 0137	**CORRECTION:** *The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate*	02/07/2018

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	01/12/2018

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

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	personal belongings were protected regarding client E's behavior. Findings include: HM (Home Manager) #1 was interviewed on 1/8/18 at 4:26 PM. HM #1 stated, "[Client E] takes everything. [Client D] can't play with his trucks. [Client E] takes them. [Client A] wants a lock for his room, [client E] takes all of his things. If he doesn't get what he wants he will take it or get aggressive." HM #1 indicated clients B and E were roommates. Staff #2 was interviewed on 1/8/18 at 4:45 PM. Staff #2 indicated she worked the evening shift from 2 PM-10 PM and on weekends from 8 AM -12 PM. When asked if the clients in the home got along, staff #2 stated, "They all do except [client E]. He doesn't get along with anybody." Staff #2 stated, "He's so aggressive. We try to redirect him. [Client D] has toys and [client E] will steal them from him. [Client D] will get mad and try to take it back. [Client D] is afraid. Sometimes [client E] pushes. We try to redirect. [Client B] likes to stay in his room. [Client B] avoids [client E] and will go to the other room to get away from him. They all avoid him." Staff #2 stated, "[Client E] steals from [client C] and goes		*personal possessions and clothing.* Specifically, all staff have been trained on expectations for one to one observation of Client E, including but not limited to preventing client E from accessing his housemate's belongings. The Residential Manager will assure one to one staffing is scheduled on all shifts and will provide the Program Manager and Operations Manager with a one to one specific schedule detailing who will be on duty to handle one to one responsibilities. Supervisory staff from in and outside of the facility will fill any gaps in coverage. Additionally, the interdisciplinary team has assisted Client A with placing a lock on his door. Fill-in staff will receive client specific training for all clients prior to working at the facility. **PERVENTION:** The Residential Manager and Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger and Registered Nurse) will review	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	through [client A's] pictures. This makes [client A] angry. [Clients B and C] are afraid." Staff #2 indicated clients B and E were roommates. MC (Med Coach) #1 was interviewed on 1/8/18 at 5 PM. MC #1 stated, "Yes, [client E] takes (others) personal belongings." Staff #1 was interviewed on 1/8/18 at 5:15 PM. Staff #1 indicated he started working at the home on 12/26/17 and worked the 4 PM -12 AM shift during weekdays. When asked if the other clients in the home were afraid of client E, staff #1 stated, "Afraid? [Clients B, C and D] are but not [clients A or F]. He steals and takes toys. [Client E's] a bully." Client E's record was reviewed on 1/11/18 at 9:18 AM. Client E's Progress Notes (PNs) dated from 11/15/17 through 1/9/18 indicated the following: PN dated 11/15/17 10 AM - 1 PM shift indicated, "[Client E] has been very aggressive this morning. He continues to go in roommates room and taking items." PN dated 11/18/17, 8 AM- 8 PM shift indicated, "Very unsettled, trying to elope from the house. Only settle (sic) a bit when		facility support documents and perform visual assessments of the facility no less than daily for the next 30 days, and after 30 days, will conduct administrative observations no less than three times weekly until all staff demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	his mom and brother visited. [Client E's] mom brought him lunch, (sic) ate fine. After his mom left [client E] was still trying to elope but staff (unspecified) kept redirecting him. [Client E] has been going in and out of other housemates' room (sic) taking their stuff, (sic) hitting [client B]." PN dated 11/19/17, 9 PM- 9 AM shift indicated, "[Client E] awake (sic) was slept around 1 AM. After (a) few hours [client E] woke up and (started) jumping, screaming and walking around the house, (sic) he trying to open the med room door also. At 7 AM, med's were giving (sic) and [client E] (was) trying to take [client D's] [toy] and push the staff and [HM #1]." PN dated 11/19/17, 8 AM- 8 PM shift indicated, "[Client E] was already awake on staff's arrival at site. He pulled staff and clients during the shift, he attempted to elope (and was) trying to take what does not belong to him." PN dated 11/20/17, 8 PM- 9 AM shift indicated, "[Client E] woke up around 2 AM and (was) trying to fight with staff and go into [client C's] room and (sic) trying to wake [client C] up and (sic) trying to fight with him and (sic) jumping and (sic) screaming."		and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: ·The role of the administrative monitor is not simply to observe & Report. ·When opportunities for training are observed, the monitor must step in and provide the training and document it. ·If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. ·Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

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	PN dated 11/20/17, 8 AM- 8 PM shift indicated, "[Client E] woke up around 2 AM and (was) trying to fight with staff and go into [client C's] room and trying to wake [client C] up and (sic) trying to fight with him. And jumping and screaming." PN dated 11/20/17, 4 PM- 12 AM shift indicated, "[Client E] started walking around going from one bedroom to another , (sic) making several demands." PN dated 11/23/17, 9 AM - 9 PM shift indicated, "[Client E] was up walking around the house upon staffs arrival, ate fine, very unsettled all day. Mom visited him and brought him lunch. Trying to elope, trying to hit staff when staff tried to stop him from going out. Still unsettled, kept going to [client A's] room packing his pictures." PN dated 11/24/17, 4 PM - 12 AM shift indicated, "[Client E] staff (sic) met him walking around in the evening, taking what does (sic) not belong to him. Attempted to elope (and) making unnecessary demands." PN dated 11/27/17 12 AM - 8 AM shift indicated client E was up during the overnight house and was going into his housemates rooms and jumping around the		as needed. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring adequate direct support staff are on duty to meet the needs of all clients. The Quality Assurance Manager and QIDP Manager or other designated Quality Assurance staff will perform spot checks of attendance records to assure ongoing compliance. If deficiencies are noted, the QA staff will notify the Program Manager, Operations Manager and Executive Director to assure prompt corrective action. Prior to each schedule period, the Operations Team will follow-up verbally and via email to assure that appropriate coverage has been arranged.	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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

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	house. PN dated 12/1/17 2 PM - 10 PM shift indicated, "[Client E] has been unsettled all evening. Attended Christmas party at the office, he refused to settle down at the party. Came back home and went to [client A's] room got most of his pictures out. This resulted in making [client A] very angry and upset. Staff redirected [client E] but he refused. He later left (sic) for [client C's] room whenever staff redirected him [client E] uses [expletives] on staff." PN dated 12/2/17 8 AM - 8 PM shift indicated, "[Client E] was already up upon staffs arrival. Very unsettled and aggressive towards housemates and staff. Kept going to [client A's] room to get his pictures and other stuff out to place items on the floor in the living room, he became aggressive when staff redirected him. Kept pulling [client B] out of the chair whenever [client B] tried to settle down on the sofa. Still unsettled at time of report. Stood right in front of staff in the dining area and peed on himself twice and he will start laughing whenever he does it." PN dated 12/3/17 8 AM - 8 PM shift indicated, "[Client E] was already awake jumping around the house upon staff arrival.		**RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	He later became aggressive to the clients and staff in the house. Taking what does not belong to him with force, going from one bedroom to another. He made several attempts to open the kitchen cabinets and deliberately peed on himself." PN dated 12/4/17 4 PM - 12 AM shift indicated, "[Client E] was running around the house with his blankets in his hand upon staff's arrival at the site. He frequently going to (sic) other consumers bedroom, packing their belongings out (sic) playing with kitchen sink, attempting to bite staff and clients. Staff made (sic) they redirected him whenever he attempts to bite and elope." PN dated 12/6/17 2 PM- 10 PM shift indicated, "[Client E] has been very unsettled upon his arrival from day program. Picking stuff from housemates room. Mostly [client A's]. Very angry. [Client E] kept saying he will bite [client C] but staff kept him in line of sight." PN dated 12/7/17 4 PM - 12 AM shift indicated, "[Client E] was trying to gain access to the kitchen while staff was preparing the dinner. Jumping around snatching other clients stuff aggressively." PN dated 12/8/17, 12 AM- 8 AM shift			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	indicated, "[Client E] slept for (a) few hours in (sic) the midnight woke up and started walking around the house and opened [client C's] door throughout the night." PN dated 12/8/17, 2 PM- 10 PM shift indicated, "Upon picking [client E] up from day program, day program staff reported [client E that (sic) he's been saying he was going to bite someone. Staff asked if [client E] mentioned any names but day program staff said he did not but he kept saying he was going to do it. [HM #1] was informed immediately. [Client E] has been very unsettled, fighting with [client D] over [client D's] toy truck and entering [client A's] room, taking his pictures and placing them on the floor. [Client A] was so angry about it but staff told [client A] to calm down. [Client E] has been using [expletives] on staff while staff were trying to redirected (sic) him. Pushing and trying to bite staff while staff told him to stay (away) from (the) hot stove and while he was trying to open the oven when the oven was in use and very hot. Staff did what they could but [client E] still remains adamant." PN dated 12/13/17, 2 PM - 10 PM shift indicated, "[Client E] was picked up at day program. Very unsettled. On getting home (sic) he starts going into [client A's] room to			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	some of his pictures out. Staff redirected him but he wouldn't listen. Trying to force some of the kitchen cabinets back open." PN dated 12/16/17, 8 AM - 8 PM shift indicated, "Very unsettled all day, fighting his housemates over their toys and stuff. Refused to be redirected." PN dated 12/17/17 8 AM- 8 PM shift indicated, "[Client E] was already awake running around upon staffs arrival at the site. He was very unsettled, stealing, aggressive towards staff and consumers attempting to bite." PN dated 12/17/17, 2 PM -10 PM shift indicated, "[Client E] has been very unsettled upon his arrival from day program. In and out of the kitchen, taking [client D's] toys and fighting him for his trucks. Went to [client A's] room and took some of his pictures and placed them on the floor in the living room. Refused to be redirected. Peed on himself." PN dated 12/19/17, 2 PM- 10 PM shift indicated, "[Client E] was picked up at day program. Came back home usual unsettled self. Fight with housemates over their belongings, taking out blankets from the closet and taking out stuff from (the) kitchen			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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

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	cabinet. Refused to be redirected very aggressive towards housemates and staff." PN dated 12/20/17, 2 PM- 10 PM shift indicated, "[Client E] has been very unsettled, fighting, refused to be redirected. Kept going in and out of [client A's] room. This makes [client A] angry and [client A] was using [expletives] while trying to explain to staff." PN dated 12/22/17, 2 PM- 10 PM shift indicated, "[Client E] was picked up at day program. Slept through while transported to the house. On his arrival at the house he became restless, wondering around the housemates room, picking their stuff and picking stuff from the kitchen cabinet. Very unsettled all evening." PN dated 12/29/17, 6 AM - 2 PM shift indicated, "[Client E] was very active this morning. Kept trying to take things from kitchen while staff was preparing breakfast. [Client E] ate breakfast, then began to bother other housemates taking their personal belongings." PN dated 1/8/18, 4 PM- 9 PM shift indicated, "[Client E] took away other clients toys."			

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	9-3-2(a)			
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 3 of 3 sampled clients (A, B and C), the facility failed to ensure clients A, B and C's personal finances were accounted for. Findings include: 1. Client A's RFMSS (Resident Fund Management Service Statement) dated 10/13/17 through 1/11/18 was reviewed on 1/11/18 at 12:40 PM. Client A's RFMSS dated 10/13/17 through 1/11/18 indicated client A received $10.00 of his personal money for "Weekly Spending" on 10/16/17, 10/23/17, 10/30/17, 11/6/17, 11/13/17, 11/17/17, 11/27/17, 12/4/17, 12/11/17, 12/18/17, 12/22/17, 1/2/18 and 1/8/18. Client A's RFMSS dated 10/13/17 through 1/11/18 indicated client A received $75.00 of his personal money for "Christmas Shopping" on 12/20/17. The review did not indicate documentation of an itemized ledger regarding client A's personal weekly spending money greater than $5.00 or client	W 0140	**CORRECTION:** *The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.* Specifically, personal financial ledgers for all clients will be updated by the Residential Manager and reviewed by the Area Supervisor and certified as accurate per facility protocol. The Residential Manager will receive detailed training and will maintain an up to date ledger to track purchases for all clients. All staff will assure that clients provide receipts for purchases as appropriate and the Residential Manager will maintain copies of receipts for purchases recorded on the ledgers. **PREVENTION:** The Residential Manager will maintain responsibility for maintaining client financial records	02/07/2018

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	A's personal Christmas shopping money in the amount of $75.00. 2. Client B's RFMSS dated 10/13/17 through 1/11/18 was reviewed on 1/11/18 at 12:43 PM. Client B's RFMSS dated 10/13/17 through 1/11/18 indicated client B received $10.00 of his personal money for "Weekly Spending" on 10/16/17, 10/23/17, 10/30/17, 11/6/17, 11/13/17, 11/17/17, 11/27/17, 12/4/17, 12/11/17, 12/18/17, 12/22/17, 1/2/18 and 1/8/18. Client B's RFMSS dated 10/13/17 through 1/11/18 indicated client B received $89.97 of his personal money for "[Store Clothes]" on 12/27/17. The review did not indicate documentation of an itemized ledger regarding client B's personal weekly spending money greater than $5.00 or client B's personal clothing shopping money in the amount of $89.97. 3. Client C's RFMSS dated 10/13/17 through 1/11/18 was reviewed on 1/11/18 at 12:45 PM. Client C's RFMSS dated 10/13/17 through 1/11/18 indicated client C received $10.00 of his personal money for "Weekly Spending" on 10/16/17, 10/23/17, 10/30/17, 11/6/17, 11/13/17, 11/17/17, 11/27/17, 12/4/17, 12/11/17, 12/18/17, 12/22/17, 1/2/18 and 1/8/18. Client C's RFMSS dated 10/13/17 through 1/11/18		and the Area Supervisor will audit these records no less than weekly. All staff will be retrained regarding the need to assist clients with budgeting and collecting receipts, with appropriate accompanying documentation. The Area Supervisor will turn in client financial records to the Business Manager no less than monthly for review and filing. Additionally, members of the Operations Team comprised of the Operations Managers, Program Managers, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators, will include audits of client finances as part of an ongoing facility audit process. Operations Team audits will occur weekly until all staff and supervisors demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. Administrative support will include assuring a complete and accurate accounting of client finances is present. **RESPONSIBLE PARTIES:** QIDP,	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	indicated client C received $89.97 of his personal money for "[Store Clothes]" on 12/27/17. The review did not indicate documentation of an itemized ledger regarding client C's personal weekly spending money greater than $5.00 or client C's personal clothing shopping money in the amount of $89.97. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/11/18 at 12:32 PM. QIDP #1 indicated there was no documentation available for review regarding clients A, B and C's petty cash ledgers. 9-3-2(a)		Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
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 3 sampled clients (A, B and C), plus 3 additional clients (D, E and F), the facility failed to implement its written policy and procedures to ensure an injury of unknown origin was immediately reported to the facility administrator regarding client A. The facility failed to implement its written	W 0149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.* Specifically: All staff have been trained on	02/07/2018

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	policy and procedures to prevent abuse and develop and implement effective corrective measures to address client E's ongoing verbal and physically aggressive behaviors (yelling, threats, biting, head butting and attempts at biting and head butting, theft/attempted theft of clients personal belongings) and verbal and physical disruption (jumping, screaming and entering other clients rooms during overnight hours to attempt to fight clients or steal their personal belongings) in the home creating an emotionally intimidating and hostile environment (an environment that is difficult or uncomfortable) for clients B, C, D and F. Findings include: 1. Observations were conducted at the group home on 1/8/18 from 4:00 PM through 5:30 PM. Client A was present in the home throughout the observation period. Client A had a 1 CM (Centimeter) circular shaped dark to light red area on his forehead above his right eyebrow area. Client A's fingernails on his left hand (dominant hand) had jagged edges with finger #5's (pinky) nail 0.4 millimeters, finger #4's (ring finger) nail 0.5 millimeters, finger #3's (middle) nail 0.2 millimeters and finger #2's (index) nail was 0.4 millimeters in length.		expectations for one to one observation of Client E, including but not limited to preventing client E from accessing his housemate's belongings. The Residential Manager will assure one to one staffing is scheduled on all shifts and will provide the Program Manager and Operations Manager with a one to one specific schedule detailing who will be on duty to handle one to one responsibilities. Supervisory staff from in and outside of the facility will fill any gaps in coverage. Additionally, the interdisciplinary team has assisted Client A with placing a lock on his door. Fill-in staff will receive client specific training for all clients prior to working at the facility. All facility supervisory and direct support staff will be retrained to report suspected abuse, neglect, mistreatment and exploitation, -including but not limited to injuries of undetermined origin. All staff have been trained on expectations for one to one observation of Client E, including but not limited to preventing client E from engaging in aggressive behavior including yelling, threats, biting, head butting and attempts at biting, head butting and	

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	Client A was interviewed on 1/8/18 at 4:11 PM. Client A was asked how he received the mark on his forehead, client A stated, "Don't know. Probably got bumped." HM (Home Manager) #1 who was present during the interview stated client A "Scratches himself sometimes". HM #1 indicated client A's finger nails were trimmed weekly. Client A was asked if he bumped into something or if he scratched himself, client A stated, "Yeah, scratched. Ran into a door." Client A's record was reviewed on 1/9/18 at 12:01 PM. Client A's PN (Progress Note's) dated from 11/1/17 through 1/8/18 did not indicate documentation of client A scratching or attempting to scratch himself. Client A's ISP (Individual Support Plan) dated 2/22/17 and BSP (Behavior Support Plan) dated 2/22/17 did not identify scratching or skin picking as targeted behaviors for client A. Client A's TR (Treatment Record) dated January 2018 indicated, "Trim fingernails and toenails weekly on Wednesday at 7 PM." Client A's TR dated January 2018 indicated staff completed/initialed completion of trimming client A's fingernails and toenails on the previous Wednesday (1/3/18).		accessing his housemate's belongings. The house manager will assure one to one staffing is scheduled on all shifts and will provide the Operations Manager with a one to one specific schedule detailing who will be on duty to handle one to one responsibilities. Supervisory staff from in and outside of the facility will fill any gaps in coverage. Additionally, the interdisciplinary team has assisted Client A with placing a lock on his door. Fill-in staff will receive client specific training for all clients prior to working at the facility, including but not limited to client E's enhanced supervision protocols. **PERVENTION:** Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to the administrator. The QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to accurately report	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	QIDP (Qualified Intellectual Disabilities Professional) #1, AS (Area Supervisor) #1, HM (Home Manager) #1 and LPN (Licensed Practical Nurse) #1 were interviewed on 1/9/18 at 1:07 PM. When asked if client A had any injuries regarding his skin, HM #1 indicated client A had a circular red area on his forehead. When asked how client A described/reported how he sustained the injury, HM #1 stated, "He said he hit a door." When asked if client A was able to self-report injuries, HM #1 stated, "No." HM #1 stated, "It looked like he scratched himself." When asked if she had witnessed client A scratching or picking his skin, HM #1 stated, "No." When asked if staff had reported seeing client A scratching or picking his skin, HM #1 stated, "No." When asked if client A's fingernails appeared to have been trimmed on 1/3/18 during the 1/8/18 interview/observations at the group home, HM #1 stated, "No, I don't believe they were trimmed." HM #1 stated, "It was an injury of unknown origin and should have been reported." QIDP #1 indicated she had not been notified of client A's 1/8/18 injury of unknown origin on his forehead. LPN #1 indicated she had not been notified of client A's 1/8/18 injury of unknown origin on his forehead. AS #1 indicated she had not been notified of client A's 1/8/18 injury of		allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, the governing body will administer written corrective action up to and including termination of employment. When incidents occur, The QIDP Manager will guide the QIDP through the investigation and corrective measure implementation process, providing follow-up as needed but no less than daily. Additionally, the Quality Assurance Manager and QIDP Manager will follow-up with administrative level program staff (Program Manager and Operations Manager) The Residential Manager and Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger and Registered Nurse) will review facility support documents and perform visual assessments of the facility no less than daily for the	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	unknown origin on his forehead. QIDP #1 indicated injuries of unknown origin should be reported immediately to the supervisor and nurse and an investigation should be initiated. An additional BDDS report was received via email and reviewed on 1/9/18 at 5:47 PM. The review indicated a BDDS report had been completed regarding client A's injury of unknown origin. The date of knowledge listed on the BDDS report was 1/9/18 at 5 PM. The review indicated client A's injury of unknown origin identified and discussed with HM #1 on 1/8/18 at 4:11 PM was not immediately reported to AS #1, QIDP #1 or LPN #1. 2. Observations were conducted at the group home on 1/8/18 from 4 PM through 5:30 PM. At 4:22 PM, client E was in the medication administration room with HM (Home Manager) #1 and was being prompted to exit the medication administration room to prepare for the evening meal by HM #1. Client E repeatedly asked for candy while attempting to walk past HM #1 toward a desk in the room. HM #1 stated, "He wants the jar of candy I keep on my desk." HM #1 then picked up a glass jar of assorted chocolate candies and asked client E "Is this what you want"? HM		next 30 days, and after 30 days, will conduct administrative observations no less than three times weekly until all staff demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	#1 then directed client E to exit the room and repeatedly told him "You can have candy after you eat dinner. You have to eat your dinner and be nice". Client E continued repeatedly asking for the candy while attempting to reach the jar in HM #1's hands. HM #1 requested staff #1 to assist redirecting client E out of the medication room and to join his housemates in the kitchen for the evening meal. Client E exited the medication administration room while HM #1 shut the medication administration room door and stood next to it holding it shut. Client E continued demanding candy from outside of the medication room door and began banging on the door while attempting to push his way inside the med room to get the candy jar from HM #1. HM #1 was interviewed on 1/8/18 at 4:26 PM. HM #1 stated client E "Perseverates over food" and "Will get aggressive towards staff and clients." When asked if any of the other clients in the home were fearful or intimidated regarding client E, HM #1 stated, "[Client F] is not. [Client A] is not. [Clients B, C and D] are. They are non-verbal so they can't tell you but you can tell by the way they act. Just visual. They don't want to be anywhere near [client E]. They go the opposite direction, both at home and work. We are in the process of		bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: ·The role of the administrative monitor is not simply to observe & Report. ·When opportunities for training are observed, the monitor must step in and provide the training and document it. ·If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. ·Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training as needed. The Executive Director and	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	putting [client E] in a different classroom than [clients B, C and D]." HM #1 indicated client E moved into the group home on 11/14/17 after the death of another client in the home. HM #1 indicated she was aware of 2 BDDS (Bureau of Developmental Disabilities Services) reports for fighting. HM #1 stated, "[Client E] takes everything. [Client D] can't play with his trucks. [Client E] takes them. [Client A] wants a lock for his room, [client E] takes all of his things. If he doesn't get what he wants he will take it or get aggressive. [Client E] will bite and head butt. He takes sheets and flushes them down the toilet." HM #1 indicated clients B and E were roommates. Staff #2 was interviewed on 1/8/18 at 4:45 PM. Staff #2 indicated she worked the evening shift from 2 PM-10 PM and on weekends from 8 AM -12 PM. When asked if the clients in the home got along, staff #2 stated, "They all do except [client E]. He doesn't get along with anybody." Staff #2 stated, "He's so aggressive. We try to redirect him. [Client D] has toys and [client E] will steal them from him. [Client D] will get mad and try to take it back. [Client D] is afraid. Sometimes [client E] pushes. We try to redirect. [Client B] likes to stay in his room. [Client B] avoids [client E] and will go to the other room to get away from		Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include: ·Assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring adequate direct support staff are on duty to meet the needs of all clients. ·Assuring corrective measures are developed after substantiated incidents and implemented effectively. The Quality Assurance Manager and QIDP Manager or other designated Quality Assurance staff will perform spot checks of attendance records to assure ongoing compliance. If deficiencies are noted, the QA staff will notify the Program Manager, Operations Manager and Executive Director to assure prompt corrective action. Prior to each schedule period, the Operations Team will follow-up	

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	him. They all avoid him." Staff #2 stated, "[Client E] steals from [client C] and goes through [client A's] pictures. This makes [client A] angry. [Clients B and C] are afraid. [Client E] does have a BSP (Behavior Support Plan) but it doesn't work. Staff #2 indicated clients B and E were roommates. MC (Med Coach) #1 was interviewed on 1/8/18 at 5 PM. MC #1 stated, "Yes, [client E] takes (others) personal belongings. He tries to make other clients to do what he wants. He will hit, head butt and takes things from the kitchen and puts them down vents and toilets. I've heard about this from other staff and seen him do it on the weekends. He doesn't follow directions." When asked if the other clients were afraid of client E, MC #1 stated, "Some are. I see it when clients leave the area to get away from him. Some are non-verbal but I can tell. [Clients B, C and D] are. [Client B] is his roommate. [Client B] is afraid of him. [Client B] has scars on his arm and finger from where [client E] bit him." MC #1 indicated clients B and E were roommates. MC #1 indicated client E was currently on 1 to 1 ratio staff supervision. MC #1 stated, "They are supposed to be having a meeting to take him off 1 to 1 ratio staff supervision, I don't think its safe. He needs 1 to 1 ratio		verbally and via email to assure that appropriate coverage has been arranged. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	staff supervision." MC #1 indicated 1 to 1 ratio staff supervision meant one staff was assigned to client E and remained shoulder to shoulder with him to monitor him and keep the other clients safe. MC #1 stated, "They want us to work by ourselves. Doesn't feel safe. If we are toileting or helping another client in the bathroom or bedroom while everyone is in the living room with [client E] he might attack them." MC #1 indicated she had expressed this concern with HM #1. MC #1 indicated she had worked in the home by herself and didn't know client E was supposed to be 1 to 1 ratio staff supervised at the time. MC #1 indicated she had only become aware of client E's 1 to 1 ratio staff supervision protocol three days ago. Staff #1 was interviewed on 1/8/18 at 5:15 PM. Staff #1 indicated he started working at the home on 12/26/17 and worked the 4 PM -12 AM shift during weekdays. Staff #1 stated he had "worked a couple of times during the week by himself." Staff #1 stated, "[Client E] is very difficult. Can't leave him alone with others. Gets violent and will attach others. Bites and head butts." When asked if the other clients in the home were afraid of client E, staff #1 stated, "Afraid? [Clients B, C and D] are but not [clients A or F]. He steals and takes toys. [Client E's]			

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	a bully." Staff #1 indicated 1 to 1 ratio staff supervision meant to maintain client E at arms length. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were viewed on 1/8/18 at 6 PM. The review indicated the following: 1. BDDS report dated 11/29/17 indicated, "Staff reported as [client B] and [client E] were in the dining area engaging in horse play. Staff discovered a bite mark with broken skin on [client B's] right arm, approximately 3 inches in length. The ResCare nurse (unknown) was present when it happened and instructed staff to clean the area and take [client B] to [medical clinic] to be assessed. [Client B] was taken to [medical clinic] where he was assessed and prescribed antibiotics for the bite. [Client E] has a history of physical aggression and harming others. Both individuals were provided emotional support from the staff. [Client E] will receive testing to rule out the presence of blood borne pathogen. The administrative team is aware of the incident and the IDT (Interdisciplinary Team) will meet to put additional protective measure in place. Staff will notify the administrative team of any further concerns."			

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	2. BDDS report dated 12/9/17 indicated, "As [client B] was exiting the medication room, before staff could intervene, [client E] grabbed [client B's] right hand and bit him. Staff immediately separated the two individuals and redirected [client E] verbally. The ResCare nurse was notified and instructed staff to have [client B]examined by a physician. [Client B] was taken to [hospital] where he was assessed and diagnosed with a bite on (his) right hand, and was prescribed an antibiotic to be taken twice daily for seven days. [Client E] has a history of physical aggression and harming others. Both individuals were provided emotional support from the staff. Immediate protective measures are in place. Specifically, [client E] has been placed on one on one supervision during wakening (sic) hours and 15 minute checks during sleeping hours. The administrative team is aware of the incident and staff will notify the administrative team of any further concerns." 3. BDDS report dated 12/29/17 indicated, "While preparing to eat breakfast, [client E] moved [client F's] chair from behind him and [client F] hit [client E] in the back of the head with an open hand. Staff immediately separated the two and verbally redirected them both. There were no injuries noted. Both individuals were provided emotional			

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	support from the staff and physical aggression is addressed in both individuals behavior support plans. The administrative team is aware of the incident and the IDT will meet to discuss additional protective measures. Staff will notify the administrative team of any further concerns." -Investigation Final Report dated 1/8/18 indicated MC #1 was the only staff on duty in the home at the time of clients E and F's incident of physical aggression. The facility's Time Detail Sheets dated 1/2/18 through 1/9/18 were reviewed on 1/9/18 at 10:49 AM. The review indicated the following: -1/2/18: The review did not indicate documentation of staff working in the home from 10 PM- 11:59 PM. -1/3/18: The review did not indicate documentation of staff working in the home from 12 AM through 7 AM and from 3 PM through 6 PM. The review indicated one staff was on duty in the home from 7 AM to 3 PM. -1/4/18: The review did not indicate documentation of staff working in the home from 3 PM to 6 PM. The review indicated			

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	one staff was on duty at the home from 6:30 PM through 11:59 PM. -1/6/18: The review indicated one staff was working in the home from 12 AM to 8 AM and from 7 PM to 11:59 PM. -1/7/18: The review indicated one staff was working in the home from 12 AM to 8 AM and from 7 PM to 11:59 PM. -1/8/18: The review indicated one staff was working in the home from 12 AM to 9 AM. Interview with HM #1 on 1/8/18 at 5:30 PM indicated clients A, B, C, D, E and F got up for day program at 6 AM, completed hygiene, received medications, participated in the home's family style morning meal and then departed for day services between 8 AM and 8:30 AM. Day Service Manager (DSM) #1 was interviewed on 1/9/18 at 9:14 AM. DSM #1 indicated clients B, C, D and F were in the same classroom. DSM #1 indicated client E had been in the same classroom until yesterday (1/8/18). DSM #1 indicated she was not aware client E had been placed on 1:1 supervision or have a copy of his most recent (12/14/17) BSP with his 1 to 1 ratio			

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	protocol. DSM #1 indicated she was not a participant in the 12/11/17 or 1/2/18 IDT meetings and the IDT recommendations regarding 1:1 supervision or keeping client E separated from clients B and F had not been communicated. DSM #1 stated, "They were in the same class and did group." DSM #1 stated, "[Client E] slept most days but has improved." Client E's day services record was reviewed on 1/9/18 at 9 AM. Client E's day services record indicated client E's ISP was dated 8/2/16, BSP was dated 8/2/16. Client E's day services record did not indicate documentation of client E's ISP dated 11/17/17, BSP dated 12/14/17. QIDP (Qualified Intellectual Disabilities Professional) #1, AS (Area Supervisor) #1, HM (Home Manager) #1 and LPN (Licensed Practical Nurse) #1 were interviewed on 1/9/18 at 1:07 PM. QIDP #1 indicated the day services should have current copies of ISP's, BSP's and High Risk Health Plans. HM #1 indicated client B's 11/28/17 and 12/11/17 bite wounds were a result of client E biting him. HM #1 indicated clients B and E were roommates. QIDP #1 indicated staff working in the home had been retrained on implementation of client E's 1 to 1 ratio staff supervision			

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	following the 1/2/18 IDT. QIDP #1 indicated staff should be implementing one to one ratio supervision during the day and completing 15 minute checks during sleep. When asked to clarify client E's 15 minute checks during sleeping hours in contrast to client E's 12/14/17 BSP protocol indicating 1 to 1 ratio should continue being implemented during the overnight/sleeping hours, QIDP #1 stated, "We discussed that and thought he probably needed the one to one ratio supervision over night but there were staffing concerns." QIDP #1 indicated the facility did not have enough overnight staff available to implement one to one ratio staff supervision as described in his 12/14/17 BSP regarding client E assessed supervision needs. QIDP #1 indicated clients B and E were roommates. QIDP #1 indicated the day services should participate in client E's 12/11/17 and 1/2/18 IDT meetings and the recommendations should have been communicated with the day services regarding client E's one to one ratio supervision. QIDP #1 indicated the day services should be tracking client F's fluid intake as described in his fluid restriction High Risk Health Plan. QIDP #1 indicated there should be two staff on duty in the home to implement client E's one to one ratio supervision.			

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	QIDP #1 indicated all allegations of abuse, neglect, mistreatment and injuries of unknown origin should be immediately reported to the administrator, reported to BDDS within 24 hours of knowledge of the allegation, thoroughly investigated and corrective measures should be developed and implemented to prevent recurrence. Client E's record was reviewed on 1/11/18 at 9:18 AM. Client E's BSP (Behavior Support Plan) dated 12/14/17 indicated the following: -"[Client E] at times will become obsessive over things. [Client E] will steal items at the store, takes items from housemates, non-compliance, obsesses over what is on his mind (always food), kitchen and food are locked. He struggles with biting self, hitting, head butts, and he has alarms on door due to eloping and will pick at his skin." -"Some of his targeted behaviors consist of physical aggression, self-injurious behavior, pacing around, leaving assigned area, and repetitive actions." -"Physical Aggression: any time [client E] strikes, spits, grabs, kicks, bites, pinches, is threatening, and throwing objects at others that have the potential to cause injury."			

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	-"Verbal Aggression: any time [client E] shouts and/or screams at peers and/or staff to include insults, vulgar comments, obscenities and demeaning comments. -"Threats to Harm Others: any time [client E] makes a statement that he will harm staff and/or peers (kill them in their sleep, burn the house down, break their knee) or refers to events in his past when he has harmed others." -"The following precursor behaviors have been identified: change (minor or major), family conflict, staff conflict, persons violating his personal space, sitting up in bed in the middle of the night, not sleeping at night, taking things from others, making threats to harm others, repeating words/phrases to staff to gain attention. [Client E] will seek out targets, i.e. he will stare for a short period of time and will have rapid eye movement prior to engaging in verbal and physical aggression." -"When [client E] engages in physical aggression, his tendency is to lash out in every direction with his hands/fists and his feet in order to attack anyone in his reach. Staff must provide personal space to his and must insure the environment surrounding			

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	[client E] is clear of obstructions and that [client E] is given plenty of space to maneuver. [Client E] has a tendency to drop to the floor when he is physically aggressive and continue to swing at and/or kick at anyone and anything within his reach." -"Property Destruction/Disruption, Self-Injury and Physical Aggression. Do not overreact, try to maintain a calm and emotionless demeanor. Immediately ensure the health and safety of everybody in the immediate area. In a firm and polite voice ask his to stop the behavior, and redirect his to a quieter area away from other, either outside (back patio) or to his room. Encourage his to use his calming strategies (alone time; journaling; listening to music; writing letters; writing and telling funny stories.) Throughout this process minimize verbal interactions with his and never get into a power struggle. If the behavior persists and he is placing himself or others in immediate danger implement You're Safe I'm Safe (YSIS). Position yourself between [client E] and his peers. In a calm but firm voice verbally redirect [client E] to a different location/area/activity. Block physical aggression and property destruction. If [client E] is continuing to place himself or others in jeopardy, use the YSIS procedures in the following order:			

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	Physically redirect. One person hold. Two person hold. When using these holds, be aware that [client E] may attempt to bite, hit or struggle, position yourself so that you are safe. If needed have his peers move to a safe location where [client E] cannot aggress towards them. Let his know what you are doing but do not engage in conversations with his." -"Staff Actions: One to One ratio Staffing. [Client E] will have a 1:1 staff as determined by the QIDP and Behaviorist. The purpose of the 1:1 staff is to provide uninterrupted observation of and intervention toward [client E] to keep him from harming himself or others. [Client E] is that staff's only focus. Staff will be in the same room with [client E] and will be positioned close enough to physically intervene using you're Safe I'm Safe (YSIS); [client E] will be within staff line of sight if he attempts to harm himself or others. This includes every room he enters as well as in his room overnight while he is asleep. Whenever [client E] is awake in a room sitting down or lying down, the staff will position themselves as close to [client E] as possible while remaining standing and be prepared to block his access to the nearest hard surface. When [client E] is asleep, staff will position themselves as close to [client E] as possible.			

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	Staff may sit or stand but must still be able to block his access to the nearest hard surface if needed. [Client E's] head and face must be visible to staff at all times when [client E] is sleeping. If [client E] pulls the blanket over his face/head, staff will immediately move it to insure his head and face is visible. Every 15 minutes staff must visually and physically check [client E] to insure he is breathing, the space around his face/neck is clear of obstructions and clear the space if necessary. The 1:1 staff may have a paper copy of [client E's] BSP and therapy coping skills for reference to assist [client E] in understanding his actions and their consequences. These copies must remain in staff's possession at all times and may be passed to the next staff during change over. Staff will not have a pen or pencil on their person while performing 1:1 with [client E]. When [client E] requires 1:1 staff, every staff scheduled on each shift will rotate through and provide direct oversight of [client E] in 30 minute intervals. Staff will change out every 30 minutes and will sign in/out on a 1:1 staffing sheet. The non-1:1 staff will conduct a room sweep and all objects will be removed from [client E's] room (including curtains/rods and all dolls) except one pillow and one blanket. Staff may talk with [client E], while on 1:1, if [client E] initiates conversation, but staff			

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	must keep it supportive, encouraging in nature and related to the behaviors he is demonstrating at the time and their resolution. This includes discussion of his BSP, proactive and reactive strategies and coping skills. No superficial conversation should occur between 1:1 staff and [client E] or 1:1 staff and other staff. The 1:1 will position themselves between [client E] and the nearest hard surface (walls, hard tables etc) while maintaining line of sight with [client E]. The 1:1 will walk slightly behind [client E] and to one side, the side closest to the nearest hard surface and close enough to physically intervene if he attempts to harm himself or others. Whenever [client E] walks into another room, the 1:1 staff will scan the room for any possible item that [client E] may use to harm himself and inform the other staff to remove the items. When [client E] is on 1:1, he may not sit on the front porch, front yard or non-fenced area of the property as there is risk of his running to the street and into traffic. He may sit on the patio in the fenced back yard. When [client E] is on 1:1, he may only be transported in the group home van and may only sit on one of the bench seats with staff sitting next to him. He may not sit in the passenger front seat. Staff will sit next to the window in order to block [client E] from hitting his head or body on it. Working on			

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	goals that allow him access to items that he could use to harm or kill himself. At the first sign of a precursor behavior by [client E] or by one of his housemates, lock the sharps (or items which can easily be made into a sharp) as well as the cleaning chemicals which could be ingested. This includes eating utensils (such as forks, spoons, knives), cooking utensils (spatulas, wooden spoons, serving spoons, measuring cups, measuring spoons, ice cream scoops, pizza cutters, whisk, cookie cutters, meat thermometers, potato peelers). This also includes cleaning chemicals (such as laundry soap, dish soap, hand soap, dryer sheets, general purpose cleaner, toilet bowel cleaner, hand sanitizer). These items should remain secured until the immediate risk from exposure has passed and/or until [client E] is off of 1:1 and has been assessed as being in control and not a danger to himself and/or others." -"Staff Actions: Day Service. If the precursors occur while at day service: his workshop supervisor will notify additional staff and QIDP. [Client E] will have 1:1 staff while at day service. That staff will remove [client E] from the day service area and sit with him in a different area. Staff will be positioned close enough to him to use day service/residential provider approved crisis intervention procedures to ensure his health			

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	and safety as well as that of peers and staff. Day service Supervisor will notify the QIDP and Behaviorist and the above steps will be followed for precursor behaviors. Day service Supervisor will notify QIDP if [client E] requires dismissal from day service and when suspension from day service is necessary." Client E's 12/11/17 IDT note indicated, "The team met because [clients B and E] has been involved in two client to client aggression incidents within the last two weeks. The team decided that it would be best to place [client E] on line of sight at all times to ensure the safety of the other clients. Staff will also keep [clients B and E] separated from one another." The list of participants was as follows: QIDP #1, HM #1, PM #1. The 12/11/17 IDT did not include documentation of Day Services staff's participation in the IDT discussion or recommendations. Client E's 1/2/18 IDT note indicated, "The team met because [clients E and F] was (sic) involved in a client to client aggression (incident). The team decided that it [client E] (sic) was to be placed on 1:1 (ratio) supervision and this will help to reduce to (sic) incidens (sic) of client to client aggression. Staff is to also ensure that the			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	two individuals are kept separated from one another." The list of participants was as follows: QIDP #1, HM #1, PM #1. The 1/2/18 IDT did not include documentation of Day Services staff's participation in the IDT discussion or recommendations. Progress Note (PN) dated 11/15/17 10 PM -10 AM shift indicated, "[Client E] was walking up and down the whole house. He didn't sleep all the night. He started requesting for (sic) all kinds of stuff. He struggled with staff because he didn't get his way to the fridge, or med room." PN dated 11/15/17 10 AM - 1 PM shift indicated, "[Client E] has been very aggressive this morning. He continues to go in roommates room and taking items. [Client E] has tried biting and pushing so that he was able to get out of (the) door or inside the med room." PN Dated 11/15/17, 2 PM -10 PM shift indicated, "Came back (from transport) very unsettled in the house. He became aggressive with [client B] and trying to head butts (sic) him. Kept going in and out of the kitchen trying to open the oven while staff was making dinner. Both staff and house manager redirected him several times. Only settled down at dinner time, ate fine and			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	stole his housemates food. Kept telling staff he was going to bite his roommate, [client B], and staff. Since then kept him on line of sight." PN dated 11/18/17, 9 PM- 9 AM indicated, "[Client E] awake around 3 AM walking up and down (sic), jumping, screaming and yelling. [Client E] (was) asking for some stuff in the house." PN dated 11/18/17, 8 AM- 8 PM shift indicated, "Very unsettled, trying to elope from the house. Only settle (sic) a bit when his mom and brother visited. [Client E's] mom brought him lunch, (sic) ate fine. After his mom left [client E] was still trying to elope but staff (unspecified) kept redirecting him. [Client E] has been going in and out of other housemates' room (sic) taking their stuff, (sic) hitting [client B]." PN dated 11/19/17, 9 PM- 9 AM shift indicated, "[Client E] awake (sic) was slept around 1 AM. After (a) few hours [client E] woke up and (started) jumping, screaming and walking around the house, (sic) he trying to open the med room door also. At 7 AM, med's were giving (sic) and [client E] (was) trying to take [client D's] [toy] and push the staff and [HM #1]."			

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	PN dated 11/19/17, 8 AM- 8 PM shift indicated, "[Client E] was already awake on staff's arrival at site. He pulled staff and clients during the shift, he attempted to elope (and was) trying to take what does not belong to him." PN dated 11/20/17, 8 PM- 9 AM shift indicated, "[Client E] woke up around 2 AM and (was) trying to fight with staff and go into [client C's] room and (sic) trying to wake [client C] up and (sic) trying to fight with him and (sic) jumping and (sic) screaming." PN dated 11/20/17, 8 AM- 8 PM shift indicated, "[Client E] woke up around 2 AM and (was) trying to fight with staff and go into [client C's] room and trying to wake [client C] up and (sic) trying to fight with him. And jumping and screaming." PN dated 11/20/17, 4 PM- 12 AM shift indicated, "[Client E] started walking around going from one bedroom to another , (sic) making several demands." PN dated 11/21/17 12 AM - 8 AM shift indicated, "Upon arrival [client E] was watching TV and walking towards [client A's] room to wake him up by keeping open his door. Also he does not allow [client C]			

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	to sleep by opening his door too. Staff redirect him to the living room which he did and continued to waking around the house." PN dated 11/22/17 12 AM - 8 AM shift indicated, "[Client E] was met in the house sitting on the floor and looking at his book. [Client E] didn't slept (sic) at all. He started walking around asking (for the) same things all the times (sic). He try ing (sic) to open the fridge and snack cabinet." PN dated 11/23/17, 12 AM - 8 AM shift indicated, "[Client E] was met on bed upon arrival. He slept a few hours and (sic) getting up to waking around for period of couple of hours. Writer prompted him to go to bed and he went back and lay (sic) on the bed." PN dated 11/23/17, 9 AM - 9 PM shift indicated, "[Client E] was up walking around the house upon staffs arrival, ate fine, very unsettled all day. Mom visited him and brought him lunch. Trying to elope, trying to hit staff when staff tried to stop him from going out. Still unsettled, kept going to [client A's] room packing his pictures." PN dated 11/24/17, 4 PM - 12 AM shift indicated, "[Client E] staff (sic) met him walking around in the evening, taking what			

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	does (sic) not belong to him. Attempted to elope (and) making unnecessary demands." PN dated 11/24/17, 12 AM -8 AM shift indicated, "[Client E] slept until 1:30 AM. He was up toileting and stay(ed) in the living room. Talking, jumping, walking around the house." PN dated 11/27/17 12 AM - 8 AM shift indicated client E was up during the overnight house and was going into his housemates rooms and jumping around the house. PN dated 12/1/7 12 AM - 8 AM shift indicated, "[Client E] at home walking around the house. Taking stuff, asking for stuff. Jumping and screaming until 4 AM. He went to bed and was up at 7 AM." PN dated 12/1/17 2 PM - 10 PM shift indicated, "[Client E] has been unsettled all evening. Attended Christmas party at the office, he refused to settle down at the party. Came back home and went to [client A's] room got most of his pictures out. This resulted in making [client A] very angry and upset. Staff redirected [client E] but he refused. He later left (sic) for [client C's] room whenever staff redirected him [client E] uses [expletives] on staff."			

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PN dated 12/2/17 12 AM - 8 AM shift indicated, "[Client E] slept till 3: 15 AM and up walking around the house. Jumping, screaming, asking for some stuff and taking some stuff."

PN dated 12/2/17 8 AM - 8 PM shift indicated, "[Client E] was already up upon staffs arrival. Very unsettled and aggressive towards housemates and staff. Kept going to [client A's] room to get his pictures and other stuff out to place item on the floor in the living room, he became aggressive when staff redirected him. Kept pulling [client B] out of the chair whenever [client B] tried to settle down on the sofa. Still unsettled at time of report. Stood right in front of staff in the dining area and peed on himself twice and he will start laughing whenever he does it."

PN dated 12/3/17 8 PM - 8 AM shift indicated, "[Client E] slept until around 2 AM and up walking around the house. Jumping and screaming and asking for some stuff. Taking stuff."

PN dated 12/3/17 8 AM - 8 PM shift indicated, "[Client E] was already awake jumping around the house upon staff arrival. He later became aggressive to the clients

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	and staff in the house. Taking what does not belong to him with force, going from one bedroom to another. He made several attempts to open the kitchen cabinets and deliberately peed on himself." PN dated 12/4/17 12 AM - 8 AM shift indicated, "[Client E] slept until 2 AM and up walking around the house. Jumping, screaming, asking for some stuff and food. He was assisted with hygiene, dressing and took his med's. Ate breakfast, trying to hold [client B's] arms and he was stopped." PN dated 12/4/17 4 PM - 12 AM shift indicated, "[Client E] was running around the house with his blankets in his hand upon staff's arrival at the site. He frequently going to (sic) other consumers bedroom, packing their belongings out (sic) playing with kitchen sink, attempting to bite staff and clients. Staff made (sic) they redirected him whenever he attempts to bite and elope." PN dated 12/6/17 12 AM - 8 AM shift indicated, "[Client E] slept until 12:20 AM and up walking around the house not sleeping until morning. Jumping, screaming and asking for stuff like food." PN dated 12/6/17 7 AM- 3 PM shift indicated, "[Client E] was constantly trying			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	to fight with his housemates saying he is going to bite [clients B and C]. I redirected [client E] away from but but he continued to push and try to force himself where they were. He then turned his attention toward staff because he was not able to go out or get to housemates." PN dated 12/6/17 2 PM- 10 PM shift indicated, "[Client E] has been very unsettled upon his arrival from day program. Picking stuff from housemates room. Mostly [client A's]. Very angry. [Client E] kept saying he will bite [client C] but staff kept him in line of sight." PN dated 12/7/17 12 AM - 8 AM shift indicated, "Upon arrival [client E] was in his room sleeping. At 1 AM, he woke up and started walking around the house. [Client E]started picking up some stuff out of from the kitchen. He did not slept (sic) at all throughout the night." PN dated 12/7/17 4 PM - 12 AM shift indicated, "[Client E] was trying to gain access to the kitchen while staff was preparing the dinner. Jumping around snatching other clients stuff aggressively." PN dated 12/8/17, 12 AM- 8 AM shift indicated, "[Client E] slept for (a) few hours			

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	in (sic) the midnight woke up and started walking around the house and opened [client C's] door throughout the night." PN dated 12/8/17, 2 PM- 10 PM shift indicated, "Upon picking [client E] up from day program, day program staff reported [client E that (sic) he's been saying he was going to bite someone. Staff asked if [client E] mentioned any names but day program staff said he did not but he kept saying he was going to do it. [HM #1] was informed immediately. [Client E] has been very unsettled, fighting with [client D] over [client D's] toy truck and entering [client A's] room, taking his pictures and placing them on the floor. [Client A] was so angry about it but staff told [client A] to calm down. [Client E] has been using [expletives] on staff while staff were trying to redirected (sic) him. Pushing and trying to bite staff while staff told him to stay (away) from (the) hot stove and while he was trying to open the oven when the oven was in use and very hot. Staff did what they could but [client E] still remains adamant." PN dated 12/10/17, 12 AM- 8 AM shift indicated, "[Client E] bit [client B] on his way out from the med room. [Client E] quickly grab (sic) [client B's] hand and bite (sic) him. Staff intervene and rescue(d)			

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	[client B] from [client E]. [Client E] attacked staff and writer redirect him to (the) living room." PN dated 12/10/17, 8 AM- 8 PM shift indicated, "[Client E] was already awake in the morning upon staffs arrival at the site. After an hour [client E] suddenly rushed to where [client C] was sitting in an attempt to bite [client C]. Immediately staff quickly intervened and redirected him from [client E]. After his breakfast he went back to [client C] again an attempt to bite but staff prevented him, while staff was trying to divert his attention from [client C] he was furious at the staff." PN dated 12/12/17 12 AM- 8 AM shift indicated, "Upon arrived (sic) [client E] was slept (sic) in his room. After 1 hour he woke up at 1:30 A and started walking around, jumping around and still picking up some stuff up (sic) and playing with it until this morning at 5:45 AM he went to his room and lay down without any issue (sic)." PN dated 12/12/17, 4 PM- 12 AM shift indicated, "[Client E] was entering the house when staff arrived, was aggressive at other clients. Staff diverted his attention when he made attempts to bite."			

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	PN dated 12/13/17, 10 PM- 9 AM shift indicated, "Upon arrived (sic) [client E] was slept (sic) in his room. After few hours he woke up at 1:20 AM and started walking around, jumping around and playing with (a) toy until this morning." PN dated 12/13/17, 2 PM - 10 PM shift indicated, "[Client E] was picked up at day program. Very unsettled. On getting home (sic) he starts going into [client A's] room to some of his pictures out. Staff redirected him but he wouldn't listen. Trying to force some of the kitchen cabinets back open." PN dated 12/16/17, 9 PM- 9 AM shift indicated, "Upon arrived [client E] was playing in the living room, after few minutes he slept (sic) and he woke up at 2 AM and started walking around, jumping around." PN dated 12/16/17, 8 AM - 8 PM shift indicated, "Very unsettled all day, fighting his housemates over their toys and stuff. Refused to be redirected." PN dated 12/17/17, 9 AM-9 PM shift indicated, "[Client E] didn't slept (sic) throughout the night. [Client E] walking around the house jumping, screaming (and) also opened other clients doors."			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	PN dated 12/17/17 8 AM- 8 PM shift indicated, "[Client E] was already awake running around upon staffs arrival at the site. He was very unsettled, stealing, aggressive towards staff and consumers attempting to bite." PN dated 12/17/17, 2 PM -10 PM shift indicated, "[Client E] has been very unsettled upon his arrival from day program. In and out of the kitchen, taking [client D's] toys and fighting him for his trucks. Went to [client A's] room and took some of his pictures and placed them on the floor in the living room. Refused to be redirected. Peed on himself." PN dated 12/18/17 8 PM- 8 AM shift indicated, "[Client E] didn't slept (sic) throughout the night. [Client E] walking around the house jumping, screaming around (sic)." PN dated 12/18/17 4 PM- 12 AM shift indicated, "[Client E] was trying to gain his access to the kitchen upon staffs arrival at the site. Several attempts were made by him to forcibly open the medications room in order to disorganize (unknown) the office. He said repeatedly that he is going to bite someone. Staff kept eyes on him throughout the shift."			

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PN dated 12/19/17, 9 PM- 9 AM shift indicated, "Upon arrived (sic) [client E] was in the living room walking around, screaming around the house. [Client E] slept around 4 AM this morning."

PN dated 12/19/17, 2 PM- 10 PM shift indicated, "[Client E] was picked up at day program. Came back home usual unsettled self. Fight with housemates over their belongings, taking out blankets from the closet and taking out stuff from (the) kitchen cabinet. Refused to be redirected very aggressive towards housemates and staff."

PN dated 12/20/17, 9 PM - 9 AM shift indicated, "[Client E] didn't sleep all through the night. His activities woke his roommate, [client B], up. He attempted to bite his roommate, [client B], countless times. Staff stood against him and redirected him though forcefully thereby also attempted biting staff. He started sleeping at about 6:45 AM."

PN dated 12/20/17, 2 PM- 10 PM shift indicated, "[Client E] has been very unsettled, fighting, refused to be redirected. Kept going in and out of [client A's] room. This makes [client A] angry and [client A] was using [expletives] while trying to explain to staff."

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PN dated 12/21/17, 12 AM- 8 AM shift indicated, "[Client E] slept (sic) upon arrived (sic). After one hour he woke up, said he needs shower and staff gave him shower. [Client E] started walking around the house. At 5:30 AM [client E] trying to attack [client B]. Staff redirected him to another area."

PN dated 12/22/17 9 PM -9 AM shift indicated, "[Client E] was asleep when staff arrived. He was woken up for his bedtime meds, he took the med and went back to sleep. He then woke up by himself at 12 AM and remained awake all through the night. He kept roaming the living room."

PN dated 12/22/17, 2 PM- 10 PM shift indicated, "[Client E] was picked up at day program. Slept through while transported to the house. On his arrival at the house he became restless, wondering around the housemates room, picking their stuff and picking stuff from the kitchen cabinet. Very unsettled all evening."

PN dated 12/29/17, 9 PM -9 AM shift indicated, "[Client E] slept between 9 PM- 12 AM. He was awake from 12 AM to this morning. He kept disturbing staff all through the night. [Client E] going to the closet to get the blankets out, taking stuff out of kitchen

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cabinet."

PN dated 12/29/17, 6 AM - 2 PM shift indicated, "[Client E] was very active this morning. Kept trying to take things from kitchen while staff was preparing breakfast. [Client E] ate breakfast, then began to bother other housemates taking their personal belongings."

PN dated 12/31/17, 6 PM- 10 AM shift indicated, "[Client E] slept upon arrived. after few hours he woke up. He was awake from 1 AM till this morning. He kept jumping around the house screaming around."

PN dated 12/31/17, 8 AM- 4 PM shift indicated, "[Client E] had a busy morning he continued to bother housemates taking their items and approaching staff in negative manners. [Client E] did not follow any instructions given by staff. [Client E] had to be seated with 1 to 1 approach to sit for long period of time. With 1 to 1 approach by staff [client E] fell asleep for 1 hour."

PN dated 1/3/18, 9 PM - 9 AM shift indicated, "[Client E] was awake when staff arrived. He later dozed off and was led to his room after he had taken his bedtime meds. He also took his morning meds and

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	ate his breakfast. No issues except his attempts twice of wanting to bite [client D]." PN dated 1/4/18, 5 PM - 9 AM shift indicated, "[Client E] was awake all the night long. He took his bedtime meds though. He also took his morning meds and has his breakfast and got dressed for day program. He attempted twice to bite [client B] and staff but staff redirected and gave him close monitoring." PN dated 1/5/18, 5 PM - 9 AM shift indicated, "[Client E] only slept for 2 hours after his bedtime meds. He was awake all throughout the night thereafter. He took his breakfast and his morning meds. He attempted to bite [client F], [client B] and staff but he was prevented." PN dated 1/8/18, 5 PM - 9 PM shift indicated, "[Client E] was awake till 4 AM. He slept briefly for 2 hours and woke up again." PN dated 1/8/18, 4 PM- 9 PM shift indicated, "[Client E] took away other clients toys." PN dated 1/9/18, 9 PM - 9 AM shift indicated, "[Client E] was awake when staff arrived. He stayed awake all through the			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	night. He kept pacing around the whole house. Staff prevented him from hitting [client B] on his bed twice. Staff also prevented himself from being bitten." Client E's 12/11/17 IDT note, 1/2/18 IDT note and record did not indicate review, discussion or recommendations to address client E's overall pattern of stealing items from peers, his identified precursor behavior including insomnia and physical and verbal aggression towards his housemates, including his roommate. QIDP #2, LPN #1 and QIDP #1 were interviewed on 1/10/18 at 12 PM. QIDP #1 stated, "The 1/2/18 IDT meeting should say 1 to 1 ratio supervision to continue. He had already been on 1 to 1 ratio supervision from the 12/11/17 IDT." QIDP #1 stated, "Staff were not implementing his 1:1 ratio supervision. We did retraining. He should be 1: 1 ratio supervision during wake hours and 15 minute checks on overnight." QIDP #1 was asked to clarify the difference in supervision recommendations from the 12/11/17 and 1/2/18 IDT notes versus client E's 12/14/17 BSP which indicated 24 hour 1 to 1 supervision, QIDP #1 stated, "We aren't doing 1 to 1 ratio supervision on the overnights. We talked about it. We had staffing issues, the BSP should be clarified."			

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	QIDP #1 indicated there was only one staff on duty at the time of the 12/28/17 incident. QIDP #1 indicated client E should have been on 1 to 1 ratio supervision at the time of the 12/28/17 incident of client to client aggression between clients E and client F. When asked if one staff working in the home could implement client E's 1 to 1 ratio supervision, QIDP #1 stated, "No. We had staffing issues." When asked if the IDT had reviewed or discussed client E's pattern of insomnia, disruptive overnight behaviors or verbal and physical intimidation and theft of clients' personal property, QIDP #1 stated, "No, just the 1: 1 supervision." When asked if she was aware of ongoing issues regarding client E's insomnia, LPN #1 stated, "Yes. I'm pretty sure he's on a sleeping pill. Several including Melatonin (sleep aid)." LPN #1 stated, "He came with an order for Ambien (sleep aid) but when he saw [primary care physician], he discontinued it. I would have to go back to look at the record of visit to see why. Don't quote me but I believe he increased the Melatonin and discontinued the Ambien but I'd have to look at the record of visit." When asked if there had been any additional follow up with client E's PCP (Primary Care			

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	Physician) or nursing measures to track/monitor his insomnia for later follow up, LPN #1 stated, "He saw [PCP] a couple of weeks later but didn't change the medication." LPN #1 stated, "It (insomnia) wasn't officially tracked. They (staff) were just kind of monitoring and then letting [HM #1] know. [HM #1] would take him to his appointments. But not officially tracked anywhere." When asked to provide documentation of client E's PCP visits regarding insomnia, LPN #1 stated, "Yes, I will have to check my folder but yes we probably do." When asked to clarify the reason for client E's 11/17/17 psychiatric services visit, LPN #1 stated, "He was seen on 11/17/17 for his initial intake. When they first get admitted they go to [clinic] to meet the doctor and do consultation to get acquainted and then they go from there." LPN #1 indicated client E had not received additional or follow up psychiatric review/services regarding insomnia, aggression or obsessive behaviors since his intake on 11/17/17. LPN #1 indicated she had not participated in any IDT meetings to discuss client E's behaviors or insomnia. LPN #1 via email correspondence on 1/10/18 at 1:53 PM provided a copy of client E's 11/16/17 Record of Visit for a physical assessment with his PCP. The			

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	11/16/17 indicated client E was given a prescription for Zolpidem 10 milligrams at bedtime for insomnia. LPN #1's electronic correspondence dated 1/10/18 indicated, "Hello, after speaking with staff, I was informed that [client E] did not go to his 2nd appointment with [PCP]. On the day that it was scheduled [client E] had to go to the hospital to get his labs drawn because he bit (sic) [client B] and we had to rule out any infectious diseases." LPN #1 did not provide additional documentation regarding client E's Ambien/Zolpidem 10 milligrams for insomnia being discontinued. LPN #1 indicated there had not been communication with client E's PCP regarding the effectiveness of client E's medications for the treatment of insomnia. The facility's policy and procedures were reviewed on 1/12/18 at 10:00 AM. The facility's Abuse, Neglect, Exploitation (and) Mistreatment Policy dated 2/26/11 indicated the following: -"Policy: Adept staff actively advocates for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, or mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of Adept, ResCare and local state			

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	and federal guidelines." -"Physical abuse: the act or failure to act that results or could result in physical injury to an individual. Non-accidental injury inflicted by another person or persons." -"Verbal abuse: the act of insulting or profane language or gestures directed toward an individual that subjects him/her to humiliation or degradation. Coarse, loud tone or language that is perceived by an individual as offending or threatening." -"Intimidation/emotional abuse: the act or failure to act that results or could result in emotional injury to an individual. The act of insulting or coarse language or gestures directed toward an individual that subject him/her to humiliation or degradation. Discouraging or inhibiting behavior by threatening both actual or implied. Attitude or acts that interfere with the psychological and social well being of an individual." -"Emotional/physical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need requirements such as food, drink, shelter,			

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	clothing and to provide a safe environment." -"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 with out a qualified person notification/review." -"Any Adept staff who suspects an individual is the victim of abuse, neglect, mistreatment, or exploitation should immediately notify this suspicion to their [supervisor]." 9-3-2(a)			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, record review and interview for 1 of 1 injuries of unknown origin reviewed, the facility failed to ensure an injury of unknown origin was immediately reported to the facility administrator regarding client A. Findings include:	W 0153	**CORRECTION:** *The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.* Specifically, all facility supervisory	02/07/2018

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	Observations were conducted at the group home on 1/8/18 from 4:00 PM through 5:30 PM. Client A was present in the home throughout the observation period. Client A had a 1 CM (Centimeter) circular shaped dark to light red area on his forehead above his right eyebrow area. Client A was interviewed on 1/8/18 at 4:11 PM. Client A was asked how he received the mark on his forehead, client A stated, "Don't know. Probably got bumped." HM (Home Manager) #1 who was present during the interview stated client A "Scratches himself sometimes". HM #1 indicated client A's finger nails were trimmed weekly. Client A was asked if he bumped into something or if he scratched himself, client A stated, "Yeah, scratched. Ran into a door." Client A's record was reviewed on 1/9/18 at 12:01 PM. Client A's PN (Progress Note's) dated from 11/1/17 through 1/8/18 did not indicate documentation of client A scratching or attempting to scratch himself. Client A's ISP (Individual Support Plan) dated 2/22/17 and BSP (Behavior Support Plan) dated 2/22/17 did not identify scratching or skin picking as targeted behaviors for client A. QIDP (Qualified Intellectual Disabilities		and direct support staff will be retrained to report suspected abuse, neglect, mistreatment and exploitation, -including but not limited to injuries of undetermined origin. **PREVENTION:** Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to the administrator. The QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to accurately report allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, the governing body will administer written corrective action up to and including termination of employment. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential	

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	Professional) #1, AS (Area Supervisor) #1, HM (Home Manager) #1 and LPN (Licensed Practical Nurse) #1 were interviewed on 1/9/18 at 1:07 PM. When asked was if client A had any injuries regarding his skin, HM #1 indicated client A had a circular red area on his forehead. When asked how client A described/reported how he sustained the injury, HM #1 stated, "He said he hit a door." When asked if client A was able to self-report injuries, HM #1 stated, "No." HM #1 stated, "It looked like he scratched himself." When asked if she had witnessed client A scratching or picking his skin, HM #1 stated, "No." When asked if staff had reported seeing client A scratching or picking his skin, HM #1 stated, "No." HM #1 stated, "It was an injury of unknown origin and should have been reported." QIDP #1 indicated she had not been notified of client A's 1/8/18 injury of unknown origin on his forehead. LPN #1 indicated she had not been notified of client A's 1/8/18 injury of unknown origin on his forehead. AS #1 indicated she had not been notified of client A's 1/8/18 injury of unknown origin on his forehead. QIDP #1 indicated injuries of unknown origin should be reported immediately to the supervisor and nurse and an investigation should be initiated.		Manager, Direct Support Staff, Operations Team, Regional Director	

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	An additional BDDS report was received via email and reviewed on 1/9/18 at 5:47 PM. The review indicated a BDDS report had been completed regarding client A's injury of unknown origin. The date of knowledge listed on the BDDS report was 1/9/18 at 5 PM. The review indicated client A's injury of unknown origin identified and discussed with HM #1 on 1/8/18 at 4:11 PM was not immediately reported to AS #1, QIDP #1 or LPN #1. 9-3-1(b)(5) 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), plus 3 additional clients (D, E and F), the facility failed to develop and implement effective corrective measures to address client E's ongoing verbal and physically aggressive behaviors (yelling, threats, biting, head butting and attempts at biting and head butting, theft/attempted theft of clients personal belongings) and verbal and physical disruption (jumping, screaming and entering other clients rooms during	W 0157	**CORRECTION:** *If the alleged violation is verified, appropriate corrective action must be taken.*Specifically, all staff have been trained on expectations for one to one observation of Client E, including but not limited to preventing client E from engaging in aggressive behavior including yelling, threats, biting, head butting and attempts at biting, head butting and accessing his housemate's belongings. The house manager will assure one to	02/07/2018

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	overnight hours to attempt to fight clients or steal their personal belongings) in the home creating an emotionally intimidating and hostile environment (an environment that is difficult or uncomfortable) for clients A, B, C, D and F. Findings include: Observations were conducted at the group home on 1/8/18 from 4 PM through 5:30 PM. At 4:22 PM, client E was in the medication administration room with HM (Home Manager) #1 and was being prompted to exit the medication administration room to prepare for the evening meal by HM #1. Client E repeatedly asked for candy while attempting to walk past HM #1 toward a desk in the room. HM #1 stated, "He wants the jar of candy I keep on my desk." HM #1 then picked up a glass jar of assorted chocolate candies and asked client E "Is this what you want"? HM #1 then directed client E to exit the room and repeatedly told him "You can have candy after you eat dinner. You have to eat your dinner and be nice". Client E continued repeatedly asking for the candy while attempting to reach the jar in HM #1's hands. HM #1 requested staff #1 to assist redirecting client E out of the medication room and to join his housemates in the		one staffing is scheduled on all shifts and will provide the Operations Manager with a one to one specific schedule detailing who will be on duty to handle one to one responsibilities. Supervisory staff from in and outside of the facility will fill any gaps in coverage. Additionally, the interdisciplinary team has assisted Client A with placing a lock on his door. Fill-in staff will receive client specific training for all clients prior to working at the facility, including but not limited to client E's enhanced supervision protocols. **PREVENTION:** When incidents occur, The QIDP Manager will guide the QIDP through the investigation and corrective measure implementation process, providing follow-up as needed but no less than daily. Additionally, the Quality Assurance Manager and QIDP Manager will follow-up with administrative level program staff (Program Manager and Operations Manager) The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per	

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	kitchen for the evening meal. Client E exited the medication administration room while HM #1 shut the medication administration room door and stood next to it holding it shut. Client E continued demanding candy from outside of the medication room door and began banging on the door while attempting to push his way inside the med room to get the candy jar from HM #1. HM #1 was interviewed on 1/8/18 at 4:26 PM. HM #1 stated client E "Perseverates over food" and "Will get aggressive towards staff and clients." When asked if any of the other clients in the home were fearful or intimidated regarding client E, HM #1 stated, "[Client F] is not. [Client A] is not. [Clients B, C and D] are. They are non-verbal so they can't tell you but you can tell by the way they act. Just visual. They don't want to be anywhere near [client E]. They go the opposite direction, both at home and work. We are in the process of putting [client E] in a different classroom than [clients B, C and D]." HM #1 indicated client E moved into the group home on 11/14/17 after the death of another client in the home. HM #1 indicated she was aware of 2 BDDS (Bureau of Developmental Disabilities Services) reports for fighting. HM #1 stated, "[Client E] takes everything. [Client D] can't play with his trucks. [Client		week, on varied shifts to assist with and monitor skills training including but not limited to including but not limited to proper implementation of behavior supports. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger and Registered Nurse) will review facility support documents and perform visual assessments of the facility no less than daily for the next 30 days, and after 30 days, will conduct administrative observations no less than three times weekly until all staff demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning	

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	E] takes them. [Client A] wants a lock for his room, [client E] takes all of his things. If he doesn't get what he wants he will take it or get aggressive. [Client E] will bite and head butt. He takes sheets and flushes them down the toilet." HM #1 indicated clients B and E were roommates. Staff #2 was interviewed on 1/8/18 at 4:45 PM. Staff #2 indicated she worked the evening shift from 2 PM-10 PM and on weekends from 8 AM -12 PM. When asked if the clients in the home got along, staff #2 stated, "They all do except [client E]. He doesn't get along with anybody." Staff #2 stated, "He's so aggressive. We try to redirect him. [Client D] has toys and [client E] will steal them from him. [Client D] will get mad and try to take it back. [Client D] is afraid. Sometimes [client E] pushes. We try to redirect. [Client B] likes to stay in his room. [Client B] avoids [client E] and will go to the other room to get away from him. They all avoid him." Staff #2 stated, "[Client E] steals from [client C] and goes through [client A's] pictures. This makes [client A] angry. [Clients B and C] are afraid. [Client E] does have a BSP (Behavior Support Plan) but it doesn't work." Staff #2 indicated clients B and E were roommates.		active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: ·The role of the administrative monitor is not simply to observe & Report. ·When opportunities for training are observed, the monitor must	

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	MC (Med Coach) #1 was interviewed on 1/8/18 at 5 PM. MC #1 stated, "Yes, [client E] takes (others) personal belongings. He tries to make other clients to do what he wants. He will hit, head butt and takes things from the kitchen and puts them down vents and toilets. I've heard about this from other staff and seen him do it on the weekends. He doesn't follow directions." When asked if the other clients were afraid of client E, MC #1 stated, "Some are. I see it when clients leave the area to get away from him. Some are non-verbal but I can tell. [Clients B, C and D] are. [Client B] is his roommate. [Client B] is afraid of him. [Client B] has scars on his arm and finger from where [client E] bit him. MC #1 indicated clients B and E were roommates. MC #1 indicated client E was currently on 1 to 1 ratio staff supervision. MC #1 stated, "They are supposed to be having a meeting to take him off 1 to 1 ratio staff supervision, I don't think it's safe. He needs 1 to 1 ratio staff supervision." MC #1 indicated 1 to 1 ratio staff supervision meant one staff was assigned to client E and remained shoulder to shoulder with him to monitor him and keep the other clients safe. MC #1 stated, "They want us to work by ourselves. Doesn't feel safe. If we are toileting or helping another client in the bathroom or bedroom while everyone is in the living room		step in and provide the training and document it. ·If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. ·Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training as needed. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring corrective measures are developed after substantiated incidents and implemented effectively. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff,	

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	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	with [client E] he might attack them." MC #1 indicated she had expressed this concern with HM #1. MC #1 indicated she had worked in the home by herself and didn't know client E was supposed to be 1 to 1 ratio staff supervised at the time. MC #1 indicated she had only become aware of client E's 1 to 1 ratio staff supervision protocol three days ago. Staff #1 was interviewed on 1/8/18 at 5:15 PM. Staff #1 indicated he started working at the home on 12/26/17 and worked the 4 PM -12 AM shift during weekdays. Staff #1 stated he had "worked a couple of times during the week by himself." Staff #1 stated, "[Client E] is very difficult. Can't leave him alone with others. Gets violent and will attach others. Bites and head butts." When asked if the other clients in the home were afraid of client E, staff #1 stated, "Afraid? [Clients B, C and D] are but not [clients A or F]. He steals and takes toys. [Client E's] a bully." Staff #1 indicated 1 to 1 ratio staff supervision meant to maintain client E at arm's length. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were viewed on 1/8/18 at 6 PM. The review indicated the following:		Operations Team, Regional Director	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	1. BDDS report dated 11/29/17 indicated, "Staff reported as [client B] and [client E] were in the dining area engaging in horse play. Staff discovered a bite mark with broken skin on [client B's] right arm, approximately 3 inches in length. The ResCare nurse (unknown) was present when it happened and instructed staff to clean the area and take [client B] to [medical clinic] to be assessed. [Client B] was taken to [medical clinic] where he was assessed and prescribed antibiotics for the bite. [Client E] has a history of physical aggression and harming others. Both individuals were provided emotional support from the staff. [Client E] will receive testing to rule out the presence of blood borne pathogen. The administrative team is aware of the incident and the IDT (Interdisciplinary Team) will meet to put additional protective measure in place. Staff will notify the administrative team of any further concerns." 2. BDDS report dated 12/9/17 indicated, "As [client B] was exiting the medication room, before staff could intervene, [client E] grabbed [client B's] right hand and bit him. Staff immediately separated the two individuals and redirected [client E] verbally. The ResCare nurse was notified and instructed staff to have [client B] examined by a physician. [Client B] was taken to			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	[hospital] where he was assessed and diagnosed with a bite on (his) right hand, and was prescribed an antibiotic to be taken twice daily for seven days. [Client E] has a history of physical aggression and harming others. Both individuals were provided emotional support from the staff. Immediate protective measures are in place. Specifically, [client E] has been placed on one on one supervision during wakening (sic) hours and 15 minute checks during sleeping hours. The administrative team is aware of the incident and staff will notify the administrative team of any further concerns." 3. BDDS report dated 12/29/17 indicated, "While preparing to eat breakfast, [client E] moved [client F's] chair from behind him and [client F] hit [client E] in the back of the head with an open hand. Staff immediately separated the two and verbally redirected them both. There were no injuries noted. Both individuals were provided emotional support from the staff and physical aggression is addressed in both individuals' behavior support plans. The administrative team is aware of the incident and the IDT will meet to discuss additional protective measures. Staff will notify the administrative team of any further concerns." -Investigation Final Report dated 1/8/18			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	indicated MC #1 was the only staff on duty in the home at the time of clients E and F's incident of physical aggression. The facility's Time Detail Sheets dated 1/2/18 through 1/9/18 were reviewed on 1/9/18 at 10:49 AM. The review indicated the following: -1/2/18: The review did not indicate documentation of staff working in the home from 10 PM- 11:59 PM. -1/3/18: The review did not indicate documentation of staff working in the home from 12 AM through 7 AM and from 3 PM through 6 PM. The review indicated one staff was on duty in the home from 7 AM to 3 PM. -1/4/18: The review did not indicate documentation of staff working in the home from 3 PM to 6 PM. The review indicated one staff was on duty at the home from 6:30 PM through 11:59 PM. -1/6/18: The review indicated one staff was working in the home from 12 AM to 8 AM and from 7 PM to 11:59 PM. -1/7/18: The review indicated one staff was working in the home from 12 AM to 8 AM			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	and from 7 PM to 11:59 PM. -1/8/18: The review indicated one staff was working in the home from 12 AM to 9 AM. Interview with HM #1 on 1/8/18 at 5:30 PM indicated clients A, B, C, D, E and F got up for day program at 6 AM, completed hygiene, received medications, participated in the home's family style morning meal and then departed for day services between 8 AM and 8:30 AM. Day Service Manager (DSM) #1 was interviewed on 1/9/18 at 9:14 AM. DSM #1 indicated clients B, C, D and F were in the same classroom. DSM #1 indicated client E had been in the same classroom until yesterday (1/8/18). DSM #1 indicated she was not aware client E had been placed on 1:1 supervision or have a copy of his most recent (12/14/17) BSP with his 1 to 1 ratio protocol. DSM #1 indicated she was not a participant in the 12/11/17 or 1/2/18 IDT meetings and the IDT recommendations regarding 1:1 supervision or keeping client E separated from clients B and F had not been communicated. DSM #1 stated, "They were in the same class and did group." DSM #1 stated, "[Client E] slept most days but has improved."			

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	Client E's day services record was reviewed on 1/9/18 at 9 AM. Client E's day services record indicated client E's ISP was dated 8/2/16, BSP was dated 8/2/16. Client E's day services record did not indicate documentation of client E's ISP dated 11/17/17, BSP dated 12/14/17. QIDP (Qualified Intellectual Disabilities Professional) #1, AS (Area Supervisor) #1, HM (Home Manager) #1 and LPN (Licensed Practical Nurse) #1 were interviewed on 1/9/18 at 1:07 PM. QIDP #1 indicated the day services should have current copies of ISP's, BSP's and High Risk Health Plans. HM #1 indicated client B's 11/28/17 and 12/11/17 bite wounds were a result of client E biting him. HM #1 indicated clients B and E were roommates. QIDP #1 indicated staff working in the home had been retrained on implementation of client E's 1 to 1 ratio staff supervision following the 1/2/18 IDT. QIDP #1 indicated staff should be implementing one to one ratio supervision during the day and completing 15 minute checks during sleep. When asked to clarify client E's 15 minute checks during sleeping hours in contrast to client E's 12/14/17 BSP protocol indicating 1 to 1 ratio should continue being implemented during the overnight/sleeping hours, QIDP #1 stated, "We discussed that			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	and thought he probably needed the one to one ratio supervision overnight but there were staffing concerns." QIDP #1 indicated the facility did not have enough overnight staff available to implement one to one ratio staff supervision as described in his 12/14/17 BSP regarding client E assessed supervision needs. QIDP #1 indicated clients B and E were roommates. QIDP #1 indicated the day services should participate in client E's 12/11/17 and 1/2/18 IDT meetings and the recommendations should have been communicated with the day services regarding client E's one to one ratio supervision. QIDP #1 indicated there should be two staff on duty in the home to implement client E's one to one ratio supervision. QIDP #1 indicated corrective measures should be developed and implemented to prevent recurrence of all allegations of abuse, neglect, mistreatment and injuries of unknown origin Client E's record was reviewed on 1/11/18 at 9:18 AM. Client E's BSP (Behavior Support Plan) dated 12/14/17 indicated the following: -"[Client E] at times will become obsessive over things. [Client E] will steal items at the			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	store, takes items from housemates, non-compliance, obsesses over what is on his mind (always food), kitchen and food are locked. He struggles with biting self, hitting, head butts, and he has alarms on door due to eloping and will pick at his skin." -"Some of his targeted behaviors consist of physical aggression, self-injurious behavior, pacing around, leaving assigned area, and repetitive actions." -"Physical Aggression: any time [client E] strikes, spits, grabs, kicks, bites, pinches, is threatening, and throwing objects at others that have the potential to cause injury." -"Verbal Aggression: any time [client E] shouts and/or screams at peers and/or staff to include insults, vulgar comments, obscenities and demeaning comments. -"Threats to Harm Others: any time [client E] makes a statement that he will harm staff and/or peers (kill them in their sleep, burn the house down, break their knee) or refers to events in his past when he has harmed others." -"The following precursor behaviors have been identified: change (minor or major), family conflict, staff conflict, persons			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	violating his personal space, sitting up in bed in the middle of the night, not sleeping at night, taking things from others, making threats to harm others, repeating words/phrases to staff to gain attention. [Client E] will seek out targets, i.e. he will stare for a short period of time and will have rapid eye movement prior to engaging in verbal and physical aggression." -"When [client E] engages in physical aggression, his tendency is to lash out in every direction with his hands/fists and his feet in order to attack anyone in his reach. Staff must provide personal space to his and must insure the environment surrounding [client E] is clear of obstructions and that [client E] is given plenty of space to maneuver. [Client E] has a tendency to drop to the floor when he is physically aggressive and continue to swing at and/or kick at anyone and anything within his reach." -"Property Destruction/Disruption, Self-Injury and Physical Aggression. Do not overreact, try to maintain a calm and emotionless demeanor. Immediately ensure the health and safety of everybody in the immediate area. In a firm and polite voice ask his to stop the behavior, and redirect his to a quieter area away from other, either outside (back patio) or to his room.			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	Encourage his to use his calming strategies (alone time; journaling; listening to music; writing letters; writing and telling funny stories.) Throughout this process minimize verbal interactions with his and never get into a power struggle. If the behavior persists and he is placing himself or others in immediate danger implement You're Safe I'm Safe (YSIS). Position yourself between [client E] and his peers. In a calm but firm voice verbally redirect [client E] to a different location/area/activity. Block physical aggression and property destruction. If [client E] is continuing to place himself or others in jeopardy, use the YSIS procedures in the following order: Physically redirect. One person hold. Two person hold. When using these holds, be aware that [client E] may attempt to bite, hit or struggle, position yourself so that you are safe. If needed have his peers move to a safe location where [client E] cannot aggress towards them. Let his know what you are doing but do not engage in conversations with his." -"Staff Actions: One to One ratio Staffing. [Client E] will have a 1:1 staff as determined by the QIDP and Behaviorist. The purpose of the 1:1 staff is to provide uninterrupted observation of and intervention toward [client E] to keep him from harming himself			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	or others. [Client E] is that staff's only focus. Staff will be in the same room with [client E] and will be positioned close enough to physically intervene using you're Safe I'm Safe (YSIS); [client E] will be within staff line of sight if he attempts to harm himself or others. This includes every room he enters as well as in his room overnight while he is asleep. Whenever [client E] is awake in a room sitting down or lying down, the staff will position themselves as close to [client E] as possible while remaining standing and be prepared to block his access to the nearest hard surface. When [client E] is asleep, staff will position themselves as close to [client E] as possible. Staff may sit or stand but must still be able to block his access to the nearest hard surface if needed. [Client E's] head and face must be visible to staff at all times when [client E] is sleeping. If [client E] pulls the blanket over his face/head, staff will immediately move it to insure his head and face is visible. Every 15 minutes staff must visually and physically check [client E] to insure he is breathing, the space around his face/neck is clear of obstructions and clear the space if necessary. The 1:1 staff may have a paper copy of [client E's] BSP and therapy coping skills for reference to assist [client E] in understanding his actions and their consequences. These copies must			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	remain in staff's possession at all times and may be passed to the next staff during change over. Staff will not have a pen or pencil on their person while performing 1:1 with [client E]. When [client E] requires 1:1 staff, every staff scheduled on each shift will rotate through and provide direct oversight of [client E] in 30 minute intervals. Staff will change out every 30 minutes and will sign in/out on a 1:1 staffing sheet. The non-1:1 staff will conduct a room sweep and all objects will be removed from [client E's] room (including curtains/rods and all dolls) except one pillow and one blanket. Staff may talk with [client E], while on 1:1, if [client E] initiates conversation, but staff must keep it supportive, encouraging in nature and related to the behaviors he is demonstrating at the time and their resolution. This includes discussion of his BSP, proactive and reactive strategies and coping skills. No superficial conversation should occur between 1:1 staff and [client E] or 1:1 staff and other staff. The 1:1 will position themselves between [client E] and the nearest hard surface (walls, hard tables etc.) while maintaining line of sight with [client E]. The 1:1 will walk slightly behind [client E] and to one side, the side closest to the nearest hard surface and close enough to physically intervene if he attempts to harm himself or others. Whenever [client E] walks			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	into another room, the 1:1 staff will scan the room for any possible item that [client E] may use to harm himself and inform the other staff to remove the items. When [client E] is on 1:1, he may not sit on the front porch, front yard or non-fenced area of the property as there is risk of his running to the street and into traffic. He may sit on the patio in the fenced back yard. When [client E] is on 1:1, he may only be transported in the group home van and may only sit on one of the bench seats with staff sitting next to him. He may not sit in the passenger front seat. Staff will sit next to the window in order to block [client E] from hitting his head or body on it. Working on goals that allow him access to items that he could use to harm or kill himself. At the first sign of a precursor behavior by [client E] or by one of his housemates, lock the sharps (or items which can easily be made into a sharp) as well as the cleaning chemicals which could be ingested. This includes eating utensils (such as forks, spoons, knives), cooking utensils (spatulas, wooden spoons, serving spoons, measuring cups, measuring spoons, ice cream scoops, pizza cutters, whisk, cookie cutters, meat thermometers, potato peelers). This also includes cleaning chemicals (such as laundry soap, dish soap, hand soap, dryer sheets, general purpose cleaner, toilet bowel cleaner, hand sanitizer).			

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	These items should remain secured until the immediate risk from exposure has passed and/or until [client E] is off of 1:1 and has been assessed as being in control and not a danger to himself and/or others." -"Staff Actions: Day Service. If the precursors occur while at day service: his workshop supervisor will notify additional staff and QIDP. [Client E] will have 1:1 staff while at day service. That staff will remove [client E] from the day service area and sit with him in a different area. Staff will be positioned close enough to him to use day service/residential provider approved crisis intervention procedures to ensure his health and safety as well as that of peers and staff. Day service Supervisor will notify the QIDP and Behaviorist and the above steps will be followed for precursor behaviors. Day service Supervisor will notify QIDP if [client E] requires dismissal from day service and when suspension from day service is necessary." Client E's 12/11/17 IDT note indicated, "The team met because [clients B and E] has been involved in two client to client aggression incidents within the last two weeks. The team decided that it would be best to place [client E] on line of sight at all times to ensure the safety of the other			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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

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	clients. Staff will also keep [clients B and E] separated from one another." The list of participants was as follows: QIDP #1, HM #1, and PM #1. The 12/11/17 IDT did not include documentation of Day Services staff's participation in the IDT discussion or recommendations. Client E's 1/2/18 IDT note indicated, "The team met because [clients E and F] was (sic) involved in a client to client aggression (incident). The team decided that it [client E] (sic) was to be placed on 1:1 (ratio) supervision and this will help to reduce to (sic) incidens (sic) of client to client aggression. Staff is to also ensure that the two individuals are kept separated from one another." The list of participants was as follows: QIDP #1, HM #1, and PM #1. The 1/2/18 IDT did not include documentation of Day Services staff's participation in the IDT discussion or recommendations. Progress Note (PN) dated 11/15/17 10 PM -10 AM shift indicated, "[Client E] was walking up and down the whole house. He didn't sleep all the night. He started requesting for (sic) all kinds of stuff. He struggled with staff because he didn't get his way to the fridge, or med room." PN dated 11/15/17 10 AM - 1 PM shift			

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	indicated, "[Client E] has been very aggressive this morning. He continues to go in roommate's room and taking items. [Client E] has tried biting and pushing so that he was able to get out of (the) door or inside the med room." PN Dated 11/15/17, 2 PM -10 PM shift indicated, "Came back (from transport) very unsettled in the house. He became aggressive with [client B] and trying to head butts (sic) him. Kept going in and out of the kitchen trying to open the oven while staff was making dinner. Both staff and house manager redirected him several times. Only settled down at dinner time, ate fine and stole his housemate's food. Kept telling staff he was going to bite his roommate, [client B], and staff. Since then kept him on line of sight." PN dated 11/18/17, 9 PM- 9 AM indicated, "[Client E] awake around 3 AM walking up and down (sic), jumping, screaming and yelling. [Client E] (was) asking for some stuff in the house." PN dated 11/18/17, 8 AM- 8 PM shift indicated, "Very unsettled, trying to elope from the house. Only settle (sic) a bit when his mom and brother visited. [Client E's] mom brought him lunch, (sic) ate fine. After			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	his mom left [client E] was still trying to elope but staff (unspecified) kept redirecting him. [Client E] has been going in and out of other housemates' room (sic) taking their stuff, (sic) hitting [client B]." The review did not indicate documentation of client E's hitting client B on 11/18/17 being reported to BDDS or investigated. PN dated 11/19/17, 9 PM- 9 AM shift indicated, "[Client E] awake (sic) was slept around 1 AM. After (a) few hours [client E] woke up and (started) jumping, screaming and walking around the house, (sic) he trying to pen the med room door also. At 7 AM, med's were giving (sic) and [client E] (was) trying to take [client D's] [toy] and push the staff and [HM #1]." PN dated 11/19/17, 8 AM- 8 PM shift indicated, "[Client E] was already awake on staff's arrival at site. He pulled staff and clients during the shift, he attempted to elope (and was) trying to take what does not belong to him." PN dated 11/20/17, 8 PM- 9 AM shift indicated, "[Client E] woke up around 2 AM and (was) trying to fight with staff and go into [client C's] room and (sic) trying to wake [client C] up and (sic) trying to fight			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	with him and (sic) jumping and (sic) screaming." PN dated 11/20/17, 8 AM- 8 PM shift indicated, "[Client E] woke up around 2 AM and (was) trying to fight with staff and go into [client C's] room and trying to wake [client C] up and (sic) trying to fight with him. And jumping and screaming." PN dated 11/20/17, 4 PM- 12 AM shift indicated, "[Client E] started walking around going from one bedroom to another, (sic) making several demands." PN dated 11/21/17 12 AM - 8 AM shift indicated, "Upon arrival [client E] was watching TV and walking towards [client A's] room to wake him up by keeping open his door. Also he does not allow [client C] to sleep by opening his door too. Staff redirect him to the living room which he did and continued to waking around the house." PN dated 11/22/17 12 AM - 8 AM shift indicated, "[Client E] was met in the house sitting on the floor and looking at his book. [Client E] didn't slept (sic) at all. He started walking around asking (for the) same things all the times (sic). He trying (sic) to open the fridge and snack cabinet."			

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	PN dated 11/23/17, 12 AM - 8 AM shift indicated, "[Client E] was met on bed upon arrival. He slept a few hours and (sic) getting up to waking around for period of couple of hours. Writer prompted him to go to bed and he went back and lay (sic) on the bed." PN dated 11/23/17, 9 AM - 9 PM shift indicated, "[Client E] was up walking around the house upon staffs arrival, ate fine, very unsettled all day. Mom visited him and brought him lunch. Trying to elope, trying to hit staff when staff tried to stop him from going out. Still unsettled, kept going to [client A's] room packing his pictures." PN dated 11/24/17, 4 PM - 12 AM shift indicated, "[Client E] staff (sic) met him walking around in the evening, taking what does (sic) not belong to him. Attempted to elope (and) making unnecessary demands." PN dated 11/24/17, 12 AM -8 AM shift indicated, "[Client E] slept until 1:30 AM. He was up toileting and stay(ed) in the living room. Talking, jumping, and walking around the house." PN dated 11/27/17 12 AM - 8 AM shift indicated client E was up during the overnight house and was going into his housemates rooms and jumping around the			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	house. PN dated 12/1/7 12 AM - 8 AM shift indicated, "[Client E] at home walking around the house. Taking stuff, asking for stuff. Jumping and screaming until 4 AM. He went to bed and was up at 7 AM." PN dated 12/1/17 2 PM - 10 PM shift indicated, "[Client E] has been unsettled all evening. Attended Christmas party at the office, he refused to settle down at the party. Came back home and went to [client A's] room got most of his pictures out. This resulted in making [client A] very angry and upset. Staff redirected [client E] but he refused. He later left (sic) for [client C's] room whenever staff redirected him [client E] uses [expletives] on staff." PN dated 12/2/17 12 AM - 8 AM shift indicated, "[Client E] slept till 3: 15 AM and up walking around the house. Jumping, screaming, asking for some stuff and taking some stuff." PN dated 12/2/17 8 AM - 8 PM shift indicated, "[Client E] was already up upon staffs arrival. Very unsettled and aggressive towards housemates and staff. Kept going to [client A's] room to get his pictures and other stuff out to place items on the floor in			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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

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	the living room, he became aggressive when staff redirected him. Kept pulling [client B] out of the chair whenever [client B] tried to settle down on the sofa. Still unsettled at time of report. Stood right in front of staff in the dining area and peed on himself twice and he will start laughing whenever he does it." PN dated 12/3/17 8 PM - 8 AM shift indicated, "[Client E] slept until around 2 AM and up walking around the house. Jumping and screaming and asking for some stuff. Taking stuff." PN dated 12/3/17 8 AM - 8 PM shift indicated, "[Client E] was already awake jumping around the house upon staff arrival. He later became aggressive to the clients and staff in the house. Taking what does not belong to him with force, going from one bedroom to another. He made several attempts to open the kitchen cabinets and deliberately peed on himself." PN dated 12/4/17 12 AM - 8 AM shift indicated, "[Client E] slept until 2 AM and up walking around the house. Jumping, screaming, and asking for some stuff and food. He was assisted with hygiene, dressing and took his med's. Ate breakfast, trying to hold [client B's] arms and he was stopped."			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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PN dated 12/4/17 4 PM - 12 AM shift indicated, "[Client E] was running around the house with his blankets in his hand upon staff's arrival at the site. He frequently going to (sic) other consumer's bedroom, packing their belongings out (sic) playing with kitchen sink, attempting to bite staff and clients. Staff made (sic) they redirected him whenever he attempts to bite and elope."

PN dated 12/6/17 12 AM - 8 AM shift indicated, "[Clie
nt E] slept until 12:20 AM and up walking around the house not sleeping until morning. Jumping, screaming and asking for stuff like food."

PN dated 12/6/17 7 AM- 3 PM shift indicated, "[Client E] was constantly trying to fight with his housemates saying he is going to bite [clients B and C]. I redirected [client E] away from but he continued to push and try to force himself where they were. He then turned his attention toward staff because he was not able to go out or get to housemates."

PN dated 12/6/17 2 PM- 10 PM shift indicated, "[Client E] has been very unsettled upon his arrival from day program. Picking stuff from housemate's room. Mostly [client

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	A's]. Very angry. [Client E] kept saying he will bite [client C] but staff kept him in line of sight." PN dated 12/7/17 12 AM - 8 AM shift indicated, "Upon arrival [client E] was in his room sleeping. At 1 AM, he woke up and started walking around the house. [Client E] started picking up some stuff out of from the kitchen. He did not slept (sic) at all throughout the night." PN dated 12/7/17 4 PM - 12 AM shift indicated, "[Client E] was trying to gain access to the kitchen while staff was preparing the dinner. Jumping around snatching other clients stuff aggressively." PN dated 12/8/17, 12 AM- 8 AM shift indicated, "[Client E] slept for (a) few hours in (sic) the midnight woke up and started walking around the house and opened [client C's] door throughout the night." PN dated 12/8/17, 2 PM- 10 PM shift indicated, "Upon picking [client E] up from day program, day program staff reported [client E that (sic) he's been saying he was going to bite someone. Staff asked if [client E] mentioned any names but day program staff said he did not but he kept saying he was going to do it. [HM #1] was informed			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	immediately. [Client E] has been very unsettled, fighting with [client D] over [client D's] toy truck and entering [client A's] room, taking his pictures and placing them on the floor. [Client A] was so angry about it but staff told [client A] to calm down. [Client e] has been using [expletives] on staff while staff were trying to redirected (sic) him. Pushing and trying to bite staff while staff told him to stay (away) from (the) hot stove and while he was trying to open the oven when the oven was in use and very hot. Staff did what they could but [client E] still remains adamant." PN dated 12/10/17, 12 AM- 8 AM shift indicated, "[Client E] bit [client B] on his way out from the med room. [Client E] quickly grab (sic) [client B's] hand and bite (sic) him. Staff intervene and rescue(d) [client B] from [client E]. [Client E] attacked staff and writer redirect him to (the) living room." PN dated 12/10/17, 8 AM- 8 PM shift indicated, "[Client E] was already awake in the morning upon staff's arrival at the site. After an hour [client E] suddenly rushed to where [client C] was sitting in an attempt to bite [client C]. Immediately staff quickly intervened and redirected him from [client E]. After his breakfast he went back to			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	[client C] again an attempt to bite but staff prevented him, while staff was trying to divert his attention from [client C] he was furious at the staff." PN dated 12/12/17 12 AM- 8 AM shift indicated, "Upon arrived (sic) [client E] was slept (sic) in his room. After 1 hour he woke up at 1:30 A and started walking around, jumping around and still picking up some stuff up (sic) and playing with it until this morning at 5:45 AM he went to his room and lay down without any issue (sic)." PN dated 12/12/17, 4 PM- 12 AM shift indicated, "[Client E] was entering the house when staff arrived, was aggressive at other clients. Staff diverted his attention when he made attempts to bite." PN dated 12/13/17, 10 PM- 9 AM shift indicated, "Upon arrived (sic) [client E] was slept (sic) in his room. After few hours he woke up at 1:20 AM and started walking around, jumping around and playing with (a) toy until this morning." PN dated 12/13/17, 2 PM - 10 PM shift indicated, "[Client E] was picked up at day program. Very unsettled. On getting home (sic) he starts going into [client A's] room to some of his pictures out. Staff redirected him			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	but he wouldn't listen. Trying to force some of the kitchen cabinets back open." PN dated 12/16/17, 9 PM- 9 AM shift indicated, "Upon arrived [client E] was playing in the living room, after few minutes he slept (sic) and he woke up at 2 AM and started walking around, jumping around." PN dated 12/16/7, 8 AM - 8 PM shift indicated, "Very unsettled all day, fighting his housemates over their toys and stuff. Refused to be redirected." PN dated 12/17/17, 9 AM-9 PM shift indicated, "[Client E] didn't slept (sic) throughout the night. [Client E] walking around the house jumping, screaming (and) also opened other clients' doors." PN dated 12/17/17 8 AM- 8 PM shift indicated, "[Client E] was already awake running around upon staff's arrival at the site. He was very unsettled, stealing, and aggressive towards staff and consumers attempting to bite." PN dated 12/17/17, 2 PM -10 PM shift indicated, "[Client E] has been very unsettled upon his arrival from day program. In and out of the kitchen, taking [client D's] toys and fighting him for his trucks. Went to			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	[client A's] room and took some of his pictures and placed them on the floor in the living room. Refused to be redirected. Peed on himself." PN dated 12/18/17 8 PM- 8 AM shift indicated, "[Client E] didn't slept (sic) throughout the night. [Client E] walking around the house jumping, screaming around (sic)." PN dated 12/18/17 4 PM- 12 AM shift indicated, "[Client E] was trying to gain his access to the kitchen upon staff's arrival at the site. Several attempts were made by him to forcibly open the medications room in order to disorganize (unknown) the office. He said repeatedly that he is going to bite someone. Staff kept eyes on him throughout the shift." PN dated 12/19/17, 9 PM- 9 AM shift indicated, "Upon arrived (sic) [client E] was in the living room walking around, screaming around the house. [Client E] slept around 4 AM this morning." PN dated 12/19/17, 2 PM- 10 PM shift indicated, "[Client E] was picked up at day program. Came back home usual unsettled self. Fight with housemates over their belongings, taking out blankets from the			

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	closet and taking out stuff from (the) kitchen cabinet. Refused to be redirected very aggressive towards housemates and staff." PN dated 12/20/17, 9 PM - 9 AM shift indicated, "[Client E] didn't sleep all through the night. His activities woke his roommate, [client B], up. He attempted to bite his roommate, [client B], countless times. Staff stood against him and redirected him though forcefully thereby also attempted biting staff. He started sleeping at about 6:45 AM." PN dated 12/20/17, 2 PM- 10 PM shift indicated, "[Client E] has been very unsettled, fighting, refused to be redirected. Kept going in and out of [client A's] room. This makes [client A] angry and [client A] was using [expletives] while trying to explain to staff." PN dated 12/21/17, 12 AM- 8 AM shift indicated, "[Client E] slept (sic) upon arrived (sic). After one hour he woke up, said he needs shower and staff gave him shower. [Client E] started walking around the house. At 5:30 AM [client E] trying to attack [client B]. Staff redirected him to another area." PN dated 12/22/17 9 PM -9 AM shift indicated, "[Client E] was asleep when staff arrived. He was woken up for his bedtime			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

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	meds, he took the med and went back to sleep. He then woke up by himself at 12 AM and remained awake all through the night. He kept roaming the living room." PN dated 12/22/17, 2 PM- 10 PM shift indicated, "[Client E] was picked up at day program. Slept through while transported to the house. ON his arrival at the house he became restless, wondering around the housemate's room, picking their stuff and picking stuff from the kitchen cabinet. Very unsettled all evening." PN dated 12/29/17, 9 PM -9 AM shift indicated, "[Client E] slept between 9 PM-12 AM. He was awake from 12 AM to this morning. He kept disturbing staff all through the night. [Client E] going to the closet to get the blankets out, taking stuff out of kitchen cabinet." PN dated 12/29/17, 6 AM - 2 PM shift indicated, "[Client E] was very active this morning. Kept trying to take things from kitchen while staff was preparing breakfast. [Client E] ate breakfast, then began to bother other housemates taking their personal belongings." PN dated 12/31/17, 6 PM- 10 AM shift indicated, "[Client E] slept upon arrived.			

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	01/12/2018

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	After few hours he woke up. He was awake from 1 AM till this morning. He kept jumping around the house screaming around." PN dated 12/31/17, 8 AM- 4 PM shift indicated, "[Client E] had a busy morning he continued to bother housemates taking their items and approaching staff in negative manners. [Client E] did not follow any instructions given by staff. [Client E] had to be seated with 1 to 1 approach to sit for long period of time. With 1 to 1 approach by staff [client E] fell asleep for 1 hour." PN dated 1/3/18, 9 PM - 9 AM shift indicated, "[Client E] was awake when staff arrived. He later dozed off and was lead to his room after he had taken his bedtime meds. He also took his morning meds and ate his breakfast. No issues except his attempts twice of wanting to bite [client D]." PN dated 1/4/18, 5 PM - 9 AM shift indicated, "[Client E] was awake all the night long. He took his bedtime meds though. He also took his morning meds and has his breakfast and got dressed for day program. He attempted twice to bite [client B] and staff but staff redirected and gave him close monitoring."			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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PN dated 1/5/18, 5 PM - 9 AM shift indicated, "[Client E] only slept for 2 hours after his bedtime meds. He was awake all throughout the night thereafter. He took his breakfast and his morning meds. He attempted to bite [client F], [client B] and staff but he was prevented."

PN dated 1/8/18, 5 PM - 9 PM shift indicated, "[Client E] was awake till 4 AM. He slept briefly for 2 hours and woke up again."

PN dated 1/8/18, 4 PM- 9 PM shift indicated, "[Client E] took away other clients toys."

PN dated 1/9/18, 9 PM - 9 AM shift indicated, "[Client E] was awake when staff arrived. He stayed awake all through the night. He kept pacing around the whole house. Staff prevented him from hitting [client B] on his bed twice. Staff also prevented himself from being bitten."

Client E's 12/11/17 IDT note, 1/2/18 IDT note and record did not indicate review, discussion or recommendations to address client E's 12/14/17 regarding the overall pattern of stealing items from peer's, his identified precursor behavior including

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	insomnia and physical and verbal aggression towards his housemates, including his roommate. QIDP #2, LPN #1 and QIDP #1 were interviewed on 1/10/18 at 12 PM. QIDP #1 stated, "The 1/2/18 IDT meeting should say 1 to 1 ratio supervision to continue. He had already been on 1 to 1 ratio supervision from the 12/11/17 IDT." QIDP #1 stated, "Staff were not implementing his 1:1 ratio supervision. We did retraining. He should be 1: 1 ratio supervision during wake hours and 15 minute checks on overnight." QIDP #1 was asked to clarify the difference in supervision recommendations from the 12/11/17 and 1/2/18 IDT notes versus client E's 12/14/17 BSP which indicated 24 hour 1 to 1 supervision, QIDP #1 stated, "We aren't doing 1 to 1 ratio supervision on the overnights. We talked about it. We had staffing issues, the BSP should be clarified." QIDP #1 indicated there was only one staff on duty at the time of the 12/28/17 incident. QIDP #1 indicated client E should have been on 1 to 1 ratio supervision at the time of the 12/28/17 incident of client to client aggression between clients E and client F. When asked if one staff working in the home could implement client E's 1 to 1 ratio supervision, QIDP #1 stated, "No. We had staffing issues."			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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When asked if the IDT had reviewed or discussed client E's pattern of insomnia, disruptive overnight behaviors or verbal and physical intimidation and theft of clients' personal property, QIDP #1 stated, "No, just the 1: 1 supervision."

When asked if she was aware of ongoing issues regarding client E's insomnia, LPN #1 stated, "Yes. I'm pretty sure he's on a sleeping pill. Several including Melatonin (sleep aid)." LPN #1 stated, "He came with an order for Ambien (sleep aid) but when he saw [primary care physician], he discontinued it. I would have to go back to look at the record of visit to see why. Don't quote me but I believe he increased the Melatonin and discontinued the Ambien but I'd have to look at the record of visit." When asked if there had been any additional follow up with client E's PCP (Primary Care Physician) or nursing measures to track/monitor his insomnia for later follow up, LPN #1 stated, "He saw [PCP] a couple of weeks later but didn't change the medication." LPN #1 stated, "It (insomnia) wasn't officially tracked. They (staff) were just kind of monitoring and then letting [HM #1] know. [HM #1] would take him to his appointments. But not officially tracked anywhere." When asked to provide

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	documentation of client E's PCP visits regarding insomnia, LPN #1 stated, "Yes, I will have to check my folder but yes we probably do." When asked to clarify the reason for client E's 11/17/17 psychiatric services visit, LPN #1 stated, "He was seen on 11/17/17 for his initial intake. When they first get admitted they go to [clinic] to meet the doctor and do consultation to get acquainted and then they go from there." LPN #1 indicated client E had not received additional or follow up psychiatric review/services regarding insomnia, aggression or obsessive behaviors since his intake on 11/17/17. LPN #1 indicated she had not participate in any IDT meetings to discuss client E's behaviors or insomnia. LPN #1 via email correspondence on 1/10/18 at 1:53 PM provided a copy of client E's 11/16/17 Record of Visit for a physical assessment with his PCP. The 11/16/17 indicated client E was given a prescription for Zolpidem 10 milligrams at bedtime for insomnia. LPN #1's electronic correspondence dated 1/10/18 indicated, "Hello, after speaking with staff, I was informed that [client E] did not go to his 2nd appointment with [PCP]. On the day that it was schedule [client E] had to go to the hospital to get his labs drawn because he bit (sic) [client B] and we had to rule out any			

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	infectious diseases." LPN #1 did not provide further documentation regarding client E's Ambien/Zolpidem 10 milligrams for insomnia being discontinued. LPN #1 indicated there had not been communication with client E's PCP regarding the effectiveness of client E's medications for the treatment of insomnia. 9-3-2(a)			
W 0158 Bldg. 00	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Facility Staffing for 3 of 3 sampled clients (A, B and C), plus 3 additional clients (D, E and F). The QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients A, B, C, D, E and F's active treatment programs by failing to provide sufficient direct care staff to implement client E's active treatment program and to manage his nighttime disruptive behaviors or implement his 1:1 staff to client ratio supervision as described in his BSP (Behavior Support Plan) and to ensure the agency owned and operated day	W 0158	**CORRECTION:** *The facility must ensure that specific facility staffing requirements are met.* Specifically, the governing body has directed the facility to modify the staffing matrix to assure client E has one to one staffing while awake, including on the overnight shift when direct support personnel are unavailable to provide coverage as described above, salaried supervisory staff will fill in, providing direct support as needed. Staff assigned to work with client E have been trained on active treatment expectations, per client E's plan.	02/07/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	service provider for clients A, B, C, D, E and F had current copies of their ISPs (Individual Support Plans), BSPs (Behavior Support Plans) or current HRHPs (High Risk Health Plans). Findings include: 1. The QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients A, B, C, D, E and F's active treatment programs by failing to provide sufficient direct care staff to implement client E's active treatment program and to manage his nighttime disruptive behaviors or implement his 1:1 staff to client ratio supervision as described in his BSP (Behavior Support Plan) and to ensure the agency owned and operated day service provider for clients A, B, C, D, E and F had current copies of their ISPs (Individual Support Plans). BSPs (Behavior Support Plans) or current HRHPs (High Risk Health Plans). Please see W159. 2. The facility failed to provide sufficient direct care staff to implement client E's active treatment program and to manage his nighttime disruptive behaviors or implement his 1:1 staff to client ratio supervision as described in his BSP (Behavior Support Plan). Please see W186.		**PREVENTION:** The Residential Manager and Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. Additionally, the Residential Manager has been directed to provide the Program Manager and Operations Manager with copies of a specific schedule listing client E's assigned one to one staff. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger and Registered Nurse) will review facility support documents and perform visual assessments of the facility no less than daily for the next 30 days, and after 30 days, will conduct administrative observations no less than three times weekly until all staff demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:	

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	01/12/2018

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	3. The facility failed to ensure the agency owned and operated day service provider for clients A, B, C, D, E and F had current copies of their ISPs (Individual Support Plans), BSPs (Behavior Support Plans) or current HRHPs (High Risk Health Plans). Please see W248. 4. The facility failed to ensure client E participated in his day service's active treatment program. Please see W249. 9-3-3(a)		Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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			Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: ·The role of the administrative monitor is not simply to observe & Report. ·When opportunities for training are observed, the monitor must step in and provide the training and document it. ·If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. ·Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training as needed. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff	

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COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

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			provide continuous active treatment during formal and informal opportunities, including but not limited to assuring adequate direct support staff are on duty to meet the needs of all clients. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), plus 3 additional clients (D, E and F), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients A, B, C, D, E and F's active treatment programs by failing to provide sufficient direct care staff to implement client E's active treatment program and to manage his nighttime disruptive behaviors or implement his 1:1 staff to client ratio supervision as described in his BSP (Behavior Support Plan) and to ensure the agency owned and operated day service provider for clients A, B, C, D, E and F had current copies of their ISPs (Individual Support Plans), BSPs (Behavior	W 0159	**CORRECTION:** *Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.* Specifically the governing body will assure that: With oversight from the governing body, the QIDP has directed the facility to modify the staffing matrix to assure client E has one to one staffing while awake, including on the overnight shift when direct support personnel are unavailable to provide coverage as described above, salaried supervisory staff will fill in,	02/07/2018

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	01/12/2018

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	Support Plans) or current HRHPs (High Risk Health Plans). Findings include: 1. The QIDP failed to integrate, coordinate and monitor client E's active treatment program by failing to provide sufficient direct care staff to implement client E's active treatment program and to manage his nighttime disruptive behaviors or implement his 1:1 staff to client ratio supervision as described in his BSP (Behavior Support Plan). Please see W186. 2. The QIDP failed to integrate, coordinate and monitor clients B, C, D, E and F's active treatment programs by failing to ensure the agency owned and operated day service provider for clients A, B, C, D, E and F had current copies of their ISPs (Individual Support Plans), BSPs (Behavior Support Plans) or current HRHPs (High Risk Health Plans). Please see W248. 3. The QIDP failed to integrate, coordinate and monitor client E's active treatment program by failing to ensure client E participated in his day services active treatment program. Please see W249. 9-3-3(a)		providing direct support as needed. Staff assigned to work with client E have been trained on active treatment expectations, per client E's plan. The QIDP has ensured that the facility is providing sufficient staff to assure client E may attend day service. Through observation the governing body has determined that this deficient practice did not affect other individuals. **PREVENTION:** The QIDP has been retrained on the need to provide current support documents to day service providers and families to assure continuity in each client's active treatment program. Members of the Operations Team comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, and Nurse Manager) will review Day service observation checklists, document receipts and e-mail properties to assure day service staff and families have been provided with copies of current support documents.	

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			The Residential Manager and Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. Additionally, the Residential Manager has been directed to provide the Program Manager and Operations Manager with copies of a specific schedule listing client E's assigned one to one staff. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger and Registered Nurse) will review facility support documents and perform visual assessments of the facility no less than daily for the next 30 days, and after 30 days, will conduct administrative observations no less than three times weekly until all staff demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:	

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			Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered. Operations Team members have been trained on monitoring	

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			expectations. Specifically, Administrative Monitoring is defined as follows: ·The role of the administrative monitor is not simply to observe & Report. ·When opportunities for training are observed, the monitor must step in and provide the training and document it. ·If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. ·Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training as needed. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff provide continuous active treatment during formal and	

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COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

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			informal opportunities, including but not limited to assuring adequate direct support staff are on duty to meet the needs of all clients, including available staff to provide one to one supervision for client E at day service. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 1 additional client (E), the facility failed to provide sufficient direct care staff to implement client E's active treatment program and to manage his nighttime disruptive behaviors or implement his 1:1 staff to client ratio supervision as described in his BSP (Behavior Support Plan). Findings include:	W 0186	**CORRECTION:** *The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.* Specifically, the governing body has directed the facility to modify the staffing matrix to assure client E has one to one staffing while awake, including on the overnight shift when direct support personnel are unavailable to provide coverage as described	02/07/2018

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	01/12/2018

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

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	HM (Home Manager) #1 was interviewed on 1/8/18 at 4:26 PM. HM #1 stated client E "Perseverates over food" and "Will get aggressive towards staff and clients." When asked if any of the other clients in the home were fearful or intimidated regarding client E, HM #1 stated, "[Client F] is not. [Client A] is not. [Clients B, C and D] are. They are non-verbal so they can't tell you but you can tell by the way they act. Just visual. They don't want to be anywhere near [client E]. They go the opposite direction, both at home and work. We are in the process of putting [client E] in a different classroom than [clients B, C and D]." HM #1 indicated client E moved into the group home on 11/14/17 after the death of another client in the home. HM #1 indicated she was aware of 2 BDDS (Bureau of Developmental Disabilities Services) reports for fighting. HM #1 stated, "[Client E] takes everything. [Client D] can't play with his trucks. [Client E] takes them. [Client A] wants a lock for his room, [client E] takes all of his things. If he doesn't get what he wants he will take it or get aggressive. [Client E] will bite and head butt. He takes sheets and flushes them down the toilet." HM #1 indicated clients B and E were roommates. Staff #2 was interviewed on 1/8/18 at 4:45 PM. Staff #2 indicated she worked the		above, salaried supervisory staff will fill in, providing direct support as needed. Staff assigned to work with client E have been trained on active treatment expectations, per client E's plan. **PREVENTION:** The Residential Manager and Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. Additionally, the Residential Manager has been directed to provide the Program Manager and Operations Manager with copies of a specific schedule listing client E's assigned one to one staff. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger and Registered Nurse) will review facility support documents and perform visual assessments of the facility no less than daily for the next 30 days, and after 30 days, will conduct administrative observations no less than three times weekly until all staff demonstrate competence. At the	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	evening shift from 2 PM-10 PM and on weekends from 8 AM -12 PM. When asked if the clients in the home got along, staff #2 stated, "They all do except [client E]. He doesn't get along with anybody." Staff #2 stated, "He's so aggressive. We try to redirect him. [Client D] has toys and [client E] will steal them from him. [Client D] will get mad and try to take it back. [Client D] is afraid. Sometimes [client E] pushes. We try to redirect. [Client B] likes to stay in his room. [Client B] avoids [client E] and will go to the other room to get away from him. They all avoid him." Staff #2 stated, "[Client E] steals from [client C] and goes through [client A's] pictures. This makes [client A] angry. [Clients B and C] are afraid. [Client E] does have a BSP (Behavior Support Plan) but it doesn't work." Staff #2 indicated clients B and E were roommates. MC (Med Coach) #1 was interviewed on 1/8/18 at 5 PM. MC #1 stated, "Yes, [client E] takes (others) personal belongings. He tries to make other clients to do what he wants. He will hit, head butt and takes things from the kitchen and puts them down vents and toilets. I've heard about this from other staff and seen him do it on the weekends. He doesn't follow directions." When asked if the other clients were afraid of client E, MC		conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment	

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	01/12/2018

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COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

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	#1 stated, "Some are. I see it when clients leave the area to get away from him. Some are non-verbal but I can tell. [Clients B, C and D] are. [Client B] is his roommate. [Client B] is afraid of him. [Client B] has scars on his arm and finger from where [client E] bit him." MC #1 indicated clients B and E were roommates. MC #1 indicated client E was currently on 1 to 1 ratio staff supervision. MC #1 stated, "They are supposed to be having a meeting to take him off 1 to 1 ratio staff supervision, I don't think its safe. He needs 1 to 1 ratio staff supervision." MC #1 indicated 1 to 1 ratio staff supervision meant one staff was assigned to client E and remained shoulder to shoulder with him to monitor him and keep the other clients safe. MC #1 stated, "They want us to work by ourselves. Doesn't feel safe. If we are toileting or helping another client in the bathroom or bedroom while everyone is in the living room with [client E] he might attack them." MC #1 indicated she had expressed this concern with HM #1. MC #1 indicated she had worked in the home by herself and didn't know client E was supposed to be 1 to 1 ratio staff supervised at the time. MC #1 indicated she had only become aware of client E's 1 to 1 ratio staff supervision protocol three days ago.		observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: ·The role of the administrative monitor is not simply to observe & Report. ·When opportunities for training are observed, the monitor must step in and provide the training and document it. ·If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. ·Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training as needed. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	Staff #1 was interviewed on 1/8/18 at 5:15 PM. Staff #1 indicated he started working at the home on 12/26/17 and worked the 4 PM -12 AM shift during weekdays. Staff #1 stated he had "worked a couple of times during the week by himself." Staff #1 stated, "[Client E] is very difficult. Can't leave him alone with others. Gets violent and will attach others. Bites and head butts." When asked if the other clients in the home were afraid of client E, staff #1 stated, "Afraid? [Clients B, C and D] are but not [clients A or F]. He steals and takes toys. [Client E's] a bully." Staff #1 indicated 1 to 1 ratio staff supervision meant to maintain client E at arms length. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were viewed on 1/8/18 at 6 PM. The review indicated the following: 1. BDDS report dated 11/29/17 indicated, "Staff reported as [client B] and [client E] were in the dining area engaging in horse play. Staff discovered a bite mark with broken skin on [client B's] right arm, approximately 3 inches in length. The ResCare nurse (unknown) was present when it happened and instructed staff to clean the area and take [client B] to		recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring adequate direct support staff are on duty to meet the needs of all clients. The Quality Assurance Manager and QIDP Manager or other designated Quality Assurance staff will perform spot checks of attendance records to assure ongoing compliance. If deficiencies are noted, the QA staff will notify the Program Manager, Operations Manager and Executive Director to assure prompt corrective action. Prior to each schedule period, the Operations Team will follow-up verbally and via email to assure that appropriate coverage has been arranged. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	[medical clinic] to be assessed. [Client B] was taken to [medical clinic] where he was assessed and prescribed antibiotics for the bite. [Client E] has a history of physical aggression and harming others. Both individuals were provided emotional support from the staff. [Client E] will receive testing to rule out the presence of blood borne pathogen. The administrative team is aware of the incident and the IDT (Interdisciplinary Team) will meet to put additional protective measure in place. Staff will notify the administrative team of any further concerns." 2. BDDS report dated 12/9/17 indicated, "As [client B] was exiting the medication room, before staff could intervene, [client E] grabbed [client B's] right hand and bit him. Staff immediately separated the two individuals and redirected [client E] verbally. The ResCare nurse was notified and instructed staff to have [client B]examined by a physician. [Client B] was taken to [hospital] where he was assessed and diagnosed with a bite on (his) right hand, and was prescribed an antibiotic to be taken twice daily for seven days. [Client E] has a history of physical aggression and harming others. Both individuals were provided emotional support from the staff. Immediate protective measures are in place. Specifically, [client E] has been placed on			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	one on one supervision during wakening (sic) hours and 15 minute checks during sleeping hours. The administrative team is aware of the incident and staff will notify the administrative team of any further concerns." 3. BDDS report dated 12/29/17 indicated, "While preparing to eat breakfast, [client E] moved [client F's] chair from behind him and [client F] hit [client E] in the back of the head with an open hand. Staff immediately separated the two and verbally redirected them both. There were no injuries noted. Both individuals were provided emotional support from the staff and physical aggression is addressed in both individuals behavior support plans. The administrative team is aware of the incident and the IDT will meet to discuss additional protective measures. Staff will notify the administrative team of any further concerns." -Investigation Final Report dated 1/8/18 indicated MC #1 was the only staff on duty in the home at the time of clients E and F's incident of physical aggression. The facility's Time Detail Sheets dated 1/2/18 through 1/9/18 were reviewed on 1/9/18 at 10:49 AM. The review indicated the following:			

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	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	-1/2/18: The review did not indicate documentation of staff working in the home from 10 PM- 11:59 PM. -1/3/18: The review did not indicate documentation of staff working in the home from 12 AM through 7 AM and from 3 PM through 6 PM. The review indicated one staff was on duty in the home from 7 AM to 3 PM. -1/4/18: The review did not indicate documentation of staff working in the home from 3 PM to 6 PM. The review indicated one staff was on duty at the home from 6:30 PM through 11:59 PM. -1/6/18: The review indicated one staff was working in the home from 12 AM to 8 AM and from 7 PM to 11:59 PM. -1/7/18: The review indicated one staff was working in the home from 12 AM to 8 AM and from 7 PM to 11:59 PM. -1/8/18: The review indicated one staff was working in the home from 12 AM to 9 AM. Interview with HM #1 on 1/8/18 at 5:30 PM indicated clients A, B, C, D, E and F got up for day program at 6 AM, completed hygiene, received medications, participated			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	in the home's family style morning meal and then departed for day services between 8 AM and 8:30 AM. QIDP (Qualified Intellectual Disabilities Professional) #1, AS (Area Supervisor) #1, HM (Home Manager) #1 and LPN (Licensed Practical Nurse) #1 were interviewed on 1/9/18 at 1:07 PM. HM #1 indicated client B's 11/28/17 and 12/11/17 bite wounds were a result of client E biting him. HM #1 indicated clients B and E were roommates. QIDP #1 indicated staff working in the home had been retrained on implementation of client E's 1 to 1 ratio staff supervision following the 1/2/18 IDT. QIDP #1 indicated staff should be implementing one to one ratio supervision during the day and completing 15 minute checks during sleep. When asked to clarify client E's 15 minute checks during sleeping hours in contrast to client E's 12/14/17 BSP protocol indicating 1 to 1 ratio should continue being implemented during the overnight/sleeping hours, QIDP #1 stated, "We discussed that and thought he probably needed the one to one ratio supervision over night but there were staffing concerns." QIDP #1 indicated the facility did not have enough overnight staff available to implement one to one ratio staff supervision as described in his 12/14/17 BSP regarding client E assessed			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	supervision needs. QIDP #1 indicated clients B and E were roommates. QIDP #1 indicated the day services should participate in client E's 12/11/17 and 1/2/18 IDT meetings and the recommendations should have been communicated with the day services regarding client E's one to one ratio supervision. QIDP #1 indicated there should be two staff on duty in the home to implement client E's one to one ratio supervision. Client E's record was reviewed on 1/11/18 at 9:18 AM. Client E's BSP (Behavior Support Plan) dated 12/14/17 indicated the following: -"[Client E] at times will become obsessive over things. [Client E] will steal items at the store, takes items from housemates, non-compliance, obsesses over what is on his mind (always food), kitchen and food are locked. He struggles with biting self, hitting, head butts, and he has alarms on door due to eloping and will pick at his skin." -"Some of his targeted behaviors consist of physical aggression, self-injurious behavior, pacing around, leaving assigned area, and repetitive actions." -"Physical Aggression: any time [client E]			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	strikes, spits, grabs, kicks, bites, pinches, is threatening, and throwing objects at others that have the potential to cause injury." -"Verbal Aggression: any time [client E] shouts and/or screams at peers and/or staff to include insults, vulgar comments, obscenities and demeaning comments. -"Threats to Harm Others: any time [client E] makes a statement that he will harm staff and/or peers (kill them in their sleep, burn the house down, break their knee) or refers to events in his past when he has harmed others." -"The following precursor behaviors have been identified: change (minor or major), family conflict, staff conflict, persons violating his personal space, sitting up in bed in the middle of the night, not sleeping at night, taking things from others, making threats to harm others, repeating words/phrases to staff to gain attention. [Client E] will seek out targets, i.e. he will stare for a short period of time and will have rapid eye movement prior to engaging in verbal and physical aggression." -"When [client E] engages in physical aggression, his tendency is to lash out in every direction with his hands/fists and his			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	feet in order to attack anyone in his reach. Staff must provide personal space to his and must insure the environment surrounding [client E] is clear of obstructions and that [client E] is given plenty of space to maneuver. [Client E] has a tendency to drop to the floor when he is physically aggressive and continue to swing at and/or kick at anyone and anything within his reach." -"Property Destruction/Disruption, Self-Injury and Physical Aggression. Do not overreact, try to maintain a calm and emotionless demeanor. Immediately ensure the health and safety of everybody in the immediate area. In a firm and polite voice ask his to stop the behavior, and redirect his to a quieter area away from other, either outside (back patio) or to his room. Encourage his to use his calming strategies (alone time; journaling; listening to music; writing letters; writing and telling funny stories.) Throughout this process minimize verbal interactions with his and never get into a power struggle. If the behavior persists and he is placing himself or others in immediate danger implement You're Safe I'm Safe (YSIS). Position yourself between [client E] and his peers. In a calm but firm voice verbally redirect [client E] to a different location/area/activity. Block physical aggression and property			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	destruction. If [client E] is continuing to place himself or others in jeopardy, use the YSIS procedures in the following order: Physically redirect. One person hold. Two person hold. When using these holds, be aware that [client E] may attempt to bite, hit or struggle, position yourself so that you are safe. If needed have his peers move to a safe location where [client E] cannot aggress towards them. Let his know what you are doing but do not engage in conversations with his." -"Staff Actions: One to One ratio Staffing. [Client E] will have a 1:1 staff as determined by the QIDP and Behaviorist. The purpose of the 1:1 staff is to provide uninterrupted observation of and intervention toward [client E] to keep him from harming himself or others. [Client E] is that staff's only focus. Staff will be in the same room with [client E] and will be positioned close enough to physically intervene using you're Safe I'm Safe (YSIS); [client E] will be within staff line of sight if he attempts to harm himself or others. This includes every room he enters as well as in his room overnight while he is asleep. Whenever [client E] is awake in a room sitting down or lying down, the staff will position themselves as close to [client E] as possible while remaining standing and be prepared to block his access to the nearest			

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COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

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	hard surface. When [client E] is asleep, staff will position themselves as close to [client E] as possible. Staff may sit or stand but must still be able to block his access to the nearest hard surface if needed. [Client E's] head and face must be visible to staff at all times when [client E] is sleeping. If [client E] pulls the blanket over his face/head, staff will immediately move it to insure his head and face is visible. Every 15 minutes staff must visually and physically check [client E] to insure he is breathing, the space around his face/neck is clear of obstructions and clear the space if necessary. The 1:1 staff may have a paper copy of [client E's] BSP and therapy coping skills for reference to assist [client E] in understanding his actions and their consequences. These copies must remain in staff's possession at all times and may be passed to the next staff during change over. Staff will not have a pen or pencil on their person while performing 1:1 with [client E]. When [client E] requires 1:1 staff, every staff scheduled on each shift will rotate through and provide direct oversight of [client E] in 30 minute intervals. Staff will change out every 30 minutes and will sign in/out on a 1:1 staffing sheet. The non-1:1 staff will conduct a room sweep and all objects will be removed from [client E's] room (including curtains/rods and			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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

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	all dolls) except one pillow and one blanket. Staff may talk with [client E], while on 1:1, if [client E] initiates conversation, but staff must keep it supportive, encouraging in nature and related to the behaviors he is demonstrating at the time and their resolution. This includes discussion of his BSP, proactive and reactive strategies and coping skills. No superficial conversation should occur between 1:1 staff and [client E] or 1:1 staff and other staff. The 1:1 will position themselves between [client E] and the nearest hard surface (walls, hard tables etc) while maintaining line of sight with [client E]. The 1:1 will walk slightly behind [client E] and to one side, the side closest to the nearest hard surface and close enough to physically intervene if he attempts to harm himself or others. Whenever [client E] walks into another room, the 1:1 staff will scan the room for any possible item that [client E] may use to harm himself and inform the other staff to remove the items. When [client E] is on 1:1, he may not sit on the front porch, front yard or non-fenced area of the property as there is risk of his running to the street and into traffic. He may sit on the patio in the fenced back yard. When [client E] is on 1:1, he may only be transported in the group home van and may only sit on one of the bench seats with staff sitting next to him. He may not sit in the			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	passenger front seat. Staff will sit next to the window in order to block [client E] from hitting his head or body on it. Working on goals that allow him access to items that he could use to harm or kill himself. At the first sign of a precursor behavior by [client E] or by one of his housemates, lock the sharps (or items which can easily be made into a sharp) as well as the cleaning chemicals which could be ingested. This includes eating utensils (such as forks, spoons, knives), cooking utensils (spatulas, wooden spoons, serving spoons, measuring cups, measuring spoons, ice cream scoops, pizza cutters, whisk, cookie cutters, meat thermometers, potato peelers). This also includes cleaning chemicals (such as laundry soap, dish soap, hand soap, dryer sheets, general purpose cleaner, toilet bowel cleaner, hand sanitizer). These items should remain secured until the immediate risk from exposure has passed and/or until [client E] is off of 1:1 and has been assessed as being in control and not a danger to himself and/or others." -"Staff Actions: Day Service. If the precursors occur while at day service: his workshop supervisor will notify additional staff and QIDP. [Client E] will have 1:1 staff while at day service. That staff will remove [client E] from the day service area and sit with him in a different area. Staff will be			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	positioned close enough to him to use day service/residential provider approved crisis intervention procedures to ensure his health and safety as well as that of peers and staff. Day service Supervisor will notify the QIDP and Behaviorist and the above steps will be followed for precursor behaviors. Day service Supervisor will notify QIDP if [client E] requires dismissal from day service and when suspension from day service is necessary." Client E's 12/11/17 IDT note indicated, "The team met because [clients B and E] has been involved in two client to client aggression incidents within the last two weeks. The team decided that it would be best to place [client E] on line of sight at all times to ensure the safety of the other clients. Staff will also keep [clients B and E] separated from one another." The list of participants was as follows: QIDP #1, HM #1, PM #1. The 12/11/17 IDT did not include documentation of Day Services staff's participation in the IDT discussion or recommendations. Client E's 1/2/18 IDT note indicated, "The team met because [clients E and F] was (sic) involved in a client to client aggression (incident). The team decided that it [client E] (sic) was to be placed on 1:1 (ratio)			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	supervision and this will help to reduce to (sic) incidents (sic) of client to client aggression. Staff is to also ensure that the two individuals are kept separated from one another." The list of participants was as follows: QIDP #1, HM #1, PM #1. The 1/2/18 IDT did not include documentation of Day Services staff's participation in the IDT discussion or recommendations. Progress Note (PN) dated 11/15/17 10 PM -10 AM shift indicated, "[Client E] was walking up and down the whole house. He didn't sleep all the night. He started requesting for (sic) all kinds of stuff. He struggled with staff because he didn't get his way to the fridge, or med room." PN dated 11/15/17 10 AM - 1 PM shift indicated, "[Client E] has been very aggressive this morning. He continues to go in roommates room and taking items. [Client E] has tried biting and pushing so that he was able to get out of (the) door or inside the med room." PN Dated 11/15/17, 2 PM -10 PM shift indicated, "Came back (from transport) very unsettled in the house. He became aggressive with [client B] and trying to head butts (sic) him. Kept going in and out of the kitchen trying to open the oven while staff			

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COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

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	was making dinner. Both staff and house manager redirected him several times. Only settled down at dinner time, ate fine and stole his housemates food. Kept telling staff he was going to bite his roommate, [client B], and staff. Since then kept him on line of sight." PN dated 11/18/17, 9 PM- 9 AM indicated, "[Client E] awake around 3 AM walking up and down (sic), jumping, screaming and yelling. [Client E] (was) asking for some stuff in the house." PN dated 11/18/17, 8 AM- 8 PM shift indicated, "Very unsettled, trying to elope from the house. Only settle (sic) a bit when his mom and brother visited. [Client E's] mom brought him lunch, (sic) ate fine. After his mom left [client E] was still trying to elope but staff (unspecified) kept redirecting him. [Client E] has been going in and out of other housemates' room (sic) taking their stuff, (sic) hitting [client B]." PN dated 11/19/17, 9 PM- 9 AM shift indicated, "[Client E] awake (sic) was slept around 1 AM. After (a) few hours [client E] woke up and (started) jumping, screaming and walking around the house, (sic) he trying to open the med room door also. At 7 AM, med's were giving (sic) and [client E] (was)			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	trying to take [client D's] [toy] and push the staff and [HM #1]." PN dated 11/19/17, 8 AM- 8 PM shift indicated, "[Client E] was already awake on staff's arrival at site. He pulled staff and clients during the shift, he attempted to elope (and was) trying to take what does not belong to him." PN dated 11/20/17, 8 PM- 9 AM shift indicated, "[Client E] woke up around 2 AM and (was) trying to fight with staff and go into [client C's] room and (sic) trying to wake [client C] up and (sic) trying to fight with him and (sic) jumping and (sic) screaming." PN dated 11/20/17, 8 AM- 8 PM shift indicated, "[Client E] woke up around 2 AM and (was) trying to fight with staff and go into [client C's] room and trying to wake [client C] up and (sic) trying to fight with him. And jumping and screaming." PN dated 11/20/17, 4 PM- 12 AM shift indicated, "[Client E] started walking around going from one bedroom to another , (sic) making several demands." PN dated 11/21/17 12 AM - 8 AM shift indicated, "Upon arrival [client E] was			

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	watching TV and walking towards [client A's] room to wake him up by keeping open his door. Also he does not allow [client C] to sleep by opening his door too. Staff redirect him to the living room which he did and continued to waking around the house." PN dated 11/22/17 12 AM - 8 AM shift indicated, "[Client E] was met in the house sitting on the floor and looking at his book. [Client E] didn't slept (sic) at all. He started walking around asking (for the) same things all the times (sic). He trying (sic) to open the fridge and snack cabinet." PN dated 11/23/17, 12 AM - 8 AM shift indicated, "[Client E] was met on bed upon arrival. He slept a few hours and (sic) getting up to waking around for period of couple of hours. Writer prompted him to go to bed and he went back and lay (sic) on the bed." PN dated 11/23/17, 9 AM - 9 PM shift indicated, "[Client E] was up walking around the house upon staffs arrival, ate fine, very unsettled all day. Mom visited him and brought him lunch. Trying to elope, trying to hit staff when staff tried to stop him from going out. Still unsettled, kept going to [client A's] room packing his pictures." PN dated 11/24/17, 4 PM - 12 AM shift			

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	indicated, "[Client E] staff (sic) met him walking around in the evening, taking what does (sic) not belong to him. Attempted to elope (and) making unnecessary demands." PN dated 11/24/17, 12 AM -8 AM shift indicated, "[Client E] slept until 1:30 AM. He was up toileting and stay(ed) in the living room. Talking, jumping, walking around the house." PN dated 11/27/17 12 AM - 8 AM shift indicated client E was up during the overnight house and was going into his housemates rooms and jumping around the house. PN dated 12/1/7 12 AM - 8 AM shift indicated, "[Client E] at home walking around the house. Taking stuff, asking for stuff. Jumping and screaming until 4 AM. He went to bed and was up at 7 AM." PN dated 12/1/17 2 PM - 10 PM shift indicated, "[Client E] has been unsettled all evening. Attended Christmas party at the office, he refused to settle down at the party. Came back home and went to [client A's] room got most of his pictures out. This resulted in making [client A] very angry and upset. Staff redirected [client E] but he refused. He later left (sic) for [client C's]			

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	room whenever staff redirected him [client E] uses [expletives] on staff." PN dated 12/2/17 12 AM - 8 AM shift indicated, "[Client E] slept till 3: 15 AM and up walking around the house. Jumping, screaming, asking for some stuff and taking some stuff." PN dated 12/2/17 8 AM - 8 PM shift indicated, "[Client E] was already up upon staffs arrival. Very unsettled and aggressive towards housemates and staff. Kept going to [client A's] room to get his pictures and other stuff out to place items on the floor in the living room, he became aggressive when staff redirected him. Kept pulling [client B] out of the chair whenever [client B] tried to settle down on the sofa. Still unsettled at time of report. Stood right in front of staff in the dining area and peed on himself twice and he will start laughing whenever he does it." PN dated 12/3/17 8 PM - 8 AM shift indicated, "[Client E] slept until around 2 AM and up walking around the house. Jumping and screaming and asking for some stuff. Taking stuff." PN dated 12/3/17 8 AM - 8 PM shift indicated, "[Client E] was already awake			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	jumping around the house upon staff arrival. He later became aggressive to the clients and staff in the house. Taking what does not belong to him with force, going from one bedroom to another. He made several attempts to open the kitchen cabinets and deliberately peed on himself." PN dated 12/4/17 12 AM - 8 AM shift indicated, "[Client E] slept until 2 AM and up walking around the house. Jumping, screaming, asking for some stuff and food. He was assisted with hygiene, dressing and took his med's. Ate breakfast, trying to hold [client B's] arms and he was stopped." PN dated 12/4/17 4 PM - 12 AM shift indicated, "[Client E] was running around the house with his blankets in his hand upon staff's arrival at the site. He frequently going to (sic) other consumers bedroom, packing their belongings out (sic) playing with kitchen sink, attempting to bite staff and clients. Staff made (sic) they redirected him whenever he attempts to bite and elope." PN dated 12/6/17 12 AM - 8 AM shift indicated, "[Client E] slept until 12:20 AM and up walking around the house not sleeping until morning. Jumping, screaming and asking for stuff like food."			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	PN dated 12/6/17 7 AM- 3 PM shift indicated, "[Client E] was constantly trying to fight with his housemates saying he is going to bite [clients B and C]. I redirected [client E] away from but but he continued to push and try to force himself where they were. He then turned his attention toward staff because he was not able to go out or get to housemates." PN dated 12/6/17 2 PM- 10 PM shift indicated, "[Client E] has been very unsettled upon his arrival from day program. Picking stuff from housemates room. Mostly [client A's]. Very angry. [Client E] kept saying he will bite [client C] but staff kept him in line of sight." PN dated 12/7/17 12 AM - 8 AM shift indicated, "Upon arrival [client E] was in his room sleeping. At 1 AM, he woke up and started walking around the house. [Client E]started picking up some stuff out of from the kitchen. He did not slept (sic) at all throughout the night." PN dated 12/7/17 4 PM - 12 AM shift indicated, "[Client E] was trying to gain access to the kitchen while staff was preparing the dinner. Jumping around snatching other clients stuff aggressively."			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	PN dated 12/8/17, 12 AM- 8 AM shift indicated, "[Client E] slept for (a) few hours in (sic) the midnight woke up and started walking around the house and opened [client C's] door throughout the night." PN dated 12/8/17, 2 PM- 10 PM shift indicated, "Upon picking [client E] up from day program, day program staff reported [client E that (sic) he's been saying he was going to bite someone. Staff asked if [client E] mentioned any names but day program staff said he did not but he kept saying he was going to do it. [HM #1] was informed immediately. [Client E] has been very unsettled, fighting with [client D] over [client D's] toy truck and entering [client A's] room, taking his pictures and placing them on the floor. [Client A] was so angry about it but staff told [client A] to calm down. [Client e] has been using [expletives] on staff while staff were trying to redirected (sic) him. Pushing and trying to bite staff while staff told him to stay (away) from (the) hot stove and while he was trying to open the oven when the oven was in use and very hot. Staff did what they could but [client E] still remains adamant." PN dated 12/10/17, 12 AM- 8 AM shift indicated, "[Client E] bit [client B] on his way out from the med room. [Client E]			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	quickly grab (sic) [client B's] hand and bite (sic) him. Staff intervene and rescue(d) [client B] from [client E]. [Client E] attacked staff and writer redirect him to (the) living room." PN dated 12/10/17, 8 AM- 8 PM shift indicated, "[Client E] was already awake in the morning upon staffs arrival at the site. After an hour [client E] suddenly rushed to where [client C] was sitting in an attempt to bite [client C]. Immediately staff quickly intervened and redirected him from [client E]. After his breakfast he went back to [client C] again an attempt to bite but st aff prevented him, while staff was trying to divert his attention from [client C] he was furious at the staff." PN dated 12/12/17 12 AM- 8 AM shift indicated, "Upon arrived (sic) [client E] was slept (sic) in his room. After 1 hour he woke up at 1:30 A and started walking around, jumping around and still picking up some stuff up (sic) and playing with it until this morning at 5:45 AM he went to his room and lay down without any issue (sic)." PN dated 12/12/17, 4 PM- 12 AM shift indicated, "[Client E] was entering the house when staff arrived, was aggressive at other clients. Staff diverted his attention when he			

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	made attempts to bite." PN dated 12/13/17, 10 PM- 9 AM shift indicated, "Upon arrived (sic) [client E] was slept (sic) in his room. After few hours he woke up at 1:20 AM and started walking around, jumping around and playing with (a) toy until this morning." PN dated 12/13/17, 2 PM - 10 PM shift indicated, "[Client E] was picked up at day program. Very unsettled. On getting home (sic) he starts going into [client A's] room to some of his pictures out. Staff redirected him but he wouldn't listen. Trying to force some of the kitchen cabinets back open." PN dated 12/16/17, 9 PM- 9 AM shift indicated, "Upon arrived [client E] was playing in the living room, after few minutes he slept (sic) and he woke up at 2 AM and started walking around, jumping around." PN dated 12/16/7, 8 AM - 8 PM shift indicated, "Very unsettled all day, fighting his housemates over their toys and stuff. Refused to be redirected." PN dated 12/17/17, 9 AM-9 PM shift indicated, "[Client E] didn't slept (sic) throughout the night. [Client E] walking around the house jumping, screaming (and)			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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

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	also opened other clients doors." PN dated 12/17/17 8 AM- 8 PM shift indicated, "[Client E] was already awake running around upon staffs arrival at the site. He was very unsettled, stealing, aggressive towards staff and consumers attempting to bite." PN dated 12/17/17, 2 PM -10 PM shift indicated, "[Client E] has been very unsettled upon his arrival from day program. In and out of the kitchen, taking [client D's] toys and fighting him for his trucks. Went to [client A's] room and took some of his pictures and placed them on the floor in the living room. Refused to be redirected. Peed on himself." PN dated 12/18/17 8 PM- 8 AM shift indicated, "[Client E] didn't slept (sic) throughout the night. [Client E] walking around the house jumping, screaming around (sic)." PN dated 12/18/17 4 PM- 12 AM shift indicated, "[Client E] was trying to gain his access to the kitchen upon staffs arrival at the site. Several attempts were made by him to forcibly open the medications room in order to disorganize (unknown) the office. He said repeatedly that he is going to bite			

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	someone. Staff kept eyes on him throughout the shift." PN dated 12/19/17, 9 PM- 9 AM shift indicated, "Upon arrived (sic) [client E] was in the living room walking around, screaming around the house. [Client E] slept around 4 AM this morning." PN dated 12/19/17, 2 PM- 10 PM shift indicated, "[Client E] was picked up at day program. Came back home usual unsettled self. Fight with housemates over their belongings, taking out blankets from the closet and taking out stuff from (the) kitchen cabinet. Refused to be redirected very aggressive towards housemates and staff." PN dated 12/20/17, 9 PM - 9 AM shift indicated, "[Client E] didn't sleep all through the night. His activities woke his roommate, [client B], up. He attempted to bite his roommate, [client B], countless times. Staff stood against him and redirected him though forcefully thereby also attempted biting staff. He started sleeping at about 6:45 AM." PN dated 12/20/17, 2 PM- 10 PM shift indicated, "[Client E] has been very unsettled, fighting, refused to be redirected. Kept going in and out of [client A's] room. This makes [client A] angry and [client A]			

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was using [expletives] while trying to explain to staff."

PN dated 12/21/17, 12 AM- 8 AM shift indicated, "[Client E] slept (sic) upon arrived (sic). After one hour he woke up, said he needs shower and staff gave him shower. [Client E] started walking around the house. At 5:30 AM [client E] trying to attack [client B]. Staff redirected him to another area."

PN dated 12/22/17 9 PM -9 AM shift indicated, "[Client E] was asleep when staff arrived. He was woken up for his bedtime meds, he took the med and went back to sleep. He then woke up by himself at 12 AM and remained awake all through the night. He kept roaming the living room."

PN dated 12/22/17, 2 PM- 10 PM shift indicated, "[Client E] was picked up at day program. Slept through while transported to the house. ON his arrival at the house he became restless, wondering around the housemates room, picking their stuff and picking stuff from the kitchen cabinet. Very unsettled all evening."

PN dated 12/29/17, 9 PM -9 AM shift indicated, "[Client E] slept between 9 PM- 12 AM. He was awake from 12 AM to this morning. He kept disturbing staff all through

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the night. [Client E] going to the closet to get the blankets out, taking stuff out of kitchen cabinet."

PN dated 12/29/17, 6 AM - 2 PM shift indicated, "[Client E] was very active this morning. Kept trying to take things from kitchen while staff was preparing breakfast. [Client E] ate breakfast, then began to bother other housemates taking their personal belongings."

PN dated 12/31/17, 6 PM- 10 AM shift indicated, "[Client E] slept upon arrived. after few hours he woke up. He was awake from 1 AM till this morning. He kept jumping around the house screaming around."

PN dated 12/31/17, 8 AM- 4 PM shift indicated, "[Client E] had a busy morning he continued to bother housemates taking their items and approaching staff in negative manners. [Client E] did not follow any instructions given by staff. [Client E] had to be seated with 1 to 1 approach to sit for long period of time. With 1 to 1 approach by staff [client E] fell asleep for 1 hour."

PN dated 1/3/18, 9 PM - 9 AM shift indicated, "[Client E] was awake when staff arrived. He later dozed off and was lead to

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

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his room after he had taken his bedtime meds. He also took his morning meds and ate his breakfast. No issues except his attempts twice of wanting to bite [client D]."

PN dated 1/4/18, 5 PM - 9 AM shift indicated, "[Client E] was awake all the night long. He took his bedtime meds though. He also took his morning meds and has his breakfast and got dressed for day program. He attempted twice to bite [client B] and staff but staff redirected and gave him close monitoring."

PN dated 1/5/18, 5 PM - 9 AM shift indicated, "[Client E] only slept for 2 hours after his bedtime meds. He was awake all throughout the night thereafter. He took his breakfast and his morning meds. He attempted to bite [client F], [client B] and staff but he was prevented."

PN dated 1/8/18, 5 PM - 9 PM shift indicated, "[Client E] was awake till 4 AM. He slept briefly for 2 hours and woke up again."

PN dated 1/8/18, 4 PM- 9 PM shift indicated, "[Client E] took away other clients toys."

PN dated 1/9/18, 9 PM - 9 AM shift

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	indicated, "[Client E] was awake when staff arrived. He stayed awake all through the night. He kept pacing around the whole house. Staff prevented him from hitting [client B] on his bed twice. Staff also prevented himself from being bitten." QIDP #2, LPN #1 and QIDP #1 were interviewed on 1/10/18 at 12 PM. QIDP #1 stated, "The 1/2/18 IDT meeting should say 1 to 1 ratio supervision to continue. He had already been on 1 to 1 ratio supervision from the 12/11/17 IDT." QIDP #1 stated, "Staff were not implementing his 1:1 ratio supervision. We did retraining. He should be 1: 1 ratio supervision during wake hours and 15 minute checks on overnight." QIDP #1 was asked to clarify the difference in supervision recommendations from the 12/11/17 and 1/2/18 IDT notes versus client E's 12/14/17 BSP which indicated 24 hour 1 to 1 supervision, QIDP #1 stated, "We aren't doing 1 to 1 ratio supervision on the overnights. We talked about it. We had staffing issues, the BSP should be clarified." QIDP #1 indicated there was only one staff on duty at the time of the 12/28/17 incident. QIDP #1 indicated client E should have been on 1 to 1 ratio supervision at the time of the 12/28/17 incident of client to client aggression between clients E and client F. When asked if one staff working in the home			

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	could implement client E's 1 to 1 ratio supervision, QIDP #1 stated, "No. We had staffing issues." Staff #3 was interviewed on 1/11/18 at 7:36 AM. Staff #3 indicated she worked the overnight shift, 9 PM to 9 AM. Staff #3 indicated she was the only staff on duty during the overnight hours and staff comes in at 6 AM. Staff #3 stated, "[Client E] is up almost every night. Up screaming and waking other clients." Staff #3 stated, "[Client C] is afraid." Staff #3 stated, "[Client E] will wake up his roommate, [client B], When [client E] is up screaming, [client B] is up too. [Client B] is afraid too. Then at 7 AM [client E] is very tired. He also takes [client A's] pictures." MC #1 was interviewed on 1/11/18 at 8:08 AM. MC #1 stated, "I came in at 6 AM. [Client E] was awake and up. Usually is when I come in. Overnight reports to me that he doesn't sleep most nights. [Client E] may be staying home today. Now that he's on 1 to 1 staff to client ratio supervision we have to send someone with him to day program." MC #1 stated, "I'm not sure what the plan is for today. [Staff #3] said [client E] didn't go to day program yesterday. Didn't have enough staff for his 1 to 1 staff to client ratio supervision so he couldn't go			

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	to the day program." QIDP #1 was interviewed on 1/11/18 at 10 AM. QIDP #1 stated, "No, [client E] did not go to day program yesterday. I don't know if he did today. [HM #1] was coordinating his day program 1:1 but I haven't heard back from her." QIDP #1 indicated client E's should attend day services. Client E's active treatment schedule was requested. QIDP #1 provided a copy of client E's active treatment schedule was provided on 1/11/18 at 12:14 PM and reviewed upon receipt. Client E's undated active treatment schedule indicated client should attend day services on Monday through Friday from 8 AM through 2 PM. 9-3-3(a)			
W 0248 Bldg. 00	483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 2 of 3 sampled clients (B and C), plus 3 additional clients (D, E and F), the facility failed to ensure the agency owned and	W 0248	**CORRECTION:** *A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the*	02/07/2018

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	operated day service provider for clients B, C, D, E and F had current copies of their ISPs (Individual Support Plans). BSPs (Behavior Support Plans) or current HRHPs (High Risk Health Plans). Findings include: Nurse Manager (NM) #1 was interviewed on 1/8/18 at 1:45 PM. NM #1 indicated clients B, C, D, E and F's High Risk Health Plans had been updated by LPN (Licensed Practical Nurse) #1. NM #1 was interviewed on 1/8/18 at 1:59 PM. NM #1 indicated the updated High Risk Health Plans would be provided via email. NM #1 provided clients B, C, D, E and F's High Risk Health Plans via email on 1/8/18 at 2:34 PM. Review of the attached risk plans indicated the following: -Client B's High Risk Health Plans regarding Skin Infection were reviewed/revised on 11/17/17. -Client C's High Risk Health Plans regarding Respiratory Infection, Skin Infection and Choking Potential were reviewed/revised on 11/17/17.		*client, and to the client, parents* (if the client is a minor) or legal guardian. Specifically, the facility's contracted day service provider has received current copies of all clients' current Individual Support Plans and Behavior Support Plans. **PREVENTION:** The QIDP has been retrained on the need to provide current support documents to day service providers and families to assure continuity in each client's active treatment program. Members of the Operations Team comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, and Nurse Manager) will review Day service observation checklists, document receipts and e-mail properties to assure day service staff and families have been provided with copies of current support documents. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	-Client D's High Risk Health Plans regarding Hypokalemia (low blood platelets), Choking, Skin Breakdown, Constipation or Bleeding were reviewed/revised on 11/17/17. -Client E's High Risk Health Plan regarding Skin Infection were reviewed/revised on 11/17/17. -Client F's High Risk Health Plans regarding Choking, Dermatitis, Hyponatremia (not enough salt in body fluids), Skin Breakdown, Respiratory Infection, Seizures and Hyperlipidemia were reviewed/revised on 11/17/17. 1. Client B's day services record was reviewed on 1/9/18 at 9:24 AM. Client B's day service record indicated client B had a High Risk Health Plan dated 8/22/17 regarding seizures. Client B's record did not indicate documentation of client B's updated/revised 11/17/17 High Risk Health Plan regarding seizures. 2. Client C's day services record was reviewed on 1/9/18 at 9:20 AM. Client C's High Risk Plans included Respiratory Infection, Skin Infection, Choking Potential all dated 8/21/17. Client C's day services			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	record did not indicate documentation of client C's updated/revised 11/17/17 High Risk Health Plans regarding Respiratory Infection, Skin Infection and Choking Potential. 3. Client D's facility record was reviewed on 1/9/18 at 11:22 AM. Client D's ISP was dated 11/2/17 and client D's BSP was dated 11/2/17. Client D's day services record was reviewed on 1/9/18 at 9:28 AM. Client D's day services record indicated client D's ISP was dated 11/22/16, BSP was dated 11/22/16 and High Risk Health Plans regarding Skin Integrity, Constipation and Choking were all dated 4/8/16. Client D's day services record did not indicate documentation of client D's ISP dated 11/2/17, BSP dated 11/22/17 or High Risk Health Plans regarding Hypokalemia (low blood platelets), Choking, Skin Breakdown, Constipation or Bleeding all dated 11/17/17. 4. Client E's facility record was reviewed on 1/9/18 at 12:24 PM. Client E's ISP was dated 11/14/17 and client E's BSP was dated 12/14/17. Client E's day services record was reviewed on 1/9/18 at 9 AM. Client E's day services record indicated client E's ISP was dated 8/2/16, BSP was dated 8/2/16 and did not include any High			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	Risk Health Plans. Client E's day services record did not indicate documentation of client E's ISP dated 11/17/17, BSP dated 12/14/17 or High Risk Health Plan regarding Skin Infection dated 11/17/17. 5. Client F's day services record was reviewed on 1/9/18 at 9:26 AM. Client F's day services record indicated client F's High Risk Health Plans regarding Hyperlipidemia, Hyponatremia, Dermatitis, Choking, Seizures, Respiratory Infection and Skin Breakdown were all dated 8/22/17. Client F's High Risk Health Plans regarding Choking, Dermatitis, Hyponatremia (not enough salt in body fluids), Skin Breakdown, Respiratory Infection, Seizures and Hyperlipidemia all dated 11/17/17. Client F's 11/17/17 Hyponatremia High Risk Plan indicated client F's fluid intake was restricted to 68 ounces per day and should be monitored and tracked. Client F's day services record did not indicate fluid tracking for December 2017 and January 2018 for client F. QIDP (Qualified Intellectual Disabilities Professional) #1, AS (Area Supervisor) #1, HM (Home Manager) #1 and LPN (Licensed Practical Nurse) #1 were interviewed on 1/9/18 at 1:07 PM. QIDP			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	#1 indicated the day services should have current copies of ISP's, BSP's and High Risk Health Plans. 9-3-4(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on record review and interview for 1 additional client (E), the facility failed to ensure client E participated in his day service's active treatment program. Findings include: MC (Med Coach) #1 was interviewed on 1/11/18 at 8:08 AM. MC #1 stated, "I came in at 6 AM. [Client E] was awake and up. Usually is when I come in. Overnight reports to me that he doesn't sleep most nights. [Client E] may be staying home today. Now that he's on 1 to 1 staff to client ratio supervision we have to send someone with him to day program." MC #1 stated, "I'm not sure what the plan is for today.	W 0249	**CORRECTION:** *As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.*Specifically, the facility is providing sufficient staff to assure client E may attend day service. Through observation the governing body has determined that this deficient practice did not affect other individuals.	02/07/2018

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	[Staff #3] said [client E] didn't go to day program yesterday. Didn't have enough staff for his 1 to 1 staff to client ratio supervision so he couldn't go to the day program." QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/11/18 at 10 AM. QIDP #1 stated, "No, [client E] did not go to day program yesterday. I don't know if he did today. [HM #1] was coordinating his day program 1:1 but I haven't heard back from her." QIDP #1 indicated client E's should attend day services. Client E's active treatment schedule was requested. QIDP #1 provided a copy of client E's active treatment schedule was provided on 1/11/18 at 12:14 PM and reviewed upon receipt. Client E's undated active treatment schedule indicated client should attend day services on Monday through Friday from 8 AM through 2 PM. 9-3-4(a)		**PREVENTION:** The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to including but not limited to proper implementation of dining plans.Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger and Registered Nurse) will review facility support documents and perform visual assessments of the facility no less than daily for the next 30 days, and after 30 days, will conduct administrative observations no less than three times weekly until all staff demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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

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			and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered. Operations Team members have been trained on monitoring expectations. Specifically,	

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	01/12/2018

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			Administrative Monitoring is defined as follows: ·The role of the administrative monitor is not simply to observe & Report. ·When opportunities for training are observed, the monitor must step in and provide the training and document it. ·If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. ·Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training as needed. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring client E attends day programming with	

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			appropriate staffing in place. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
W 0318 Bldg. 00	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Health Care Services for 3 of 3 sampled clients (A, B and C), plus 3 additional clients (D, E and F). The facility nurse failed to ensure client D had an annual physical examination, failed to ensure clients A, B, C, D and E had routine and recommended vision assessments and services, failed to monitor and proactively address client E's chronic insomnia and day time lethargy, failed to ensure staff working with clients B, C, D, E and F were trained regarding their individual High Risk Health Plans, failed to ensure clients A, B, D, E and F's dental recommendations were implemented and clients received routine dental examinations and failed to ensure staff administered client C's medication without error.	W 0318	**CORRECTION:** *The facility must ensure that specific health care services requirements are met.* Specifically: Specifically: Client D has received a physical examination from his primary care physician. Through a review of facility medical records, the governing body has determined that all clients who reside in the facility have current annual physical examinations. All clients who reside in the facility have received current vision assessments.	02/07/2018

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	Findings include: 1. The facility nurse failed to ensure client D had an annual physical examination. Please see W322. 2. The facility nurse failed to ensure clients A, B, C, D and E had routine and recommended vision assessments and services. Please see W323. 3. The facility nurse failed to monitor and proactively address client E's chronic insomnia and day time lethargy. Please see W331. 4. The facility nurse failed to ensure staff working with clients A, B, C, D, E and F were trained regarding their individual High Risk Health Plans. Please see W342. 5. The facility nurse failed to ensure clients A, B, D, E and F's dental recommendations were implemented and clients received routine dental examinations. Please see W356. 6. The facility nurse failed to ensure staff administered client C's medication without error. Please see W369.		The interdisciplinary team has developed a comprehensive high risk plan to monitor and address client E's insomnia. All staff will be trained on implementation of the plan. Additionally, client E has an appointment with his new attending psychiatrist on 2/5/18 to review his current psychotropic medication regime to determine if adverse interactions could be impacting client E's ability to sleep through the night. All facility staff have been retrained on implementation of high risk plans and the plans are stored in a manner to provide staff with easy access to review when needed. The team has scheduled comprehensive dental examinations for all clients who reside at the facility at the earliest available appointments. Specifically, all facility staff have been retrained to on proper measurement of liquid medication, prior to administration. Although this deficient practice did not affect additional clients, the facility nurse will review agency medication and	

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	9-3-6(a)		treatment administration protocols with all staff. **PERVENTION:** The nurse formerly assigned to the facility has been placed on administrative leave pending a full review of her work product to determine necessary corrective measures and appropriate performance action, and a new nurse has been assigned to the facility. The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to physical examinations occur no less than annually. The QIDP will work with the facility nurse will coordinate training with the facility direct support medical coach and Residential Manager to assure that all medical assessments and evaluations occur as required. The QIDP will coordinate with the facility nurse and facility direct	

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			support staff and supervisors to facilitate ongoing training toward competency in implementation of high risk plans. The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to assuring staff administer medications without error. The Area Supervisor will be present at the facility observing the staff's provision of skills training and documentation no less than weekly. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger and Registered Nurse) will review facility support documents and perform visual assessments of the facility no less than daily for the next 30 days, and after 30 days, will conduct administrative observations no less than three times weekly until all staff demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional	

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			Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight	

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			shift no less than twice monthly –more frequently if training issues or problems are discovered. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: ·The role of the administrative monitor is not simply to observe & Report. ·When opportunities for training are observed, the monitor must step in and provide the training and document it. ·If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. ·Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training as needed. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive	

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			Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include: ·Assuring that routine medical assessments, including but not limited to annual physical and visual examinations, occur as required. ·Assuring that routine dental evaluations and recommended dental follow-up occur as required. ·Assuring Medications are administered without error. Additional Preventative Healthcare Services Measures: 1.Nursing caseloads have been reduced to 3-4 SGL homes per nurse. 2.The Nurse Manager will no longer be responsible for a caseload. 3.The Nurse Manager will do side by side audits of SGL home with the assigned nurse weekly. 4.Copies of Nurse Manager Audits will be provided to the Executive Director and Regional Director (Area Manager) for review. 5.The Executive Director and Regional Director will meet with the Nurse Manager weekly to review concerns raised through	

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			audits, incident reports or other concerns brought to management attention. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director	
W 0322 Bldg. 00	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 1 additional client (D), the facility failed to ensure client D had an annual physical examination. Findings include: Client D's record was reviewed on 1/9/18 at 11:22 AM. Client D's Annual Physical Examination form was dated 8/27/16. Client D's record did not indicate documentation of an annual physical assessment. QIDP (Qualified Intellectual Disabilities Professional) #1, AS (Area Supervisor) #1, HM (Home Manager) #1 and LPN (Licensed Practical Nurse) #1 were interviewed on 1/9/18 at 1:07 PM. When asked if client D's 8/27/16 annual physical was the most current, HM #1 stated, "Yes, I	W 0322	**CORRECTION:** The facility must provide or obtain preventive and general medical care. Specifically, client D has received a physical examination from his primary care physician. Through a review of facility medical records, the governing body has determined that all clients who reside in the facility have current annual physical examinations. **PREVENTION:** The nurse formerly assigned to the facility has been placed on administrative leave pending a full review of her work product to determine necessary corrective measures and appropriate performance action, and a new	02/07/2018

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	can't get [client D] to an appointment. He will walk out." 9-3-6(a)		nurse has been assigned to the facility. The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to physical examinations occur no less than annually. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, and Nurse Manager) as well as the QIDP will maintain a daily presence in the facility for the next 30 days and three times weekly thereafter until staff demonstrate competence, as determined by the Executive Director and Regional Director (Area Manager). After this period of intensive administrative monitoring, the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than twice monthly to assure that routine medical assessments, including but not limited to annual physical examinations, occur as required. Additionally: 1.Nursing caseloads have been reduced to 3-4 SGL homes per nurse.	

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			2.The Nurse Manager will no longer be responsible for a caseload. 3.The Nurse Manager will do side by side audits of SGL home with the assigned nurse weekly. 4.Copies of Nurse Manager Audits will be provided to the Executive Director and Regional Director (Area Manager) for review. 5.The Executive Director and Regional Director will meet with the Nurse Manager weekly to review concerns raised through audits, incident reports or other concerns brought to management attention. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director	
W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 3 of 3 sampled clients (A, B and C), plus 2 additional clients (D and E), the facility nurse failed to ensure clients A, B, C, D and E had routine and recommended vision assessments and services.	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, all clients who reside in the facility have received current vision	02/07/2018

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	01/12/2018

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	Findings include: 1. Client A's record was reviewed on 1/9/18 at 12:01 PM. Client A's Vision Examination form dated 3/8/16 indicated client A had a recommendation/referral to be evaluated by a cornea specialist. Client A's record did not indicate documentation of additional vision or specialist evaluation. 2. Client B's record was reviewed on 1/9/18 at 10:48 PM. Client B's record did not indicate documentation of a vision examination. 3. Client C's record was reviewed on 1/9/18 at 10:19 AM. Client C's Annual Hearing Test dated 2/4/16 indicated a recommendation for client C to be evaluated by an ENT (Ear Nose and Throat) specialist regarding Cerumen (ear wax) removal. Client C's record did not indicate documentation of ENT assessment or services. 4. Client D's record was reviewed on 1/9/18 at 11:22 AM. Client D's Vision Examination form dated 5/16/16 indicated, "Unable to examine. Recommend exam in (the) facility where he lives." Client D's record did not indicate documentation of additional visual examinations or follow up.		assessments. **PREVENTION:** The nurse formerly assigned to the facility has been placed on administrative leave pending a full review of her work product to determine necessary corrective measures and appropriate performance action, and a new nurse has been assigned to the facility. The QIDP will work with the facility nurse will coordinate training with the facility direct support medical coach and Residential Manager to assure that all medical assessments and evaluations occur as required. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, and Nurse Manager) will maintain a daily presence in the facility for the next 30 days and three times weekly thereafter until staff demonstrate competence, as determined by the Executive Director and Regional Director (Area Manager). After this period of intensive administrative monitoring, the Operations Team	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	5. Client E's record was reviewed on 1/9/18 at 12:24 PM. Client E's record did not indicate documentation of a vision examination. QIDP (Qualified Intellectual Disabilities Professional) #1, AS (Area Supervisor) #1, HM (Home Manager) #1 and LPN (Licensed Practical Nurse) #1 were interviewed on 1/9/18 at 1:07 PM. HM #1 indicated she had been unaware of client A's recommendations regarding assessment by a cornea specialist until recently and was currently in the process of scheduling an appointment. HM #1 indicated client B would refuse evaluations or be uncooperative. HM #1 indicated she was in the process of identifying an eye care professional who would provide services for client B. HM #1 indicated client C had not been taken to an ENT or received other follow up hearing evaluations since 2/4/16. HM #1 indicated client E should have his vision assessed. 9-3-6(a)		will incorporate medical chart reviews into their formal audit process, which will occur no less than twice monthly to assure that examinations including but not limited to vision evaluations take place as required. Additionally: 1.Nursing caseloads have been reduced to 3-4 SGL homes per nurse. 2.The Nurse Manager will no longer be responsible for a caseload. 3.The Nurse Manager will do side by side audits of SGL home with the assigned nurse weekly. 4.Copies of Nurse Manager Audits will be provided to the Executive Director and Regional Director (Area Manager) for review. 5.The Executive Director and Regional Director will meet with the Nurse Manager weekly to review concerns raised through audits, incident reports or other concerns brought to management attention. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Heath Services Team, Direct Support Staff, Operations Team, Regional Director	

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W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 additional client (E), the facility nurse failed to monitor and proactively address client E's chronic insomnia and day time lethargy. Findings include: Day Service Manager (DSM) #1 was interviewed on 1/9/18 at 9:14 AM. DSM #1 stated, "[Client E] slept most days but has improved." Client E's record was reviewed on 1/11/18 at 9:18 AM. Client E's Progress Notes (PNs) dated from 11/15/17 through 1/9/18 indicated the following: Progress Note (PN) dated 11/15/17 10 PM -10 AM shift indicated, "[Client E] was walking up and down the whole house. He didn't sleep all the night. He started requesting for (sic) all kinds of stuff. He struggled with staff because he didn't get his way to the fridge, or med room." PN dated 11/18/17, 9 PM- 9 AM indicated, "[Client E] awake around 3 AM walking up and down (sic), jumping,	W 0331	**CORRECTION:** *The facility must provide clients with nursing services in accordance with their needs.* Specifically: the interdisciplinary team has developed a comprehensive high risk plan to monitor and address client E's insomnia. All staff will be trained on implementation of the plan. Additionally, client E has an appointment with his new attending psychiatrist on 2/5/18 to review his current psychotropic medication regime to determine if adverse interactions could be impacting client E's ability to sleep through the night consistently. **PERVENTION:** The nurse formerly assigned to the facility has been placed on administrative leave pending a full review of her work product to determine necessary corrective measures and appropriate performance action, and a new nurse has been assigned to the facility.	02/07/2018

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	15G449	A. BUILDING 00 B. WING	01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	screaming and yelling. [Client E] (was) asking for some stuff in the house." PN dated 11/19/17, 9 PM- 9 AM shift indicated, "[Client E] awake (sic) was slept around 1 AM. After (a) few hours [client E] woke up and (started) jumping, screaming and walking around the house, (sic) he trying to open the med room door also." PN dated 11/20/17, 8 PM- 9 AM shift indicated, "[Client E] woke up around 2 AM and (was) trying to fight with staff and go into [client C's] room and (sic) trying to wake [client C] up and (sic) trying to fight with him and (sic) jumping and (sic) screaming." PN dated 11/20/17, 8 AM- 8 PM shift indicated, "[Client E] woke up around 2 AM and (was) trying to fight with staff and go into [client C's] room and trying to wake [client C] up and (sic) trying to fight with him. And jumping and screaming." PN dated 11/21/17 12 AM - 8 AM shift indicated, "Upon arrival [client E] was watching TV and walking towards [client A's] room to wake him up by keeping open his door. Also he does not allow [client C] to sleep by opening his door too. Staff redirect him to the living room which he did		The nurse manager will review all reports of significant health and safety issues and will meet with the Quality Assurance Manager or designee weekly to discuss health and safety issues including but not limited to needed updates to risk plans, monitoring of chronic health conditions, appropriate communication with doctors and other outside medical professionals, as well as staff training needs. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) as well as the QIDP will maintain a daily presence in the facility for the next 30 days and three times weekly thereafter until staff demonstrate competence, as determined by the Executive Director and Regional Director (Area Manager). After this period of intensive administrative monitoring, the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than twice monthly. These administrative documentation reviews will include: 1.Assuring chronic healthcare	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	and continued to waking around the house." PN dated 11/22/17 12 AM - 8 AM shift indicated, "[Client E] was met in the house sitting on the floor and looking at his book. [Client E] didn't slept (sic) at all. He started walking around asking (for the) same things all the times (sic). He trying (sic) to open the fridge and snack cabinet." PN dated 11/23/17, 12 AM - 8 AM shift indicated, "[Client E] was met on bed upon arrival. He slept a few hours and (sic) getting up to waking around for period of couple of hours. Writer prompted him to go to bed and he went back and lay (sic) on the bed." PN dated 11/24/17, 12 AM -8 AM shift indicated, "[Client E] slept until 1:30 AM. He was up toileting and stay(ed) in the living room. Talking, jumping, walking around the house." PN dated 11/27/17 12 AM - 8 AM shift indicated client E was up during the overnight house and was going into his housemates rooms and jumping around the house. PN dated 12/1/17 12 AM - 8 AM shift indicated, "[Client E] at home walking around the house. Taking stuff, asking for		conditions are properly monitored by facility nursing. 2.Assuring comprehensive High Risk Plans address all clients' chronic healthcare conditions. 3.Assuring staff are trained and demonstrate competency in caring for chronic health conditions and implementing high risk plans. 4.Assuring facility nursing has monitored clients' doctors regarding emerging medical conditions and informed clients' medical condition including but not limited to insomnia 5.Assuring routine and preventative healthcare occurs as required. Additionally: 1.Nursing caseloads have been reduced to 3-4 SGL homes per nurse. 2.The Nurse Manager will no longer be responsible for a caseload. 3.The Nurse Manager will do side by side audits of SGL home with the assigned nurse weekly. 4.Copies of Nurse Manager Audits will be provided to the Executive Director and Regional Director (Area Manager) for review. 5.The Executive Director and Regional Director will meet with the Nurse Manager weekly to review concerns raised through	

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	stuff. Jumping and screaming until 4 AM. He went to bed and was up at 7 AM." PN dated 12/2/17 12 AM - 8 AM shift indicated, "[Client E] slept till 3: 15 AM and up walking around the house. Jumping, screaming, asking for some stuff and taking some stuff." PN dated 12/3/17 8 PM - 8 AM shift indicated, "[Client E] slept until around 2 AM and up walking around the house. Jumping and screaming and asking for some stuff. Taking stuff." PN dated 12/4/17 12 AM - 8 AM shift indicated, "[Client E] slept until 2 AM and up walking around the house. Jumping, screaming, asking for some stuff and food." PN dated 12/6/17 12 AM - 8 AM shift indicated, "[Client E] slept until 12:20 AM and up walking around the house not sleeping until morning. Jumping, screaming and asking for stuff like food." PN dated 12/7/17 12 AM - 8 AM shift indicated, "Upon arrival [client E] was in his room sleeping. At 1 AM, he woke up and started walking around the house. [Client E]started picking up some stuff out of from the kitchen. He did not slept (sic) at all		audits, incident reports or other concerns brought to management attention. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director	

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	throughout the night." PN dated 12/8/17, 12 AM- 8 AM shift indicated, "[Client E] slept for (a) few hours in (sic) the midnight woke up and started walking around the house and opened [client C's] door throughout the night." PN dated 12/12/17 12 AM- 8 AM shift indicated, "Upon arrived (sic) [client E] was slept (sic) in his room. After 1 hour he woke up at 1:30 AM and started walking around, jumping around and still picking up some stuff up (sic) and playing with it until this morning at 5:45 AM he went to his room and lay down without any issue (sic)." PN dated 12/13/17, 10 PM- 9 AM shift indicated, "Upon arrived (sic) [client E] was slept (sic) in his room. After few hours he woke up at 1:20 AM and started walking around, jumping around and playing with (a) toy until this morning." PN dated 12/16/17, 9 PM- 9 AM shift indicated, "Upon arrived [client E] was playing in the living room, after few minutes he slept (sic) and he woke up at 2 AM and started walking around, jumping around." PN dated 12/17/17, 9 AM-9 PM shift indicated, "[Client E] didn't slept (sic)			

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	throughout the night. [Client E] walking around the house jumping, screaming (and) also opened other clients doors." PN dated 12/18/17 8 PM- 8 AM shift indicated, "[Client E] didn't slept (sic) throughout the night. [Client E] walking around the house jumping, screaming around (sic)." PN dated 12/19/17, 9 PM- 9 AM shift indicated, "Upon arrived (sic) [client E] was in the living room walking around, screaming around the house. [Client E] slept around 4 AM this morning." PN dated 12/20/17, 9 PM - 9 AM shift indicated, "[Client E] didn't sleep all through the night. His activities woke his roommate, [client B], up. He attempted to bite his roommate, [client B], countless times. Staff stood against him and redirected him though forcefully thereby also attempted biting staff. He started sleeping at about 6:45 AM." PN dated 12/21/17, 12 AM- 8 AM shift indicated, "[Client E] slept (sic) upon arrived (sic). After one hour he woke up, said he needs shower and staff gave him shower. [Client E] started walking around the house."			

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	PN dated 12/22/17 9 PM -9 AM shift indicated, "[Client E] was asleep when staff arrived. He was woken up for his bedtime med's, he took the med and went back to sleep. He then woke up by himself at 12 AM and remained awake all through the night. He kept roaming the living room." PN dated 12/22/17, 2 PM- 10 PM shift indicated, "[Client E] was picked up at day program. Slept through while transported to the house." PN dated 12/29/17, 9 PM -9 AM shift indicated, "[Client E] slept between 9 PM-12 AM. He was awake from 12 AM to this morning. He kept disturbing staff all through the night. [Client E] going to the closet to get the blankets out, taking stuff out of kitchen cabinet." PN dated 12/31/17, 6 PM- 10 AM shift indicated, "[Client E] slept upon arrived. After few hours he woke up. He was awake from 1 AM till this morning. He kept jumping around the house screaming around." PN dated 1/4/18, 5 PM - 9 AM shift indicated, "[Client E] was awake all the night long."			

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	PN dated 1/5/18, 5 PM - 9 AM shift indicated, "[Client E] only slept for 2 hours after his bedtime med's. He was awake all throughout the night thereafter." PN dated 1/8/18, 5 PM - 9 PM shift indicated, "[Client E] was awake till 4 AM. He slept briefly for 2 hours and woke up again." PN dated 1/9/18, 9 PM - 9 AM shift indicated, "[Client E] was awake when staff arrived. He stayed awake all through the night. He kept pacing around the whole house." QIDP #2, LPN #1 and QIDP #1 were interviewed on 1/10/18 at 12 PM. When asked if she was aware of ongoing issues regarding client E's insomnia, LPN #1 stated, "Yes. I'm pretty sure he's on a sleeping pill. Several including Melatonin (sleep aid)." LPN #1 stated, "He came with an order for Ambien (sleep aid) but when he saw [primary care physician], he discontinued it. I would have to go back to look at the record of visit to see why. Don't quote me but I believe he increased the Melatonin and discontinued the Ambien but I'd have to look at the record of visit." When asked if there had been any additional follow up with client E's PCP (Primary Care			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	Physician) or nursing measures to track/monitor his insomnia for later follow up, LPN #1 stated, "He saw [PCP] a couple of weeks later but didn't change the medication." LPN #1 stated, "It (insomnia) wasn't officially tracked. They (staff) were just kind of monitoring and then letting [HM #1] know. [HM #1] would take him to his appointments. But not officially tracked anywhere." When asked to provide documentation of client E's PCP visits regarding insomnia, LPN #1 stated, "Yes, I will have to check my folder but yes we probably do." When asked to clarify the reason for client E's 11/17/17 psychiatric services visit, LPN #1 stated, "He was seen on 11/17/17 for his initial intake. When they first get admitted they go to [clinic] to meet the doctor and do consultation to get acquainted and then they go from there." LPN #1 indicated client E had not received additional or follow up psychiatric review/services regarding insomnia, aggression or obsessive behaviors since his intake on 11/17/17. LPN #1 indicated she had not participate in any IDT meetings to discuss client E's behaviors or insomnia. LPN #1 via email correspondence on 1/10/18 at 1:53 PM provided a copy of client E's 11/16/17 Record of Visit for a physical assessment with his PCP. The			

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	11/16/17 indicated client E was given a prescription for Zolpidem 10 milligrams at bedtime for insomnia. LPN #1's electronic correspondence dated 1/10/18 indicated, "Hello, after speaking with staff, I was informed that [client E] did not go to his 2nd appointment with [PCP]. On the day that it was scheduled [client E] had to go to the hospital to get his labs drawn because he bit (sic) [client B] and we had to rule out any infectious diseases." LPN #1 did not provide additional documentation regarding client E's Ambien/Zolpidem 10 milligrams for insomnia being discontinued. LPN #1 indicated there had not been communication with client E's PCP regarding the effectiveness of client E's medications for the treatment of insomnia. Observations were conducted at the group home on 1/10/18 from 4 PM through 5:45 PM. Client E slept on the home's living room couch from 4 PM through 4:40 PM. Staff #1 was interviewed on 1/10/18 at 4:43 PM. Staff #1 indicated client E was asleep on the couch. Staff #1 indicated he was client E's assigned 1 to 1 ratio supervision staff before being relieved to administer the home's evening medications. Staff #1 stated, "He sleeps off and on. Sleeps about 15 minutes to an hour and then up. During the			

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	day and at night too." MC (Med Coach) #1 was interviewed on 1/11/18 at 8:08 AM. MC #1 stated, "I came in at 6 AM. [Client E] was awake and up. Usually is when I come in. Overnight reports to me that he doesn't sleep most nights." 9-3-6(a)			
W 0342 Bldg. 00	483.460(c)(5)(iii) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. Based on record review and interview for 3 of 3 sampled clients (A, B and C), plus 3 additional clients (D, E and F), the nurse failed to ensure staff working with clients A, B, C, D, E and F were trained regarding their individual High Risk Health Plans. Findings include: Nurse Manager (NM) #1 was interviewed on 1/8/18 at 1:45 PM. NM #1 indicated	W 0342	**CORRECTION:** *Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.* Specifically,	02/07/2018

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	clients A, B, C, D, E and F's High Risk Health Plans had been updated by LPN #1. NM #1 was interviewed on 1/8/18 at 1:59 PM. NM #1 indicated the updated High Risk Health Plans would be provided via email. NM #1 provided clients A, B, C, D, E and F's High Risk Health Plans via email on 1/8/18 at 2:34 PM. Review of the attached risk plans indicated the following: -Client A's High Risk Health Plans regarding Allergies, Anemia, Prostate Cancer, Seizures, Choking, Skin Infection and Respiratory Infection were reviewed/revised on 11/17/17. -Client B's High Risk Health Plans regarding Skin Infection were reviewed/revised on 11/17/17. -Client C's High Risk Health Plans regarding Respiratory Infection, Skin Infection and Choking Potential were reviewed/revised on 11/17/17. -Client D's High Risk Health Plans regarding Hypokalemia (low blood platelets), Choking, Skin Breakdown, Constipation or Bleeding were reviewed/revised on		all facility staff have been retrained on implementation of high risk plans and the plans are stored in a manner to provide staff with easy access to review when needed. **PREVENTION:** The nurse formerly assigned to the facility has been placed on administrative leave pending a full review of her work product to determine necessary corrective measures and appropriate performance action, and a new nurse has been assigned to the facility. The QIDP will coordinate with the facility nurse and facility direct support staff and supervisors to facilitate ongoing training toward competency in implementation of high risk plans. The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to including but not limited to proper	

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	11/17/17. -Client E's High Risk Health Plan regarding Skin Infection were reviewed/revised on 11/17/17. -Client F's High Risk Health Plans regarding Choking, Dermatitis, Hyponatremia (not enough salt in body fluids), Skin Breakdown, Respiratory Infection, Seizures and Hyperlipidemia were reviewed/revised on 11/17/17. NM #1 was interviewed on 1/8/18 at 2:56 PM. NM #1 indicated all staff had been trained on clients A, B, C, D, E and F's updated High Risk Plans by LPN #1. Staff #2 was interviewed on 1/8/18 at 4:45 PM. Staff #2 indicated she worked the evening shift from 2 PM-10 PM and on weekends from 8 AM -12 PM. When asked if she had received any recent retraining regarding client high risk plans, staff #2 stated, "No." Staff #2 stated she "remembers signing some training but nothing at the home with [LPN (Licensed Practical Nurse) #1]." MC (Med Coach) #1 was interviewed on 1/8/18 at 5 PM. When asked to describe clients A, B, C, D, E and F's High Risk		implementation of high risk plans.Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger and Registered Nurse) will review facility support documents and perform visual assessments of the facility no less than daily for the next 30 days, and after 30 days, will conduct administrative observations no less than three times weekly until all staff demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.	

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	Health Plans, MC #1 stated, "Don't think [client C] has one. [Clients A, D and F] not had house training on them." MC #1 indicated she had received some client specific training for the home but was uncertain whom she had been trained on. MC #1 indicated client A had skin picking behaviors. MC #1 indicated client F was on a fluid restriction. MC #1 indicated client D was had incontinence issues, stole food and should be monitored when he ate. MC #1 did not demonstrate retention or knowledge of client C's choking risk plan, client B's seizure risk plan, client A's allergy and sinusitis risk plan or client D's constipation and Thrombocytopenia (low blood platelet) risk plans. Staff #1 was interviewed on 1/8/18 at 5:15 PM. Staff #1 indicated he started working at the home on 12/26/17 and worked the 4 PM -12 AM shift during weekdays. When asked to describe clients A, B, C, D, E and F's High Risk Health Plans and BSP, staff #1 stated, "Don't know about risk plans. [Client C] was on leave when I started and just came back this week so only worked with him for about one week. [Clients B and C] were both gone and just recently came back. [Client D] has to be watched for choking and will eat fast. He has to have help getting in and out of the shower."		Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: ·The role of the administrative monitor is not simply to observe & Report. ·When opportunities for training are observed, the monitor must step in and provide the training and document it.	

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	Staff #1 did not demonstrate retention or knowledge of client C's choking risk plan, client B's seizure risk plan, client A's allergy and sinusitis risk plan or client D's constipation and Thrombocytopenia (low blood platelet) risk plans. Client B's day services record was reviewed on 1/9/18 at 9:24 AM. Client B's day service record indicated client B had a High Risk Health Plan dated 8/22/17 regarding seizures. Client B's record did not indicate documentation of client B's updated/revised 11/17/17 High Risk Health Plan regarding seizures. Client C's day services record was reviewed on 1/9/18 at 9:20 AM. Client C's High Risk Plans included Respiratory Infection, Skin Infection, Choking Potential all dated 8/21/17. Client C's day services record did not indicate documentation of client C's updated/revised 11/17/17 High Risk Health Plans regarding Respiratory Infection, Skin Infection and Choking Potential. Client D's day services record was reviewed on 1/9/18 at 9:28 AM. Client D's day services record indicated client D's ISP was dated 11/22/16, BSP was dated 11/22/16 and High Risk Health Plans		·If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. ·Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training as needed. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring staff demonstrate competency in implementing high risk plans. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director	

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	15G449	A. BUILDING 00 B. WING	01/12/2018

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	regarding Skin Integrity, Constipation and Choking were all dated 4/8/16. Client D's day services record did not indicate documentation of client D's ISP dated 11/2/17, BSP dated 11/22/17 or High Risk Health Plans regarding Hypokalemia (low blood platelets), Choking, Skin Breakdown, Constipation or Bleeding all dated 11/17/17. Client E's day services record was reviewed on 1/9/18 at 9 AM. Client E's day services record indicated client E's ISP was dated 8/2/16, BSP was dated 8/2/16 and did not include any High Risk Health Plans. Client E's day services record did not indicate documentation of client E's ISP dated 11/17/17, BSP dated 12/14/17 or High Risk Health Plan regarding Skin Infection dated 11/17/17. Client F's day services record was reviewed on 1/9/18 at 9:26 AM. Client F's day services record indicated client F's High Risk Health Plans regarding Hyperlipidemia, Hyponatremia, Dermatitis, Choking, Seizures, Respiratory Infection and Skin Breakdown were all dated 8/22/17. Client F's High Risk Health Plans regarding Choking, Dermatitis, Hyponatremia (not enough salt in body fluids), Skin Breakdown, Respiratory Infection, Seizures			

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	and Hyperlipidemia all dated 11/17/17. Client F's 11/17/17 Hyponatremia High Risk Plan indicated client F's fluid intake was restricted to 68 ounces per day and should be monitored and tracked. Client F's day services record did not indicate fluid tracking for December 2017 and January 2018 for client F. Day Services training logs were reviewed on 1/9/18 at 9:30 AM. The review did not indicate documentation of staff training regarding clients B, C, D, E or F's updated/most current High Risk Health Plans dated 11/17/17 by LPN #1. DSM #1 was interviewed on 1/9/18 at 9:31 AM. DSM #1 indicated LPN #1 had not provided training for day services staff regarding clients B, C, D, E or F's updated/most current High Risk Health Plans dated 11/17/17. Client A's group home record was reviewed on 1/9/18 at 12:01 PM. Client A's High Risk Health Plans regarding Allergies, Anemia, Prostate Cancer, Seizures, Choking, Skin Infection and Respiratory Infection were all dated 10/18/16. Client A's record did not indicate documentation of updated/revised High Risk Health Plans since 10/18/16.			

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	Client B's group home record was reviewed on 1/9/18 at 10:48 AM. Client B's Record of Visit form dated 11/28/17 indicated he was evaluated and treated for a human bite wound. Client B's Record of Visit form dated 12/11/17 indicated client B was evaluated and treated for a human bite wound. Client B's record did not indicate documentation of client B's 11/17/17 High Risk Health Plan regarding Skin Infection. Client C's group home record was reviewed on 1/9/18 at 10:19 AM. Client C's record did not indicate documentation of client C's updated/revised 11/17/17 High Risk Health Plans regarding Respiratory Infection, Skin Infection and Choking Potential. Client D's group home record was reviewed on 1/9/18 at 11:22 AM. Client D's record did not indicate documentation of client D's ISP dated 11/2/17, BSP dated 11/22/17 or High Risk Health Plans regarding Hypokalemia (low blood platelets), Choking, Skin Breakdown, Constipation or Bleeding all dated 11/17/17. Client E's group home record was reviewed on 1/9/18 at 12:24 PM. Client E's record did not indicate documentation of client E's High Risk Health			

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	Plan regarding Skin Infection dated 11/17/17. Client F's group home record was reviewed on 1/9/18 at 11:47 AM. Client F's record did not indicate documentation of client F's High Risk Health Plans regarding Choking, Dermatitis, Hyponatremia (not enough salt in body fluids), Skin Breakdown, Respiratory Infection, Seizures and Hyperlipidemia all dated 11/17/17. QIDP (Qualified Intellectual Disabilities Professional) #1, AS (Area Supervisor) #1, HM (Home Manager) #1 and LPN (Licensed Practical Nurse) #1 were interviewed on 1/9/18 at 1:07 PM. QIDP #1 indicated the day services should have current copies of ISP's, BSP's and High Risk Health Plans. When asked to provide documentation of staff training regarding updated/current High Risk Health Plans, LPN #1 indicated clients A, B, C, D, E and F's charts at the group home and at day services should contain the 11/17/17 updated High Risk Health Plans. LPN #1 indicated all staff working with clients A, B, C, D, E and F should be trained regarding clients A, B, C, D, E and F's High Risk Health Plans. LPN #1 stated, "Yes, the in-service paper should be here (looking			

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	through the home's MAR). Can't find it. I will have to get back to you." LPN #1 stated, "Yes, I did an in-service on High Risk Plans and updated the risk plans." LPN #1 indicated she had not conduct retraining on high risk health plans with day services staff. No additional documentation of staff training was provided by LPN #1. 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 2 of 3 sampled clients (A and B), plus 3 additional clients (D, E and F), the nurse failed to ensure clients A, B, D, E and F's dental recommendations were implemented and clients received routine dental examinations. Findings include: 1. Client A's record was reviewed on 1/9/18 at 12:01 PM. Client A's Dental Summary Progress Report dated 3/21/17 indicated client A had recommendations for follow up services and assessment on	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 health.* Specifically, the team has scheduled comprehensive dental examinations for all clients who reside at the facility at the earliest available appointments. **PREVENTION:**	02/07/2018

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	5/17/17. Client A's record did not indicate documentation of additional dental services or follow up assessments. 2. Client B's record was reviewed on 1/9/18 at 10:48 PM. Client B's Record of Visit form dated 2/15/17 indicated client B was taken for a dental examination but refused to participate. Client B's record did not indicate additional documentation of dental examinations or visits for desensitization attempts. 3. Client D's record was reviewed on 1/9/18 at 11:22 AM. Client D's Dental Summary Progress Report dated 4/18/15 indicated client D should return annually for a dental examination. Client D's record did not indicate additional documentation of dental assessment or examinations since 4/18/15. 4. Client E's record was reviewed on 1/9/18 at 12:24 PM. Client E's record did not indicate documentation of a dental examination. 5. Client F's record was reviewed on 1/9/18 at 11:47 AM. Client E's Dental Summary Progress Report dated 4/11/14 indicated client E had recommendations for the extraction of his teeth and dentures. Client		The nurse formerly assigned to the facility has been placed on administrative leave pending a full review of her work product to determine necessary corrective measures and appropriate performance action, and a new nurse has been assigned to the facility. The QIDP will work with the facility nurse will coordinate training with the facility direct support medical coach and Residential Manager to assure that all medical assessments and evaluations occur as required. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, and Nurse Manager) will maintain a daily presence in the facility for the next 30 days and three times weekly thereafter until staff demonstrate competence, as determined by the Executive Director and Regional Director (Area Manager). After this period of intensive administrative monitoring, the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than twice monthly to assure that	

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	E's record did not indicate additional documentation of follow up or annual dental services since 4/11/14. QIDP (Qualified Intellectual Disabilities Professional) #1, AS (Area Supervisor) #1, HM (Home Manager) #1 and LPN (Licensed Practical Nurse) #1 were interviewed on 1/9/18 at 1:07 PM. HM #1 indicated clients A, B, D, E and F's dental recommendations should be implemented and clients should have routine dental examinations. 9-3-6(a)		examinations including but not limited to dental evaluations take place as required. Additionally: 1.Nursing caseloads have been reduced to 3-4 SGL homes per nurse. 2.The Nurse Manager will no longer be responsible for a caseload. 3.The Nurse Manager will do side by side audits of SGL home with the assigned nurse weekly. 4.Copies of Nurse Manager Audits will be provided to the Executive Director and Regional Director (Area Manager) for review. 5.The Executive Director and Regional Director will meet with the Nurse Manager weekly to review concerns raised through audits, incident reports or other concerns brought to management attention. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Heath Services Team, Direct Support Staff, Operations Team, Regional Director	
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are			

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	self-administered, are administered without error. Based on observation, record review and interview for 1 of 3 sampled clients (C), the facility failed to ensure staff administered client C's medication without error. Findings include: Observations were conducted at the group home on 1/10/18 from 4:00 PM through 5:45 PM. At 4:56 PM, staff #1 prepared client C's 5 PM medications on the medication administration room countertop. Staff #1 dispensed/poured 30 milliliters of client C's Metoclopramide (GERD-gastroesophageal reflux disease) 5 milligrams/5 milliliters syrup into a 30 milliliters sized administration cup. Client C's Metoclopramide 5 milligrams/5 milliliters syrup pharmacy label indicated, "Metoclopramide 5 milligrams/5 milliliters syrup. Give 2 teaspoons (10 milliliters) by mouth twice daily at 5 PM and 9 PM for GERD." Prior to staff #1's administration of client C's medications the surveyor asked staff #1 to clarify the dose of Metoclopramide 5 milligrams/5 milliliters syrup he was about to administer to client C. Staff #1 stated, "Yes"	W 0369	**CORRECTION:** *The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.* Specifically, all facility staff have been retrained to on proper measurement of liquid medication, prior to administration. Although this deficient practice did not affect additional clients, the facility nurse will review agency medication and treatment administration protocols with all staff. **PREVENTION:** The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to assuring staff administer medications without error. The Area Supervisor will be present at the facility observing the staff's provision of skills training and documentation no less than weekly. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers,	02/07/2018

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	he had completed the preparation of client C's medications and "was going to administer 30 milliliters" of client C's Metoclopramide 5 milligrams/5 milliliters syrup. Surveyor advised not to administer the 30 milliliters and to check the pharmacy prescription dosage. HM (Home Manager) #1 was present at the time and indicated staff #1 was prevented by the surveyor from administering 30 milliliters of client Metoclopramide 5 milligrams/5 milliliters syrup. HM #1 indicated administration of the wrong dosage of medication was considered a medication error. HM #1 then had staff #1 switch with another staff working in the home to finish client C's medication administration. Client C's MAR (Medication Administration Record) dated January 2018 was reviewed on 1/11/18 at 9:04 AM. Client C's MAR dated January 2018 indicated, "Metoclopramide 5 milligrams/5 milliliters syrup. Give 2 teaspoons (10 milliliters) by mouth twice daily at 5 PM and 9 PM for GERD." Nurse Manager (NM) #1 was interviewed on 1/11/18 at 10:00 AM. NM #1 indicated client C's medications should be administered as ordered by the physician.		Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger and Registered Nurse) will review facility support documents and perform visual assessments of the facility no less than daily for the next 30 days, and after 30 days, will conduct administrative observations no less than three times weekly until all staff demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the	

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	9-3-6(a)		following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: ·The role of the administrative monitor is not simply to observe & Report. ·When opportunities for training are observed, the monitor must step in and provide the training and document it. ·If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. ·Assuring the health and safety	

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			of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training as needed. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring staff administer medication without error. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Heath Services Team, Direct Support Staff, Operations Team, Regional Director	
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 3 of 3 sampled clients (A, B and C), plus 3	W 0440	**CORRECTION:**	02/07/2018

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	additional clients (D, E and F), the facility failed to conduct quarterly evacuation drills for each shift of personnel for clients A, B, C, D, E and F. Findings include: The facility's Fire Evacuation Drill Records were reviewed on 1/11/18 at 12:50 PM. The review indicated two fire drills had been completed in 2017. The two drills were conducted on 1/14/17 at 10 AM for the first shift of staff and the second was conducted on 1/19/17 at 5 PM for the second shift of staff. The review did not indicate documentation of additional evacuation drills being completed in 2017 or 2018 for clients A, B, C, D, E and F. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/11/18 at 1:29 PM. QIDP #1 indicated fire evacuation drills should be completed one per quarter for each shift of personnel. QIDP #1 indicated there was not additional documentation available for review regarding fire evacuation drills completed during 2017. 9-3-7(a)		The facility must hold evacuation drills at least quarterly for each shift of personnel. Specifically, the facility has conducted additional evacuation drills on each shift during the current quarter. **PREVENTION:** Professional staff will be retrained regarding the need to conduct evacuation drills on each shift for all staff each quarter. The Operations Team will review all facility evacuation drill reports and follow up with professional staff as needed to assure drills occur as scheduled. Program Manager will track evacuation drill compliance and follow up with facility professional staff and the agency Safety Committee accordingly. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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