STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G141	A. BUILDING 00 B. WING	09/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUTNAM COUNTY COMPREHENSIVE SERVICES INC	914 TENNESSEE ST GREENCASTLE, IN46135

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W0000	This visit was for a fundamental recertification and state licensure survey. Survey Dates: September 6, 7, 8, 9 and 12, 2011. Facility Number: 000678 Provider Number: 15G141 AIM Number: 100234430 Surveyor: Steven Schwing, Medical Surveyor III These deficiencies also reflect state findings in accordance with 431 IAC 1.1. Quality Review completed 9-29-11 by C. Neary, Program Coordinator.	W0000		
W0104	The governing body must exercise general policy, budget, and operating direction over the facility. Based on interview and record review for 1 of 3 clients in the sample (#1), the governing body failed to ensure the client did not have to earn his own money as a reward for good behavior. Findings include: A review of the clients' finances was conducted on 9/7/11 at 10:00 AM. Client #1's ledger, September 2011, for his behavior reward money indicated he had $26.50. A count of the money indicated client #1 had $27.00 in his behavior reward jar. A review of client #1's Behavior Support Plan, dated 1/27/11, was conducted on 9/7/11 at 10:51 AM. Client #1's plan indicated the use of a "Good Behavior jar." The plan indicated staff were to inform client #1 they would be assisting him to save a portion of his earnings for a "good behavior treat" at the end of each month. But, if he destroys the property of another client, he will have to pay for the item from this jar. Each day, client #1 was to deposit $1.00 in quarters into the jar. At the	W0104	Client #1's Behavior Management plan has been revised to remove using client #1's personal money for a reward. In the future we will not accept plans that rely on using the consumers money for rewards. A policy has been revised and will be distributed at the next Human Rights Committee meeting. All other plans have been reviewed to ensure that the consumer is NOT using their money for a behavior reward. Revised Behavior plan attached. Revised behavior plan attached Revised Review of Behavior Management Programs attached	10/11/2011

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

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	end of the month, one-half of the jar's balance was to be given to client #1 for an appropriate expenditure of his choice. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/7/11 at 10:00 AM. The QMRP indicated the money being given as a reward was client #1's own money. The money was taken out of his personal spending money and placed into the jar. The QMRP indicated the money he was being rewarded should not be coming from client #1's personal spending money. An interview with the home manager (HM) was conducted on 9/8/11 at 12:01 PM. The HM indicated the money being placed into the Good Behavior jar was coming from client #1's personal spending money. The HM indicated client #1 should not have to earn his own money. 1.1-3-1(a)			
W0125	The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, interview and record review for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients' rights by: 1) locking the thermostat, 2) locking client #3's cigarettes and 3) the use of bells on the bedroom doors of clients #1, #3, #5 and #6. Findings: 1) Observations were conducted in the group home on 9/6/11 from 3:01 PM to 5:45 PM and 9/7/11 from 6:00 AM to 8:20 AM. During the observations, the thermostat in the hallway near	W0125	PCCS goes to great lengths to ensure the rights of all clients, both as clients of the facility and as citizens of the United States. We encourage the clients to own and use their own personal items in the manner they see fit unless it could cause themselves or someone else harm. In the examples cited in the survey regarding use of bells on client's doors I see where it could be construed that they were for staff	10/11/2011

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	the living room had a locked plastic cover. On 9/6/11 at 4:30 PM, staff #2 indicated the thermostat was locked to keep clients and staff from turning the temperature up and down. Staff #2 indicated the staff had access; the clients did not have access. This affected clients #1, #2, #3, #4, #5 and #6. A review of client #1's record was conducted on 9/7/11 at 10:51 AM. Client #1 did not have documentation in his record indicating access to the thermostat needed to be restricted. A review of client #2's record was conducted on 9/8/11 at 10:45 AM. Client #2 did not have documentation in his record indicating access to the thermostat needed to be restricted. A review of client #3's record was conducted on 9/8/11 at 11:26 AM. Client #3 did not have documentation in his record indicating access to the thermostat needed to be restricted. A review of client #4's record was conducted on 9/8/11 at 12:02 PM. Client #4 did not have documentation in his record indicating access to the thermostat needed to be restricted. A review of client #5's record was conducted on 9/8/11 at 12:05 PM. Client #5 did not have documentation in his record indicating access to the thermostat needed to be restricted. A review of client #6's record was conducted on 9/8/11 at 12:08 PM. Client #6 did not have documentation in his record indicating access to the thermostat needed to be restricted. An interview with the home manager (HM) was conducted on 9/6/11 at 5:01 PM. The HM		convenience. However, that is not the case! These are personal items of the consumers placed by them where they chose. As a result of the survey we have moved the item from the bedroom door of clients #3 and #6. After talking to them they understand and are agreeable to relocating the chime in their room. Unfortunately, Client # 1 does not understand. His item was actually a decoration made by him, placed on an exterior door knob used only during drills or in the event of a real evacuation. We tried moving it to his closet door, he responded by moving it to his bedroom door. We have further tried setting it on his bookcase which is next to his bed. Again he moved it back to his bedroom door. In order to determine if it could be used for staff convenience I left the decoration on his bedroom door knob and repeatedly opened and closed the door. It never made a sound at all until I let the door hit my foot. There were staff located in 3 rooms of the house and none of them heard anything! In the case of client #1 we have decided that he may continue to choose where to locate his decoration in his bedroom as it would be a violation of his rights to remove it and it causes him stress when we move it around. Frankly, if we had a need for alarms on any doors we would go through the proper procedures as we have in the	

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	indicated the locked cover over the thermostat was in place to keep the clients and staff from turning the temperature up and down. The HM indicated it was not addressed in any of the clients' plans. On 9/8/11 at 12:01 PM, the HM indicated the locked thermostat was a restrictive intervention. The HM indicated there was no documentation indicating the purpose of the restriction. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/8/11 at 12:01 PM. The QMRP indicated there was no documentation indicating the purpose of the locked thermostat. 2) An observation was conducted at the group home on 9/7/11 from 6:00 AM to 8:20 AM. At 7:40 AM, client #3 received 3 cigarettes from the locked medicine closet in the recreation room. An interview with staff #4 indicated client #3 received 3 cigarettes in the morning and 3 in the evening. Staff #4 indicated the cigarettes were accessible only by the staff. A review of client #3's record was conducted on 9/8/11 at 11:26 AM. There was no documentation in client #3's record to indicate his cigarettes needed to be locked. An interview with the HM was conducted on 9/8/11 at 12:01 PM. The HM indicated there was no plan addressing client #3's locked cigarettes. An interview with the QMRP was conducted on 9/8/11 at 12:01 PM. The QMRP indicated client #3 should have access to his cigarettes. 3) Observations were conducted in the group home on 9/6/11 from 3:01 PM to 5:45 PM and 9/7/11 from 6:00 AM to 8:20 AM. During the		past when it was an issue. Elopment has not been a problem in this home is several years. In regards to client # 3's cigarettes. When he began smoking again he asked staff to keep them for him so he could space them over time between pay days. We are not trying to restrict his right to smoke or even the quanity he smokes. There have been several times that he has in fact asked for extra cigarettes and staff give them to him. There have also been times that he has carried his own and then is upset because he runs out too quickly and has to go without. He also is at risk for being manipulated by others and he has let people "bum smokes" causing him to be short. At his quarterly conference on 9-15-11 Client #3 was asked again if he wanted staff to maintain his cigarettes he stated yes. Residential Director also inquired if he knew he could carry his own and he said yes. Quarterly minutes attached. Again we will recognize the wishes of the consumer in this instance. But will also be sure that it is addressed in his IPP and at each quarterly meeting. Additionally, we provide staff training to be sure everyone understands that Clt #3 can change his mind at any time and have possession of as many cigarettes has he would like or can afford. In regards to the locked thermostat it was originally	

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	observations, clients #1 and #5's bedroom door had bells on the door knob. Clients #3 and #6 had bells attached to a hanger from the top of the door. Both bedroom doors, when opened or closed, chimed due to the bells that were present. A review of client #1's record was conducted on 9/7/11 at 10:51 AM. Client #1 did not have documentation in his record indicating a need for the use of bells on his bedroom door. A review of client #3's record was conducted on 9/8/11 at 11:26 AM. Client #3 did not have documentation in his record indicating a need for the use of bells on his bedroom door. A review of client #5's record was conducted on 9/8/11 at 12:05 PM. Client #5 did not have documentation in his record indicating a need for the use of bells on his bedroom door. A review of client #6's record was conducted on 9/8/11 at 12:08 PM. Client #6 did not have documentation in his record indicating a need for the use of bells on his bedroom door. An interview with the QMRP was conducted on 9/7/11 at 11:46 AM. The QMRP indicated none of the clients needed bells on their bedroom doors. An interview with the HM was conducted on 9/8/11 at 12:01 PM. The HM indicated the use of bells on the bedroom doors was not needed. 1.1-3-2(a)		covered shortly after moving into the house due to ongoing damage to furnishings and equipment due to client behaviors. It was to prevent breakage only! It was never included in a plan as its intent was never restrictive in nature as evidenced by all staff having acess to the key. At anytime a resident would want the temperature increased or decreased it was accessible. However, since the property damage concerns that were originally present have decreased dramatically we removed the thermostat cover at the time of survey. QMRP will continue to include right restrictions in the clients program plans when needed. HRC approval will be sought for any approval of restrictive measures. A minimum of one HRC meeting per year will be conducted in the home to provide an opportunity for HRC members to review the house for precieved restrictions and provide feedback. IPP Addendum attached Staff Meeting Agenda and Minutes 10-11-2011 attached Staff Meeting signature page attached Quarterly Review meeting minutes attached	
W0126	The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Based on observation, record review and interview	W0126	Effective 10-4-11 only real money	10/11/2011

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	for 1 of 3 non-sampled clients (#6), the facility failed to ensure the client learned money management skills with real currency. Findings include: An observation was conducted at the group home on 9/6/11 from 3:01 PM to 5:45 PM. At 5:05 PM, client #6 was in the recreation room working on improving his money management skills with staff #1. Client #6 was using paper money (fake) and plastic coins. A review of client #6's Individual Program Plan (IPP), dated 3/24/11, was conducted on 9/8/11 at 12:03 PM. His money management training objective was to learn to make change from purchases of up to $5.00 An interview with the home manager (HM) was conducted on 9/8/11 at 12:01 PM. The HM indicated there was no specific reason the clients were using fake money. The HM indicated the clients had real money in the home and it was available to use. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/8/11 at 12:01 PM. The QMRP indicated the client had real money in the home to use. 1.1-3-2(a)		is being used for financial programming. All fake money has been removed from the home. All staff we be re-trained at a staff meeting on 10-14-11. In the meantime staff that are working have been advised to use rec fund money when running money goals. This affects all six residents. The QMRP will develop training programs to utilize the most natural training methods when working on goals. Staff and clients will be encouraged to make suggestions on ways to make training more "natural".Staff Meeting Agenda and Minutes attached	
W0149	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 12 of 12 incidents of client to client abuse affecting clients #1, #2, #3, #4 and #5, the facility neglected to implement its policies and procedures to investigate incidents of client to client abuse.	W0149	Residential Director reviewed Agency policies and met with the new Quality Assurance Director to discuss the Investigation process which will be re-implemented	10/11/2011

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	Findings include: A review of the facility's incident reports was conducted on 9/6/11 at 3:05 PM. The following Bureau of Developmental Disabilities Services (BDDS) reports of client to client abuse did not include documentation the facility conducted investigations: 1. On 1/6/11 at 2:37 PM at the facility-operated workshop, client #4 walked by another client (report did not indicate who) and grabbed him by the coat collar. Staff released client #4's hold using a hand release. 2. On 1/8/11 at 7:30 PM, client #4 tackled client #3 in the living room. Upon landing on him, client #4 began punching client #3 on the back. Two staff used a two-man transport to separate the clients. 3. On 2/10/11 at 9:05 AM at the facility-operated workshop, client #1 hit another client (report did not indicate who) on the back. The other client tackled client #1 and sat on top of him holding his arms. Staff assisted the other client off of client #1 using a 2 man transport. Client #1 had red pin-point dots on the inside of his ankle. 4. On 2/16/11 at 7:57 AM, client #4 pushed client #3 against the refrigerator. Client #4 grabbed client #3 around his upper arms and neck and would not let go. Staff used a hand release. Client #3 had a scratch on his right cheek and a small, red abrasion on the left side of his neck. Client #4 was not injured. 5. On 2/24/11 at 10:00 AM at the facility-operated workshop, client #4 grabbed client #3 by the head and neck. Staff intervened and released the hold. Client #4 then kicked client #3 on the left leg. 6. On 3/6/11 at 9:15 AM, client #4 was "inappropriately assertive" toward client #3. Client #4 apologized and shook client #3's hand.		immediately. Residential Director met with QMRP on 10-7-11 to review Investigation procedure specifically who to contact to initiate an investigtion and how to identify implementing any needed safeguards.Effective immediately all peer to peer aggression will be investigated to determine if there is abuse. The agency has developed a policy and procedure to identify, report and investigate all allegations of abuse, neglect and mistreatment. All newly hired staff will participate in training to help them identify abuse and neglect. Ongoing training will also be provided to keep staff aware of abuse, neglect and mistreatment. The agency has reviewed and revised its policies on abuse and neglect. The new policies and procedures address: · Immediate reporting of abuse, neglect, mistreatment or injuries of unknown origin to the administrator. · Immediate investigation into all allegations of abuse, neglect and injuries of unknown origin. · Immediate implementation of protections during the investigation, i.e. the staff person under investigation will be suspended from their duties pending outcome. An aggressive house-mate may be relocated to another site to prevent ongoing aggression if it is determined to be in the best interest of the housemates. Investigation results will be reported to the Executive Director	

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	Client #4 would not release his grip and then grabbed client #3 around the neck with both arms and pulled him to the ground. 7. On 3/21/11 at 3:10 PM, client #1 kicked client #5. 8. On 4/25/11 at 5:00 PM, client #1 shoved his dishes and bowls of food across the dinner table. The report did not indicate who the dishes and bowls hit. 9. On 5/2/11 at 5:25 PM, client #1 threw another client's hat on floor. When the other client (the report did not indicate who) picked it up, client #1 kicked an ottoman into the client's legs. 10. On 5/16/11 at 11:05 AM at the facility-operated workshop, client #4 grabbed client #3 from behind and took him to the floor. Client #3 had a red mark on his neck and one on his left arm (no description of the injuries in the report). The facility's narrative report, dated 5/16/11, indicated client #4 re-opened two scrapes on his left palm and had a new scrape on his left palm. 11. On 6/9/11 at 8:30 AM, client #2 smacked a client (report did not indicate who) on the arm while getting into the van after being asked to move over. The report indicated there were no injuries. 12. On 8/7/11 at 8:05 PM, client #4 stomped on a client's foot while in the kitchen (report did not indicate who). A review of the facility's Individual Abuse and Neglect/Mistreatment Policy, dated 11/9/07, was conducted on 9/6/11 at 2:23 PM. The policy indicated the following, "[Facility name] shall prohibit any form of mistreatment, exploitation, neglect or abuse, including financial, physical, verbal, mental or sexual abuse. Any form of abuse, including but not limited to humiliation, harassment and threats of punishment or		or other State Officials in 5 working days of the incident. If charges are substantiated appropriate corrective action will be taken and documented. Staff have been trained and the Reporting Procedures are Posted in the Group Home. Documentation and investigation outcome will be forwarded to Risk Management for further action. A tracking system has been developed to identify trends in behaviors, PRN medication and restraint use. This information will be updated daily and analyzed by the QMRP, Residential Director and Quality Assurance Director. The Human Rights Committee will also be provided copies of this information as well. The information gathered will be used for the following but not limited to; develop client program plans, behavior plans, staffing plans and training agendas. Revised Administrative On-call Procedure attachedMinutes of meeting with QA Director and Human Resources Coordinator attached	

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	deprivation will not be tolerated." The policy indicated, "Any reports of such mistreatments, abuse or neglect shall be thoroughly investigated by the Investigation Committee, reviewed by the Executive Director and reported to the Human Rights Committee." The policy indicated, "Suspected abuse, neglect or exploitation (hitting or inappropriate touching another consumer/staff/community person or consumer to consumer...)." An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/8/11 at 12:01 PM. The QMRP indicated client to client aggression was abuse. The QMRP indicated client to client abuse should be investigated.			
W0153	1.1-3-2(a) 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 record review and interview for 13 of 16 Bureau of Developmental Disabilities Services (BDDS) reports reviewed affecting clients #1, #2, #3, #4 and #5, the facility failed to report immediately to the administrator allegations of client to client abuse. Findings include: A review of the facility's incident reports was conducted on 9/6/11 at 3:05 PM. The following BDDS reports of client to client abuse did not include documentation the facility immediately notified the administrator: 1. On 1/6/11 at 2:37 PM at the facility-operated workshop, client #4 walked by another client	W0153	Residential Director investigated this citation and determined that we are in fact reporting to the Administrator as soon as a situation is secure. However, it appears that staff are not completing the documentation to show the time this contact was made. In the situation of the Group Homes Direct Care immediately report to the On Call Administrative staff who in turn calls or text messages the Residential Director and Executive Director simultaneously. Residential	10/11/2011

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	(report did not indicate who) and grabbed him by the coat collar. Staff released client #4's hold using a hand release. 2. On 1/8/11 at 7:30 PM, client #4 tackled client #3 in the living room. Upon landing on him, client #4 began punching client #3 on the back. Two staff used a two-man transport to separate the clients. 3. On 2/10/11 at 9:05 AM at the facility-operated workshop, client #1 hit another client (report did not indicate who) on the back. The other client tackled client #1 and sat on top of him holding his arms. Staff assisted the other client off of client #1 using a 2 man transport. Client #1 had red pin-point dots on the inside of his ankle. 4. On 2/16/11 at 7:57 AM, client #4 pushed client #3 against the refrigerator. Client #4 grabbed client #3 around his upper arms and neck and would not let go. Staff used a hand release. Client #3 had a scratch on his right cheek and a small, red abrasion on the left side of his neck. 5. On 2/24/11 at 10:00 AM at the facility-operated workshop, client #4 grabbed client #3 by the head and neck. Staff intervened and released the hold. Client #4 then kicked client #3 on the left leg. 6. On 3/6/11 at 9:15 AM, client #4 was "inappropriately assertive" toward client #3. Client #4 apologized and shook client #3's hand. Client #4 would not release his grip and then grabbed client #3 around the neck with both arms and pulled him to the ground. 7. On 3/21/11 at 3:10 PM, client #1 kicked client #5. 8. On 4/25/11 at 5:00 PM, client #1 shoved his dishes and bowls of food across the dinner table. The report did not indicate who the dishes and bowls hit; the report indicated all other clients at the dinner table were checked for injuries. 9. On 5/2/11 at 5:25 PM, client #1 threw another client's hat on floor. When the other client (the		Director met with the Quality Assurance Director to discuss the need for vigilance in reviewing all Incident Reports for accuracy and completion. It was determined that all QMRP's will include the time of contacting the Administrator in the body of their state incident reports. Direct Care staff will document on the in-house incident report form. All staff will be re-trained on the revised Incident Reporting procedure on 10-11-11. Staff Meeting Agenda, Minutes and Signature page attached Revised Administrative On-call policy attached	

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	report did not indicate who) picked it up, client #1 kicked an ottoman into the client's legs. 10. On 5/16/11 at 11:05 AM at the facility-operated workshop, client #4 grabbed client #3 from behind and took him to the floor. Client #3 had a red mark on his neck and one on his left arm (no description of the injuries in the report). The facility's narrative report, dated 5/16/11, indicated client #4 re-opened two scrapes on his left palm and had a new scrape on his left palm. 11. On 6/9/11 at 8:30 AM, client #2 smacked a client (report did not indicate who) on the arm while getting into the van after being asked to move over. 12. On 8/7/11 at 8:05 PM, client #4 stomped on a client's foot while in the kitchen (report did not indicate who). An interview with the QMRP was conducted on 9/8/11 at 12:01 PM. The QMRP indicated the facility did not have documentation the administrator was immediately notified of client to client abuse.			
W0154	1.1-3-2(a) The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 12 of 12 incidents of client to client abuse affecting clients #1, #2, #3, #4 and #5, the facility neglected to investigate incidents of client to client abuse. Findings include: A review of the facility's incident reports was conducted on 9/6/11 at 3:05 PM. The following Bureau of Developmental Disabilities Services (BDDS) reports of client to client abuse did not include documentation the facility conducted	W0154	Residential Director reviewed Agency policies and will meet with the new Quality Assurance Director to discuss the Investigation process which will be implemented immediately. Residential Director met with QMRP to review Investigation procedure specifically who to contact to initiate an investigtion and how to identify implementing any needed safeguards. Effective immediately all peer to peer	10/11/2011

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	investigations: 1. On 1/6/11 at 2:37 PM at the facility-operated workshop, client #4 walked by another client (report did not indicate who) and grabbed him by the coat collar. Staff released client #4's hold using a hand release. 2. On 1/8/11 at 7:30 PM, client #4 tackled client #3 in the living room. Upon landing on him, client #4 began punching client #3 on the back. Two staff used a two-man transport to separate the clients. 3. On 2/10/11 at 9:05 AM at the facility-operated workshop, client #1 hit another client (report did not indicate who) on the back. The other client tackled client #1 and sat on top of him holding his arms. Staff assisted the other client off of client #1 using a 2 man transport. Client #1 had red pin-point dots on the inside of his ankle. 4. On 2/16/11 at 7:57 AM, client #4 pushed client #3 against the refrigerator. Client #4 grabbed client #3 around his upper arms and neck and would not let go. Staff used a hand release. Client #3 had a scratch on his right cheek and a small, red abrasion on the left side of his neck. 5. On 2/24/11 at 10:00 AM at the facility-operated workshop, client #4 grabbed client #3 by the head and neck. Staff intervened and released the hold. Client #4 then kicked client #3 on the left leg. 6. On 3/6/11 at 9:15 AM, client #4 was "inappropriately assertive" toward client #3. Client #4 apologized and shook client #3's hand. Client #4 would not release his grip and then grabbed client #3 around the neck with both arms and pulled him to the ground. 7. On 3/21/11 at 3:10 PM, client #1 kicked client #5. 8. On 4/25/11 at 5:00 PM, client #1 shoved his dishes and bowls of food across the dinner table. The report did not indicate who the dishes and bowls hit; the report indicated all other clients at the dinner table were checked for injuries. 9. On 5/2/11 at 5:25 PM, client #1 threw another client's hat on floor. When the other client (the report did not indicate who) picked it up, client #1 kicked an ottoman into the client's legs.		aggression will be investigated to determine if there is abuse. Minutes of meeting with QA Director attachedInvestigation Protocol Policy attached	

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	10. On 5/16/11 at 11:05 AM at the facility-operated workshop, client #4 grabbed client #3 from behind and took him to the floor. Client #3 had a red mark on his neck and one on his left arm (no description of the injuries in the report). The facility's narrative report, dated 5/16/11, indicated client #4 re-opened two scrapes on his left palm and had a new scrape on his left palm. 11. On 6/9/11 at 8:30 AM, client #2 smacked a client (report did not indicate who) on the arm while getting into the van after being asked to move over. 12. On 8/7/11 at 8:05 PM, client #4 stomped on a client's foot while in the kitchen (report did not indicate who). A review of the facility's Individual Abuse and Neglect/Mistreatment Policy, dated 11/9/07, was conducted on 9/6/11 at 2:23 PM. The policy indicated, "Any reports of such mistreatments, abuse or neglect shall be thoroughly investigated by the Investigation Committee, reviewed by the Executive Director and reported to the Human Rights Committee." An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/8/11 at 12:01 PM. The QMRP indicated client to client aggression was abuse. The QMRP indicated client to client abuse should be investigated. 1.1-3-2(a)			
W0249	As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 1 of 3 clients in the sample (#1), the facility	W0249	Residential Director met with QMRP and discussed the issue of	10/11/2011

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	failed to implement his behavior support plan as written. Findings include: Observations were conducted in the group home on 9/6/11 from 3:01 PM to 5:45 PM and 9/7/11 from 6:00 AM to 8:20 AM. During the observations, client #1 was wearing two long sleeve shirts with collars. Staff were not observed to prompt client #1 to remove one of the 2 long sleeve shirts during the observations. The outside temperatures during the observations were in the 60's. A review of client #1's record was conducted on 9/7/11 at 10:51 AM. His Behavior Support Plan, dated 1/27/11, indicated he had a strategy addressing "layering." The plan indicated the following, "[Client #1] frequently engages in clothes layering to meet accelerated sensory needs. It has been determined by his IDT (Interdisciplinary Team) that [client #1's] limited layering presents no health or safety hazard to [client #1] and will not be considered a targeted behavior. So as to facilitate the health and comfort of [client #1] when he engages in layering, the following guidelines will be implemented. [Client #1] will be allowed to layer clothing and use other items to better meet his sensory needs: Summer (daytime highs above 70 degrees): T-shirts - [Client #1] may wear up to 1 t-shirts under a short-sleeve dress shirt, or other short-sleeve shirt style. Winter (daytime highs under 70 degrees): T-shirts - [Client #1] may wear up to 1 t-shirt under his dress shirt." The behavior documentation forms for September 2011, reviewed on 9/8/11 at 1:15 PM, did not		staff not documenting. It was determined that there is some problem at times with staff failing to document. It was decided that failing to document would be treated in the same manner as medication errors and be subject to the same disciplinary action. A policy has been developed and will be reviewed with staff on 10-11-11. Policy on Doucmentation of Active Treatment attached Staff Meeting Agenda, Minutes and Signature page attached Employee Warnings re: documentation attached	

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	indicate staff tracked client #1's use of two long sleeve shirts on 9/6/11 and 9/7/11. An interview with the home manager (HM) on 9/8/11 at 1:28 PM indicated the staff did not document client #1's wearing of 2 long sleeve shirts. The HM indicated the staff should implement the plan as written. 1.1-3-4(a)			
W0264	The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Based on observation, interview and record review for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility's specially constituted committee (HRC) failed to review and monitor: 1) the locking of the thermostat, 2) the locking of client #3's cigarettes and 3) the use of bells on the bedroom doors of clients #1, #3, #5 and #6. Findings: 1) Observations were conducted in the group home on 9/6/11 from 3:01 PM to 5:45 PM and 9/7/11 from 6:00 AM to 8:20 AM. During the observations, the thermostat in the hallway near the living room had a locked plastic cover. On 9/6/11 at 4:30 PM, staff #2 indicated the thermostat was locked to keep clients and staff from turning the temperature up and down. Staff #2 indicated the staff had access; the clients did	W0264	The ageny's HRC didnt review or monitor any of the three items mentioned; locked thermostat, maintaining client #3 cigarettes or the client decorations which were placed in their personal space. If in fact there was any intent to restrict a clients rights a plan would have been implemented and reviewed by HRC and implemented only after their approval. As stated previously, client #1 will continue to place the ornament he made anywhere in his room so long as it does not pose a health or safety threat to himself or others. the other clients have agreed to move the chime to their closet door. Per client #3's continued request that staff	10/10/2011

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	not have access. This affected clients #1, #2, #3, #4, #5 and #6. There was no documentation in the clients' record or presented during the survey the HRC reviewed and monitored the locking of the thermostat: A review of client #1's record was conducted on 9/7/11 at 10:51 AM. Client #1 did not have documentation in his record indicating access to the thermostat needed to be restricted. A review of client #2's record was conducted on 9/8/11 at 10:45 AM. Client #2 did not have documentation in his record indicating access to the thermostat needed to be restricted. A review of client #3's record was conducted on 9/8/11 at 11:26 AM. Client #3 did not have documentation in his record indicating access to the thermostat needed to be restricted. A review of client #4's record was conducted on 9/8/11 at 12:02 PM. Client #4 did not have documentation in his record indicating access to the thermostat needed to be restricted. A review of client #5's record was conducted on 9/8/11 at 12:05 PM. Client #5 did not have documentation in his record indicating access to the thermostat needed to be restricted. A review of client #6's record was conducted on 9/8/11 at 12:08 PM. Client #6 did not have documentation in his record indicating access to the thermostat needed to be restricted. An interview with the home manager (HM) was conducted on 9/6/11 at 5:01 PM. The HM indicated the locked cover over the thermostat was in place to keep the clients and staff from turning		maintain his cigarettes we will continue to do so however his IPP will have an addendum to reflect this desire and it will be reviewed at minimum in each quarterly review and documented in the meeting notes. As far as the locked thermostat is concerned we have removed the cover so it is accessible to everyone. The intent was never to restrict the consumers from accessing it. We will continue to seek HRC approval for those items and situations which are intended to restrict a consumers rights. To further invoke suggestions from HRC we will schedule at least one meeting per year to be held in the group homes thus affording them the opportunity for observing and making suggestions. All suggestions and recommendations will be documented in the HRC meeting minutes. Residential Director met with QMRP to advise him of the location change at least once per year. HRC will continue to review, monitor and make suggestions regarding all current and future restrictive plans. IPP Adendum attachedHRC Meeting Agenda attached	

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the temperature up and down. The HM indicated it was not addressed in any of the clients' plans. On 9/8/11 at 12:01 PM, the HM indicated the locked thermostat was a restrictive intervention. The HM indicated there was no documentation indicating the purpose of the restriction.

An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/8/11 at 12:01 PM. The QMRP indicated there was no documentation indicating the purpose of the locked thermostat or that the HRC reviewed and monitored this practice.

2) An observation was conducted at the group home on 9/7/11 from 6:00 AM to 8:20 AM. At 7:40 AM, client #3 received 3 cigarettes from the locked medicine closet in the recreation room. An interview with staff #4 indicated client #3 received 3 cigarettes in the morning and 3 in the evening. Staff #4 indicated the cigarettes were accessible only by the staff.

A review of client #3's record was conducted on 9/8/11 at 11:26 AM. There was no documentation in client #3's record to indicate his cigarettes needed to be locked. There was no documentation the HRC reviewed and monitored the locking of client #3's cigarettes.

An interview with the HM was conducted on 9/8/11 at 12:01 PM. The HM indicated there was no plan addressing client #3's locked cigarettes.

An interview with the QMRP was conducted on 9/8/11 at 12:01 PM. The QMRP indicated client #3 should have access to his cigarettes.

3) Observations were conducted in the group home on 9/6/11 from 3:01 PM to 5:45 PM and

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	9/7/11 from 6:00 AM to 8:20 AM. During the observations, the clients #1 and #5 bedroom door had bells on the door knob. Clients #3 and #6 had bells attached to a hanger from the top of the door. Both bedroom doors, when opened or closed, chimed due to the bells that were present. There was no documentation presented during the survey that the HRC reviewed and monitored the use of bells: A review of client #1's record was conducted on 9/7/11 at 10:51 AM. Client #1 did not have documentation in his record indicating a need for the use of bells on his bedroom door. A review of client #3's record was conducted on 9/8/11 at 11:26 AM. Client #3 did not have documentation in his record indicating a need for the use of bells on his bedroom door. A review of client #5's record was conducted on 9/8/11 at 12:05 PM. Client #5 did not have documentation in his record indicating a need for the use of bells on his bedroom door. A review of client #6's record was conducted on 9/8/11 at 12:08 PM. Client #6 did not have documentation in his record indicating a need for the use of bells on his bedroom door. An interview with the QMRP was conducted on 9/7/11 at 11:46 AM. The QMRP indicated none of the clients needed bells on their bedroom doors. The QMRP indicated there was no documentation the HRC reviewed and monitored the use of bells. An interview with the HM was conducted on 9/8/11 at 12:01 PM. The HM indicated the use of bells on the bedroom doors was not needed.			

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W0323	1.1-3-4(a) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 3 clients in the sample (#2), the facility failed to ensure a vision exam was conducted. Findings include: A review of client #2's record was conducted on 9/8/11 at 10:45 AM. Client #2's current vision exam, dated 3/6/09, indicated he needed glasses. There was no documentation in client #2's record indicating an exam had been conducted since 3/6/09. An interview with the home manager (HM) was conducted on 9/8/11 at 12:01 PM. The HM indicated client #2 should have a vision exam. An interview with the nurse was conducted on 9/8/11 at 1:45 PM. The nurse indicated vision exams should be conducted. She indicated there should be no delay in this exam. 1.1-3-6(a)	W0323	File review of all residents was conducted to ensure we are obtaining the hearing and vision evaluation required at their annual physical appointment. It was found that the same problem exsisted for all six residents. Client #2 did in fact have an annual physical in Oct 2009. At that time the doctors office had recently become automated and were no longer using our Annual Physical Form. Unfortunately they failed to document the hearing and vision evaluation in their system. As a result we started asking the doctor to complete the hearing and vision on our Annual Physical form while the remainder of the physical information is found on their computer generated report. (Client #2's 2009, 2010 and 2011 physicals attached). Dr Black agreed to this and is currently completing the vision and hearing evaluation on our form. Acute Medical Care will try to find a way to get their system to cue the doctor to obtain the vision and hearing evaluation at time of annual physical. All staff have been trained to take the annual physical form and to ensure we have documentation of annual vision and hearing evaluation.	10/10/2011

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			The agency nurse will review the annual physical at her next monthly review to ensure it includes vision and hearing evaluations. Staff Meeting, Agenda, Minutes and signature page attached Client #2's 2009, 2010 and 2011 annual physicals attached	
W0331	The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 3 clients in the sample (#1), the nurse failed to ensure: 1) recommendations by a physician were implemented and 2) a plan was developed for the treatment of a decubitus ulcer. Findings include: A review of client #1's record was conducted on 9/7/11 at 10:51 AM. -On 5/17/11, client #1 was seen by his physician for a spot on his right ankle that itched and looked dry. The diagnosis was an abscess. The report indicated to follow-up in 2 weeks if not resolved. There was no documentation in client #1's record to indicate a follow-up was conducted. -The monthly nursing review, dated 5/31/11, indicated there was a scab on client #1's right ankle, medial side. There was no documentation staff should follow-up with the physician. -On 6/30/11, the nurse conducted a quarterly review. The review indicated there was a hard, sharp scab to the inside of his right ankle. The recommendations indicated the nurse spoke to the staff to apply lotion to soften the area. There was no documentation staff should follow-up with the physician. -On 7/21/11, client #1 was seen by his physician. The assessment included a decubitus ulcer on his ankle. The plan indicated to start a Unaboot.	W0331	Residential Director met with the Nurse and House Manager to discuss the physician recommedation regarding client #1's right ankle. During this conversation it was determined that in the future the nurse would be more specific in her description of wounds. In her professional opinion the spot on his ankle was improved and resolving. There were no signs of reddness or infection consequently there was no need for the follow-up appointment at this time. On June 21 Client #1 saw the nurse again as well as the Podiatrist. She recommended lotion be used on the hard scab. The Podiatrist didn't find the scab on his right ankle noteworthy. The appointment on July 21 was with a doctor unfamiliar with client #1. His regular doctor was not available that day. He was being seen for another health issue and the House Manager mentioned his ankle. It was at this time that it was diagnosed as a decubitus ulcer. The nurse and House Manager	10/11/2011

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	- On 7/22/11, client #1 was seen by his physician to have his ankle wrapped with Unaboot to help in healing area of his ankle. -On 7/31/11, the nurse conducted a monthly review. The nurse indicated the medial aspect of his right ankle was covered with gauze and tape. The nurse documented in the medical appointments/visits summary section the following: "2. Decubitus ulcer R (right) ankle - start Unaboot, redress weekly." The nurse indicated client #1 refused her to do an assessment of his ankle. The nurse documented in the recommendations section the home manager reported that client #1 was going to return to the physician due to non-use of Unaboot as it was restricting circulation to his foot. -On 8/1/11, client #1 was seen by his physician. The report indicated the Unaboot did not work for client #1 as he was irritated by it. The exam indicated, "Less than a dime size lesion of the R medial ankle. Appears to be a second degree ulcer." The treatment indicated return in 2 weeks and stop Unaboot. -On 8/22/11, client #1 was seen by his physician. The history of present illness indicated the following, "Pt (patient) with poor wound healing of the R medial ankle wound. Not much worse, but not resolving. Has been given referal to podiatry and has appt (appointment) tomorrow. Did change shoes recently. I advised need to rotate shoes to see if this helped cut back on rubbing." There was no documentation in client #1's record to indicate the recommendation to rotate shoes was implemented. -On 8/23/11, client #1 was seen by the podiatrist. The narrative/recommendations section indicated the following, "Ulcer medial malleolus right ankle. Unna Boot and surgical shoe needs to be worn until I see [client #1] back in one week." -On 8/30/11, client #1 was seen by the podiatrist.		were providing the treatment of the decubitus ulcer themselves instead of having direct care staff implement the doctors order. They both followed the doctor recommended treatment with client #1. Client #1 did receive regular and on going medical care and treatment to his right ankle. However we recognize the need for written documentation for treatment. To that end we have developed a policy regarding using the MAR for documentation of treatments, therapies as well as medication administration. Under this policy and procedure all treatments will be described and tracked on the MAR. All staff will be trained at a full staff meeting on 10-11-11. The QMRP in conjunction with the nurse have developed a Health Related Incident Management Plan that includes what is now diagnosed as a venous stasis ulcer. Treatment of the ulcer is now included on Client #1's MAR. A state incident report has been filed and follow-up reports will continue until the incident is closed. Client will continue to follow up with all medical appointments until physician determines otherwise. In the future all treatments will be included on the Health Related Incident Management Plan and the MAR until discontinued by the appropriate medical professional. Client 1's MAR attached Client's 1's Health Related Incident and	

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	The narrative/recommendations indicated the following, "ulcer medial R ankle. [Approximately] .8 cm (centimeters) diameter. I will manage wound once per week. Nurse to remove dressing on Friday and place a small piece of Fibracol into wound and cover with gauze." -On 9/6/11, client #1 was seen by podiatrist. The narrative/recommendations indicated the following, "Debrided wound right ankle. Apply small piece of Fibracol to ulcer base and then cover with Bio-clusive dressing. Change every 4-5 days. Return in 2 weeks." There was no documentation in client #1's record indicating the nurse developed a plan to care for client #1's wound. There was a Health Care Management Plan, undated, that did not include a care plan for decubitus ulcer. An interview with the nurse was conducted on 9/8/11 at 1:45 PM. The nurse indicated there was no treatment plan for the ulcer. She indicated it should have been added to his risk plan. The nurse stated she "missed" the fact that it was a decubitus ulcer; she indicated she saw nothing with that diagnosis. The nurse indicated she did not know the origin of the ulcer. She indicated it may have been his shoes being too tight. An interview with the home manager (HM) was conducted on 9/8/11 at 12:01 PM. The HM indicated she thought the decubitus ulcer was due to client #1's shoes being too tight. The HM indicated there was no plan for staff to implement to monitor client #1's tying of his shoes. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/8/11 at 12:01 PM. The QMRP indicated he did not develop a plan for staff to monitor client		Management Plan attached	

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	#1's decubitus ulcer. 1.1-3-6(a)			
W0362	A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview for 3 of 3 clients in the sample (#1, #2 and #3), the facility failed to ensure quarterly pharmacy reviews were conducted. Findings include: A review of client #1's record was conducted on 9/7/11 at 10:51 AM. Two pharmacy reviews, dated 12/8/10 and 7/15/11, were reviewed. The pharmacy review dated 3/18/11 indicated the following from the pharmacist, "I met with [home manager] and did a thorough inspection of the drug storage and expiration dates of all meds for all clients. [Home manager] indicated that there were few changes in the client's drug regiment (sic) and would email me when any occurred...". There was no documentation from the pharmacist she reviewed client #1's drug regimen on 3/18/11. There was no documentation the recommendations from the 12/8/10 and 7/15/11 pharmacy audits were reviewed by the home manager, Qualified Mental Retardation Professional, nurse or physician. A review of client #2's record was conducted on 9/8/11 at 10:45 AM. Two pharmacy reviews, dated 12/8/10 and 7/15/11, were reviewed. The pharmacy review dated 3/18/11 indicated the following from the pharmacist, "I met with [home manager] and did a thorough inspection of the drug storage and expiration dates of all meds for all clients. [Home manager] indicated that there were few changes in the client's drug regiment (sic)and would email me when any occurred...".	W0362	Pharmacist was contacted regarding the content of her quarterly reviews. Effectively immediately she will begin including each clients drug regimen, including rountine medications, PRN medications, Acute Medications on each quarterly review. In addition she will include possible drug interactions and any recommedations. All reviews will be signed and dated by the Pharmacist. The Pharmacist reviews will be faxed to both the agency nurse and the Medical Director for review and input. Copies of the fax transmittal sheets will be maintained. The House Manager will work with the Nurse, Medical Director and Pharmacist to address any recommendations.September Pharmacist Review attachedSchedule of Pharmacy Reviews through Sept. 2012 attached	10/10/2011

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	There was no documentation from the pharmacist she reviewed client #2's drug regimen on 3/18/11. There was no documentation the recommendations from the 12/8/10 and 7/15/11 pharmacy audits were reviewed by the home manager, Qualified Mental Retardation Professional, nurse or physician. A review of client #3's record was conducted on 9/8/11 at 11:26 AM. Two pharmacy reviews, dated 12/8/10 and 7/15/11, were reviewed. The pharmacy review dated 3/18/11 indicated the following from the pharmacist, "I met with [home manager] and did a thorough inspection of the drug storage and expiration dates of all meds for all clients. [Home manager] indicated that there were few changes in the client's drug regiment (sic) and would email me when any occurred...". There was no documentation from the pharmacist she reviewed client #3's drug regimen on 3/18/11. There was no documentation the recommendations from the 12/8/10 and 7/15/11 pharmacy audits were reviewed by the home manager, Qualified Mental Retardation Professional, nurse or physician. An interview with the home manager (HM) was conducted on 9/8/11 at 12:01 PM. The HM indicated the pharmacist should conduct quarterly reviews of the clients' medication regimen. The HM indicated it was the HM's responsibility to ensure the physician received a copy of the pharmacy reviews; she indicated she did not have documentation the reviews were sent to the physician for review. An interview with the nurse was conducted on 9/8/11 at 1:45 PM. The nurse indicated the pharmacist should be conducting quarterly reviews of the clients' medication regimen. The nurse			

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	indicated she did not have documentation indicating she reviewed the pharmacist's recommendations. The nurse indicated the HM should submit the pharmacy reviews to the physician. 1.1-3-6(a)			
W0440	The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure quarterly evacuation drills were conducted for each shift. Findings include: A review of the facility's evacuation drills was conducted on 9/6/11 at 3:31 PM. The following affected clients #1, #2, #3, #4, #5 and #6. -Day shift (6:00 AM to 9:00 AM): There were no drills conducted from 10/5/10 to 2/10/11. -Evening shift (3:00 PM to 9:00 PM): There were no drills conducted from 9/8/10 to 1/16/11 and 4/6/11 to 9/6/11. -Night shift (10:00 PM to 6:00 AM): There were no drills conducted from 11/21/10 to 3/28/11 and 3/28/11 to 8/20/11. An interview with the home manager (HM) was conducted on 9/6/11 at 3:42 PM. The HM indicated there should be one drill per shift per quarter. 1.1-3-7(a)	W0440	Residential Director reviewed policy and procedures with Management staff, identifying areas in need of revision. Updates have been made and staff were trained on 9-30-11. All residents are assessed at least annually and currently two individuals have been identified as potentially needing additional protections during evacuations. Procedures have been updated to reflect those needs. All fire drills have been scheduled for the next 15 months and are posted on the communication board for staff. Management is to immediately review all drills for accuracy and potential problems as well as timeliness. After completing any required follow-up the completed drill is to be submitted to the Quality Assurance Director for further review. Staff will complete fire safety training at their monthly staff meetings and it will be documented. Residential Director met with House Manager and issued a verbal waring regarding the importance of ensuring the timeliness of drills. It	09/30/2011

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			was agreed that disciplinary action would follow immediately any staff failing to complete assigned drills. Repeat failures could results in termination.Staff meeting agenda and minutes Sept 30, 2011 attachedStaff meeting agenda and minutes Oct 11, 2011 attachedSchedule of drills attached	
W0448	The facility must investigate all problems with evacuation drills, including accidents. Based on record review and interview for 4 of 6 clients living in the group home (#1, #2, #4 and #5), the facility failed to investigate issues noted during evacuation drills. Findings include: A review of the facility's evacuation drills was conducted on 9/6/11 at 3:31 PM. -On 4/6/11 at 4:45 PM, client #1 was verbally prompted to exit the home during a fire drill. Client #1 refused, sat down and ignored staff. Client #1 was taken by the hand and escorted out of the home. There was no investigation into the issues noted during the drill. The drill took 2 minutes and 10 seconds to complete. -On 3/28/11 at 5:45 AM, a fire drill was conducted. Clients #4 and #5 were trying to put something on and staff assisted them out of the bedroom. Client #1 required staff assistance to get him out and client #1 was slightly agitated with the drill. The drill took 2 minutes and 25 seconds to complete. There was no investigation into the issues noted during the drill. -On 3/20/11 at 6:50 AM, a fire drill was conducted. Client #2 stopped three times to complain. The drill took 4 minutes to complete. There was no investigation into the issues noted during the drill.	W0448	Residential Director met with Management to discuss the need to review all evacuation drills and to investigate all problems with evacuation drills, including accidents. The Fire drill rooster has been updated to include a space for management review. Furthermore, a procedure is currently in place for copies of all evacuation drills to be forwarded to Quality Assurance Director for review. The House Manager will review drills weekly and indicate any follow-up required prior to submitting to the Quality Assurance Director. 1. Original Drill remains in the House 2. Copy of Drill sent to Quality Assurance Director at the Home Office Fire Drill Rooster attachedCompleted Drill attachedFire Evacuation Plan TH attached	09/30/2011

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	-On 1/16/11 at 7:00 PM, a fire drill was conducted. Client #2 was lying down at the time of the drill. It took "several prompts" to get him up. There was no investigation into the issues noted during the drill. -On 11/14/10 at 12:15 AM, a fire drill was conducted. Client #2 was looking for slippers and took 4 minutes and 45 seconds to evacuate. Client #5 was slow getting dressed, requiring 6 verbal prompts. The drill took 8 minutes and 58 seconds to complete. There was no investigation into the issues noted during the drill. -On 11/5/10 at 5:55 AM, a fire drill was conducted. Client #1 was in the kitchen at the time the drill started. He was directed to go out the kitchen door; he went to his bedroom to get his coat. Client #4 stood and looked at staff "wondering" what to do and waiting for instructions. Client #5 "took his time after deciding what shoes to wear, putting them on, then out back door." The drill took 8 minutes to complete. There was no investigation into the issues noted during the drill. An interview with the home manager (HM) was conducted on 9/6/11 at 3:40 PM. The HM indicated the targeted time to complete evacuations drills was 2 minutes. The HM indicated there was no documentation the facility investigated issues noted during drills. 1.1-3-7(a)			
W9999	The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.: 1) 431 IAC 1.1-3-2 Resident Protections (c) The residential provider shall demonstrate that its employment practices assure that no staff person	W9999	1) 431 IAC 1.1-3-2 The Human Resource Coordinator is responsible for assuring that the agency does not employ anyone who has a conviction of a crime substantially related to a dependent population or any	10/11/2011

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	would be employed where there is: (3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5, and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section. THIS STATE RULE WAS NOT MET AS EVDICENCED BY: Based on record review and interview for 1 of 3 employee files reviewed (#4), the facility failed to ensure three reference checks were completed. Findings include: A review of the employee files was conducted on 9/6/11 at 2:33 PM. Staff #4's employee file contained two references; staff #4's hire date was 4/20/09. An interview with the home manager (HM) was conducted on 9/8/11 at 12:01 PM. The HM indicated the employee's files should contain three references. The HM indicated these references should be obtained prior to the staff working in the home. 1.1-3-2(c)(3) 2) 431 IAC 1.1-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division. This state rule was not met as evidenced by: A review of the facility's incident reports was conducted on 9/6/11 at 3:05 PM. There was no BDDS report indicating the facility report a decubitus ulcer. A review of client #1's record was conducted on		violent crime. She is responsible for assuring we obtain as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5, and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section. Due to an oversight staff #4's personel file was missing a third reference check. The Human Resource Coordinator will conduct periodic file audits to ensure that required documents are located in staff personal files. Effective immediately the Human Resources Coordinator will notify the House Manager when all pre-employment documents are in-house giving approval to start new employee. Due to an oversight in our State Reportable Incident Policy and Procedures the Decubitus Ulcer was not reported. The Policy has been updated to include Decubitus Ulcer. A State Reportable Incident has been filed and a copy is in the Incident Report file in the Group Home. The Quality Assurance director has been contacted and made aware that he is to provided revised Policies to all staff. All residential staff are being re-trained on state reportble incidents on 10-11-11. The QMRP and House Managers have already been re-trained. State Reportable Incident and Management Policy attached	

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	9/7/11 at 10:51 AM. -On 5/17/11, client #1 was seen by his physician for a spot on his right ankle that itched and looked dry. The diagnosis was an abscess. The report indicated to follow-up in 2 weeks if not resolved. There was no documentation in client #1's record to indicate a follow-up was conducted. -The monthly nursing review, dated 5/31/11, indicated there was a scab on client #1's right ankle, medial side. There was no documentation staff should follow-up with the physician. -On 6/30/11, the nurse conducted a quarterly review. The review indicated there was a hard, sharp scab to the inside of his right ankle. The recommendations indicated the nurse spoke to the staff to apply lotion to soften the area. There was no documentation staff should follow-up with the physician. -On 7/21/11, client #1 was seen by his physician. The assessment included a decubitus ulcer on his ankle. The plan indicated to start a Unaboot. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 9/6/11 at 4:12 PM. The QMRP indicated there was no BDDS report completed for client #1's decubitus ulcer. 1.1-3-1(b)		Staff Meeting Agenda and Minutes attached Incident Report filed attached	