STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G422	A. BUILDING 00 B. WING	06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	5843 N SHERMAN AVE INDIANAPOLIS, IN 46220

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W0000	This visit was for the extended recertification and state licensure survey. Dates of Survey: May 29, 30, 31, June 1, 4, 5, 6, and 7, 2012. Facility Number: 000936 Provider Number: 15G422 AIMS Number: 100244610 Surveyors: Susan Eakright, Medical Surveyor III/QMRP-Team Leader Amber Bloss, Medical Surveyor III/QMRP These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/14/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0104	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 7 of 7 clients (clients #1, #2, #3, #4, #5, #6, and #7) who resided in the home, the governing body failed to exercise operating direction over the group home to ensure maintenance was completed which included missing light bulbs, a broken vacuum cleaner, the bedroom windows, and missing hardware on the bedroom furniture. Findings include: On 5/29/12 from 5:25pm until 7:15pm, and on 5/30/12 from 5:25am until 8:20am, clients #1, #2, #3, #4, #5, #6, and #7 walked throughout the group home, accessed their bedrooms, and the two hallway bathrooms. The two hallway bathrooms were missing light bulbs. The smaller bathroom had three of three (3/3) missing light bulbs above the sink and mirror. Client #1 and #6's bedroom had two of two (2/2) white vinyl windows with a black substance covering the window casing inside the length and width of the window. On 5/29/12 at 7pm, client #5 got out the	W0104	**CORRECTION:** *The governing body must exercise general policy, budget, and operating direction over the facility.* Specifically, Missing hardware on bedroom furniture has been replaced, the abnormally loud vacuum has been replaced and all light fixtures are equipped with working light bulbs. **PREVENTION:** Professional staff will be retrained regarding the need submit requests for repairs upon discovery of maintenance needs, as well as the need to conduct ongoing assessments of the home's environment to identify maintenance and safety issues.. Members of the Quality Assurance and Operations Teams will periodically perform home environment audits and on ongoing basis to assure appropriate upkeep occurs at the facility and to assist with expediting purchases as appropriate. **RESPONSIBLE PARTIES:** QDDPD, Home Manager, Support Associates, Operations Team, Quality Assurance Team **CORRECTION:** *The governing body must exercise general policy, budget, and operatingdirection over the facility.* Specifically, Missing	07/07/2012

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	facility vacuum and clients #1, #2, #4, #6, and #7 were watching television in the living room. Client #5 plugged in the vacuum and the vacuum motor made a loud constant grinding sound. Client #2 put her hands over her ears then stated to GHS (Group Home Staff) #2 "It vibrates the windows too." GHS #2 stated "It needs a belt." Clients #1, #2, and #7 indicated the vacuum was loud and they did not like the sound. On 5/30/12 at 6:30am, GHS #4 stated the black substance on client #1 and #6's bedroom windows was "mold." GHS #4 indicated she cleaned the other windows of the black substance in the group home at night and stated she "was not allowed to clean" client #1 and #6's bedroom windows at night because the clients were sleeping. At 6:30am, GHS #4 indicated client #1, #2, #3, #6, and #7's dressers were missing the hardware to pull their dressers drawers open. GHS #4 indicated clients #1, #2, #3, #6, and #7 needed hardware on their bedroom furniture. At 6:30am, GHS #4 indicated clients #1, #2, #3, #4, #5, #6, and #7 used the hallway bathrooms and needed light to bathe, shave, and personal hygiene. GHS #4 stated she "did not know" how long the light bulbs were missing. On 5/30/12 at 8:20am, the facility's		hardware on bedroom furniturehas been replaced, the abnormally loud vacuum has been replaced and all lightfixtures are equipped with working light bulbs. **PREVENTION:** Professional staff will beretrained regarding the need submit requests for repairs upon discovery ofmaintenance needs, as well as the need to conduct ongoing assessments of thehome's environment to identify maintenance and safety issues.. Members of the Quality Assurance and OperationsTeams will periodically perform home environment audits and on ongoing basis toassure appropriate upkeep occurs at the facility and to assist with expeditingpurchases as appropriate. **RESPONSIBLE PARTIES:** QDDPD, Home Manager, SupportAssociates, Operations Team, Quality Assurance Team	

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	Maintenance and Repair log/communication information was requested from the agency's QMRP-D (Qualified Mental Retardation Professional Designee). The QMRP-D indicated no maintenance information was available for review. On 5/30/12 at 12:20pm, the facility's Maintenance and Repair log/communication information was requested from the agency's QMRP-D (Qualified Mental Retardation Professional Designee). The QMRP-D indicated no maintenance information was available for review. On 5/31/12 at 9:45am, the facility's Maintenance and Repair log/communication information was requested from the agency's QMRP (Qualified Mental Retardation Professional). At 3:40pm, the QMRP indicated no maintenance information was available for review. On 6/1/12 at 10:45am, an interview with the QMRP was completed. The QMRP indicated no maintenance repair information was available for review. 9-3-1(a)			

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W0122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the Condition of Participation of Client Protections is not met for 4 of 4 sample clients (clients #1, #2, #3, and #4) and for 3 additional clients (clients #5, #6, and #7). The facility failed to ensure clients were not subjected to the potential of abuse, neglect, and/or mistreatment, failed to implement the facility's policy and procedure to prohibit abuse, neglect, and/or mistreatment, failed to report and investigate allegations of abuse/neglect and unknown injuries, failed to complete corrective action and failed to report the results of investigations within 5 working days. Findings include: Please refer to W149. The facility neglected to implement its Abuse/Neglect policy for 7 of 7 clients (clients #1, #2, #3, #4, #5, #6, and #7) to immediately report unknown injuries and allegations of staff abuse, neglect and/or mistreatment according to state law, neglected to thoroughly investigate and report the results of investigations for unknown injuries and allegations of staff abuse, neglect, and mistreatment to ensure clients were not subjected to staff abuse, neglect, or mistreatment.	W0122	**CORRECTION:** *The facility must ensure that specific client protections requirements are met.* Specifically, *The facility must develop and implement written policies and procedures that prohibit mistreatment,neglect or abuse of the client.* Specifically, the staff responsible for an incident of neglect and misuse of client property on 5/15/12 has been terminated. a BDDS Incident report will be submitted regarding staff misuse of client #3's library card. Additionally, follow-up reports will be submitted to the BDDS regarding the results of investigations into incidents that occurred on 10/17/11 (2), 10/27/11, 12/27/113/25/12, 3/27/12, 4/21/12 and 5/15/12. Investigations will be completed for Client #7's injury of unknown origin on 10/27/11, client #3's suicidal gesture on 3/25/12, Client #3's elopement incident on 3/27/12 and client to client aggression between Client #3 and Client #6 on 4/21/12. **PREVENTION:** An additional level of supervision has been added to the facility's organizational structure. A Home Manager will be reporting directly to the QDDP to facilitate timely reporting,prompt investigation and implementation of corrective measures as well as follow-up	07/07/2012

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	Please refer to W153. The facility failed for 3 of 24 BDDS reports reviewed and for 2 of 3 investigations of injuries of unknown origin and allegations of abuse, neglect, and/or mistreatment reviewed (for clients #1, #2, #3, #4, #5, #6, and #7) to immediately report to the Administrator in accordance to state law allegations of abuse, neglect, and/or mistreatment and injuries of unknown origin. Please refer to W154. The facility failed for 4 of 24 BDDS (Bureau of Developmental Disability Services) reports of abuse, neglect, and/or mistreatment and injuries of unknown origin (for clients #3, #6, and #7), to complete a thorough investigation for allegations of abuse, neglect, and/or mistreatment and injuries of unknown origin. Please refer to W156. The facility failed for 6 of 24 BDDS (Bureau of Developmental Disability Services) reports reviewed and for 2 of 3 investigations reviewed to report the results of investigations within 5 working days for clients #1, #2, #3, #4, #5, #6, and #7. Please refer to W157. The facility failed for 5 of 24 BDDS (Bureau of Developmental Disability Services) reports reviewed and 2 of 3 investigation reports reviewed to complete effective		with appropriate parties as required. Facility professional staff will receive be provided with clear expectations regarding reporting, follow-up and investigation of incidents. Facility supervisory staff will be retrained regarding agency investigation procedures,with emphasis on timely completion. Retraining will focus on the need to develop and maintain sound time management skills and to request assistance from the Operations Team as needed. Additionally, training will stress the importance of prioritizing facility support tasks to assure that alleged violations are investigated without delay and that follow-up occurs as required. The Quality Assurance and Operations Teams will monitor compliance with investigation timelines and coordinate corrective measures as needed. **PREVENTION:** **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team	

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	corrective action for injuries of unknown origin and allegations of abuse, neglect, and/or mistreatment to protect clients #1, #2, #3, #4, #5, #6, and #7 from the potential of abuse, neglect, and/or mistreatment. 9-3-2(a)			

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W0140	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 observation, record review, and interview, the facility failed for 4 of 4 sample clients (clients #1, #2, #3, and #4) and for three additional clients (clients #5, #6, and #7) to maintain a system which assured a complete accounting of clients' personal funds. Findings include: On 5/30/12 from 5:25am until 8:20am, clients #1, #2, #3, #4, #5, #6, and #7 indicated they liked to carry their own money, wanted to have their money to take to workshop, and did not have their personal money available to them. On 5/30/12 at 7:40am, client #1, #2, #3, #4, #5, #6, and #7's personal financial information was requested for review at the group home and the Residential Manager (RM) indicated no petty cash was available in the group home for clients #1, #2, #3, #4, #5, #6, and #7. At 7:40am, the RM stated clients received money "every week or so, sometimes longer" and spent their money with staff. The RM indicated there were no receipts.	W0140	**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, the team will complete updated financial assessments for all clients and develop money disbursement protocols in accordance with their current budgeting skills. Professional staff will maintain an up to date ledger to track purchases for all clients including a daily sign-out log for money tobe spent at day service and workshops. All staff will assure that clients provide receipts for purchases as appropriate and the Home Manager will maintain copies of receipts for purchases recorded on the ledgers. **PREVENTION:** The Home Manager will maintain responsibility for maintaining client financial records and the QMRP will audit these records no less than weekly. All staff will be retrained regarding the need to assist clients with budgeting and collecting receipts.The Home Manager will turn in client financial records to the Business manager no less than monthly for review and filing. Additionally, members of the Operations and	07/07/2012

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	The RM provided blank balance sheets for 5/2012 for clients #1, #2, #3, #4, #5, #6, and #7. The RM indicated the following information: -Client #4 had no money use recorded for 5/2012 and no balance recorded. -Client #7 had no money use recorded for 5/2012 and no balance recorded. -Client #3 had been approved to carry $10.00 by the agency Interdisciplinary Team, she had received $10.00 on 4/26/12, and no record of 5/2012 money use was recorded. Client #3 had no balance recorded. -Client #1 had no money use recorded for 5/2012 and had been approved to carry $10.00. Client #1 had no balance recorded. -Client #6 had been approved to carry $20.00, had received $20.00 in 4/2012 no date documented, and had no money use recorded for 5/2012. Client #6 had no balance recorded. -Client #5 had no money use recorded for 5/2012, had received $10.00 on 3/16/12 and 2/24/12, and had been approved to carry $10.00. Client #5 had no balance recorded. -Client #2 had no money use recorded for 5/2012, had been approved to carry $10.00, and had received $10.00 on 4/5/12 and 4/26/12. Client #2 had no balance recorded.		Quality Assurance Teams will include audits of client finances as part of an ongoing facility audit process. **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team	

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	On 5/30/12 at 12:45pm, the QMRP-D (Qualified Mental Retardation Professional-Designee) indicated clients' cash was not kept at the group home. The QMRP-D indicated the agency practice was for clients to request money, staff then forward the request for the funds, the agency issues an authorization to go to the bank, the client goes to the bank and retrieves their funds, and the clients individually keep their money. The QMRP-D indicated the log sheets were to track how often requests were made. On 5/30/12 at 1:15pm, the QMRP-D provided "Accounting" information for clients' accounts documented by the agency for the clients' personal funds. Clients #1, #2, #3, and #4's personal funds "Accounting" form indicated deposits, checks for withdrawals to pay monthly fee, and indicated "spending money." No receipts for "spending money" were available for review. The QMRP-D stated "no reconciliation" sheets to ensure a complete and accurate accounting of client funds were available for review. The QMRP-D indicated the balance of clients' personal funds account was kept by the agency on the account summary. The QMRP-D indicated the balance was not available at the group home for client #1, #2, #3, #4, #5, #6, and #7's personal			

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	funds. The QMRP-D indicated there was not a complete accounting of client #1, #2, #3, #4, #5, #6, and #7's personal funds. 9-3-2(a)			

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W0149	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 interview, and record review, for 7 of 7 clients (clients #1, #2, #3, #4, #5, #6, and #7), the facility neglected to implement its Abuse/Neglect policy to immediately report unknown injuries and allegations of staff abuse, neglect and/or mistreatment according to state law, neglected to thoroughly investigate and report the results of investigations for unknown injuries and allegations of staff abuse, neglect, and mistreatment to ensure clients were not subjected to staff abuse, neglect, or mistreatment. Findings include: 1. On 5/29/12 at 4pm, the facility's BDDS (Bureau of Developmental Disability Services) reports were reviewed. On 5/30/12 at 12:30pm, the facility's investigations were reviewed. The reviews indicated the following allegations of abuse, neglect, and/or mistreatment: -A 5/16/12 BDDS report for an incident on 5/15/12 at 7:30pm, indicated when a "day shift staff reported to work (on 5/16/12) [client #6] told her that on the	W0149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.* Specifically, a BDDS Incident report will be submitted regarding staff misuse of client #3's library card. Additionally, follow-up reports will be submitted to the BDDS regarding the results of investigations into incidents that occurred on 10/17/11 (2), 10/27/11, 12/27/11, 3/25/12, 3/27/12, 4/21/12 and 5/15/12. Investigations will be completed for Client #7's injury of unknown origin on 10/27/11, client #3's suicidal gesture on 3/25/12, Client #3's elopement incident on 3/27/12 and client to client aggression between Client #3 and Client #6 on 4/21/12. **PREVENTION:** An additional level of supervision has been added to the facility's organizational structure. A Home Manager will be reporting directly to the QDDP to facilitate timely reporting, prompt investigation and implementation of corrective measures as well as follow-up with appropriate parties as required. Facility professional staff will receive be provided with clear expectations regarding reporting,follow-up and	07/07/2012

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	previous evening when [Group Home Staff (GHS) #6] was transporting he and his housemates home from the library (clients #1, #2, #3, #4, #5, #6, and #7) she detoured into an apartment complex and they observed a man yelling at and hitting a woman who was holding a child. [Client #6] alleged that [GHS #6] got out of the van, left the individuals without supervision, and chased after the man. [Client #6's] housemates corroborated his statement. [Clients #1, #2, #3, #4, #5, #6, and #7] indicated the man [GHS #6] was chasing had a firearm." The report indicated staff reported the allegation and GHS #6 was suspended pending an investigation. -The 5/16/12 Investigation into the 5/15/12 at 7:30pm incident indicated "Incident Description:" on 5/16/12 at 7am, clients #1, #3, and #6 told of the incident to the day shift staff. The description of the incident indicated "On 5/15/12 while returning from the library [GHS #6] drove them into an apartment complex in the vicinity of [street #1] and [street #2], in [name of city] and left them alone on the van while [GHS #6] intervened in a domestic dispute. Additionally, they said that they believed a man involved in the dispute had a firearm. During the initial course of the investigation additional allegations		investigation of incidents. Facility supervisory staff will be retrained regarding agency investigation procedures, with emphasis on timely completion. Retraining will focus on the need to develop and maintain sound time management skills andto request assistance from the Operations Team as needed. Additionally,training will stress the importance of prioritizing facility support tasks to assure that alleged violations are investigated without delay and that follow-up occurs as required. The Quality Assurance and Operations Teams will monitor compliance with investigation timelines and coordinate corrective measures as needed. **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team	

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	emerged suggesting that on the evening of Tuesday, 5/15/12, (that) [GHS #6] used [client #3's] library card to check out movies for [GHS #6's] personal use and that this resulted in [client #3] incurring late fees of $9.43." The 5/16/12 Investigation for the 5/15/12 incident indicated the following witness statements: -Client #7 stated "Yeah honey, [GHS #6] got out of the van. The boy hit the girl." -Client #3 stated "On our way home, [GHS #6] took us to some apartments. [GHS #6] got out of the van and ran up to the apartment and left us by ourselves. She went after this guy who hit the girl with the baby in her hand. The police came. A ... guy was calling [GHS #6] a b----. She went after him and was cussing at him and yelling. It was a bad neighborhood around [street #1] and [street #2]. Three police came. [GHS #6] said he had a gun but I didn't see any gun. I didn't hear gunshots. [GHS #6] left us alone on the van. The guy called her a b---- and said he would shoot her." -Client #4 stated "On Tuesday we went to the library. We went somewhere else after. [GHS #6] got off the van and talked to somebody."			

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-Client #6 stated "When [GHS #6] took us back from the library, she turned into an apartment building parking lot. A man and a woman were fighting. I didn't see the man hit her. There was a little boy involved. [GHS #6] got out of the van and was fussing at the man. [GHS #6] followed [the man] up the stairs in the building and left us on the van. We was scared (sic). [GHS #6] came back and called the police because she said he pulled a gun on her. I didn't see the gun."

-Client #1 stated "[GHS #6] took us to the library. She didn't take us home. We went somewhere else. The police came by and the suspect had a gun. [GHS #6] got out of the van. The suspect got a gun and tried to shoot [GHS #6]...It was scary...I was scared."

-Client #2 stated "[GHS #6] took us to the library. [GHS #6] stopped the van and got out. A boy yelled at her and cussed her out...He didn't shoot anybody. I was scared."

-GHS #6 stated "I worked by myself. I always work by myself. We went to the library after dinner. We were there about an hour and a half...I didn't check anything out that day. On my way to the house, I realized I had left one of the

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	library cards on the counter so I had to go back. I turned around in an apartment complex. I saw a man and a lady with a baby fighting. He was actually beating on her and she wasn't fighting back. I did stop and say something to them and told them I was going to call the police and I did call the police...I got out on the side of the van. I didn't leave the van. I said Hey that is child endangerment and I'm calling the police...Before the police came, they went into the apartment building so the police couldn't go in after them because they (police) didn't know where they lived. The man did not have a weapon. I wouldn't have got out of the van if there was a weapon...The guy was cussing me out saying I'll shoot you. He was mad because I stopped him from doing something he shouldn't have been doing...." The 5/16/12 Investigation "Conclusion and Findings" indicated clients #1, #2, #3, #4, #5, #6, and #7 were on the van returning from the library with GHS #6 who took the van into an apartment complex, got out of the van, and left the clients unsupervised on the van. The investigation indicated it was verified that client #3 "could not check out items from the library because [client #3] had incurred $9.43 in late fees" checked out by GHS #6 for GHS #6's personal use.			

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	The investigation conclusion indicated "The evidence substantiates that the actions [GHS #6] resulted in the individuals who lived [in the group home] experiencing mental anguish." No corrective action was available for review. No written results of the investigation were reported to BDDS. The findings indicated the staff did not return to the library to retrieve the library card which was left behind at the library. -No BDDS report was available for review for the allegation of staff using client #3's library card on 5/15/12 which incurred late fees. 2. On 5/29/12 at 4pm, the facility's BDDS (Bureau of Developmental Disability Services) reports were reviewed. On 5/30/12 at 12:30pm, the facility's investigations were reviewed. The reviews indicated the following allegations of abuse, neglect, and/or mistreatment: -A 4/22/12 BDDS report for an incident on 4/22/12 at 8am, indicated client #6 had reported to a facility staff on day shift that on 4/21/12 client #3 hit him in the chest and client #6 complained that his chest was sore. No investigation, corrective action, and results of the investigation reported to BDDS were available for			

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	review. -A 3/31/12 BDDS report for an incident on 3/25/12 at 9am, indicated client #3 went to the kitchen, "grabbed" a knife, threatened to hurt herself, and later handed the knife to staff. No investigation of this incident and no corrective action for incident reporting were available for review. No results of the investigation reported to BDDS were available for review. -A 3/27/12 BDDS report for an incident on 3/27/12 at 11:25am, indicated client #3 had gone AWOL (Absent Without Leave) from workshop twice; client #3 left a third time running into traffic down [street #3] into moving traffic threatening to commit suicide. The corrective action was client #3 had not returned to day services workshop since incident. No investigation was available for review. No results of the investigation reported to BDDS were available for review. -No BDDS report for this investigation was available for review. An investigation into a 12/27/11 incident indicated client #6 "reported to [GHS #1] on Saturday, 12/24/11 he observed [GHS #7] prevent [client #4] from exiting the bathroom by propping a vacuum cleaner against the bathroom door." The			

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	investigation indicated GHS #1 reported the allegation on 12/27/11. The investigation indicated GHS #7 had her HR (Human Resource) file reviewed which indicated GHS #7 "received corrective actions": Counseling 8/2/10 for failure to report suspected neglect in a timely manner, on 2/8/11 for failure to work shift as scheduled, and on 10/17/11 "for alleged physical abuse-not substantiated." The investigation indicated "Conclusions: The evidence does not substantiate that [GHS #7] prevented [client #4] from exiting the bathroom by propping a vacuum cleaner against the door." No results of the investigation reported to BDDS were available for review. -A 10/27/11 BDDS report for client #7's unknown injury discovered on 10/27/11 at 10:15pm, indicated staff found an unknown "0.75 inch bruise under" client #7's right eye. The report indicated client #7's unknown bruise was "being investigated" and no investigation was available for review. No corrective action was available for review. No reported results of the investigation to BDDS was available for review. -A 10/17/11 BDDS report for an incident on 10/17/11 at 4:45pm, client #6 reported to the administrative staff that "an			

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	unspecified time over the past weekend" GHS #7 "slammed the fire door into his buttocks over the weekend." The report indicated GHS #7 was "suspended pending an investigation." The 10/24/11 investigation completed by the Compliance Coordinator (CC) indicated unsubstantiated abuse and neglect. The CC indicated client #6 and GHS #7's "personalities conflict." The CC indicated client #6 hit, bumped into, or fell into the fire door because "it was unwitnessed" incident. The CC indicated the same weekend client #4's unknown black eye was observed by the facility staff on 10/15/11 and 10/16/11 and client #4's unknown black eye was not reported until 10/17/11. No reported results of the investigation to BDDS were available for review. -A 10/17/11 BDDS report for client #4's unknown injury discovered on 10/17/11 at 7:20am, indicated client #4's left eye was red and blue over his eye brow with slight swelling. An investigation into the 10/17/11 incident for client #6 indicated staff noticed client #4's unknown black eye on 10/15/11 and 10/16/11 and did not report it until 10/17/11. GHS #3's witness statement indicated when she left on 10/15/11 at 7am, "there was nothing wrong with [client #4's] eye." No reported results of the investigation to			

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	BDDS were available for review. On 6/1/12 at 10:45am, an interview with the QMRP (Qualified Mental Retardation Professional), the Quality Assurance Manager (QAM), and the QMRP-D (QMRP-Designee) was completed. The QMRP indicated the facility followed the BDDS guidelines to immediately report, investigate, and to report the results of the completed investigations to the Administrator according to State Law for allegations of abuse, neglect, and/or mistreatment. The QAM stated "action was not always completed" because he was not able to substantiate the allegation. When asked if any allegation in the past year had been substantiated, the QAM indicated he could not recall. The QMRP and the QAM both indicated staff were trained annually for reporting allegations and injuries of unknown origin immediately to BDDS according to state law. The QAM and the QMRP both indicated no documented evidence was available for review of completed corrective action. On 6/1/12 at 10:45am, an interview with the QMRP, QAM, and QMRP-D was completed. The three staff indicated the facility's investigations were not thorough because no outcome information was documented. The QMRP, QAM, and the			

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	QMRP-D stated "some" allegations had BDDS reports, "not all" investigations completed had been reported to BDDS, no results of investigations had been reported, and no documented corrective action to prevent future events had been completed. The QMRP indicated neglect was the failure to provide services and the failure to act. The QAM stated GHS #6 "was still suspended at this time (6/1/12)." QAM indicated client #3 was reimbursed the $9.43 for late fees from her library card being used by GHS #6. The QMRP indicated client #3, who was an identified AWOL risk, was left alone with clients #1, #2, #4, #5, #6, and #7 on the van on 5/15/12. On 5/29/12 at 12:30pm, the facility's 9/14/2007 policy and procedure for "Incident Management: Incident Reports and BDDS Reportable's" was reviewed. The policy and procedure indicated the agency prohibited abuse, neglect, and/or mistreatment "of clients by anyone." The policy and procedure indicated "All Adept employees are required to complete a written incident report when encountering any incident involving changes in an individual's physical condition, mental status, or any unusual event." The policy indicated "BDDS Reportable's...are Suspected abuse, neglect, or exploitation...missing person, Criminal			

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	activity...injuries of unknown origin...." On 5/30/12 at 12:30pm, the facility's 9/14/2007 policy and procedure for "Abuse, Neglect, and Exploitation" was reviewed and indicated the following. -"Physical Abuse: the act or failure to act that results or could result in physical injury to an individual." -"Verbal Abuse: the act of insulting or profane language or gestures directed toward an individual." -"Emotional/physical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm." On 5/30/12 at 12:30pm, the facility's 9/14/2007 policy and procedure for "Investigations" was reviewed an indicated the following. -"Ensure alleged incidents of abuse, neglect, mistreatment, exploitation, or injuries of unknown origin are fully investigated within 5 (five) calendar days from the date of the allegation was made and investigations was initiated." -"A thorough investigation final report will be written at the completion of the investigation. The report shall include, but is not limited to, the following: Description of the allegation or incident. Purpose of the investigation. Parties providing information. Summary of information and findings, evidence			

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	collected, witnesses interviewed, date of the investigation, name of the investigator. Description and chronology of what happened...Finding of fact and determination as to whether or not the allegations are substantiated, unsubstantiated, or inconclusive. Concerns and recommendations...Methods to prevent future incidents (corrective action)." 9-3-2(a)			

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W0153	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 record review and interview, for 3 of 24 BDDS reports reviewed and for 2 of 3 investigations of injuries of unknown origin and allegations of abuse, neglect, and/or mistreatment reviewed (for clients #1, #2, #3, #4, #5, #6, and #7), the facility failed to immediately report to the Administrator in accordance with state law allegations of abuse, neglect, mistreatment and injuries of unknown origin. Findings include: On 5/29/12 at 4pm, the facility's BDDS (Bureau of Developmental Disability Services) reports and on 5/30/12 at 12:30pm, the facility's investigations were reviewed. Both reviews indicated the following allegations of abuse, neglect, and/or mistreatment: -The 5/16/12 Investigation into the 5/15/12 at 7:30pm incident indicated "Incident Description:" on 5/16/12 at 7am, clients #1, #3, and #6 told of the	W0153	**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, a BDDS Incident report will be submitted regarding staff misuse of a client #3's library card. Additionally, follow-up reports will be submitted to the BDDS regarding the results of investigations into incidents that occurred on 10/17/11 (2), 10/27/11, 12/27/11, 3/25/12, 3/27/12, 4/21/12 and5/15/12. **PREVENTION:** Facility professional staff will receive be provided with clear expectations regarding reporting, follow-up for all required incidents. Facility supervisory staff will be retrained regarding agency reporting procedures, with emphasis on timely completion. Retraining will focus on the need to develop and maintain sound time management skills and to request assistance from the Operations Team as needed. Additionally, training will stress the importance of prioritizing facility support tasks	07/07/2012

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	incident to the day shift staff. The description of the incident indicated on 5/15/12 while returning from the library [GHS #6] drove them into an apartment complex in the vicinity of [street #1] and [street #2]." The investigation indicated "During the initial course of the investigation additional allegations emerged suggesting that on the evening of Tuesday, 5/15/12, (that) [GHS #6] used [client #3's] library card to check out movies for [GHS #6's] personal use and that this resulted in [client #3] incurring late fees of $9.43." No BDDS report was available of the allegation that GHS #6 used client #3's library card on 5/15/12 and incurred late fees. -A 3/31/12 BDDS report for an incident on 3/25/12 at 9am, indicated client #3 went to the kitchen, "grabbed" a knife, threatened to hurt herself, and later handed the knife to staff. The incident was not reported timely to BDDS. -No BDDS report for this investigation was available for review. An investigation into a 12/27/11 incident indicated client #6 "reported to [GHS #1] on Saturday, 12/24/11 he observed [GHS #7] prevent [client #4] from exiting the bathroom by propping a vacuum cleaner against the bathroom door." The		to assure that alleged violations are reported without delay and that follow-up occurs as required. The Quality Assurance and Operations Teams will monitor compliance with reporting timelines and coordinate corrective measures as needed. **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team	

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	investigation indicated GHS #1 reported the allegation on 12/27/11. The investigation indicated GHS #7 had her HR (Human Resource) file reviewed which indicated GHS #7 "received corrective actions: Counseling 8/2/10 for failure to report suspected neglect in a timely manner, on 2/8/11 for failure to work shift as scheduled, and on 10/17/11 "for alleged physical abuse-not substantiated." The investigation indicated "Conclusions: The evidence does not substantiate that [GHS #7] prevented [client #4] from exiting the bathroom by propping a vacuum cleaner against the door." No evidence was available for review of notification of the Administrator. -A 10/17/11 BDDS report for an incident on 10/17/11 at 4:45pm, client #6 reported to the administrative staff that "an unspecified time over the past weekend" GHS #7 "slammed the fire door into his buttocks over the weekend." The report indicated GHS #7 was "suspended pending an investigation." The 10/24/12 investigation completed by the Compliance Coordinator (CC) indicated unsubstantiated abuse and neglect. The CC indicated client #6 and GHS #7's "personalities conflict." The CC indicated client #6 hit, bumped into, or fell into the fire door because "it was			

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	15G422	A. BUILDING 00 B. WING	06/07/2012

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	unwitnessed" incident. The CC indicated the same weekend client #4's unknown black eye was observed by the facility staff on 10/15/11 and 10/16/11 and client #4's unknown black eye was not reported until 10/17/11. Client #4's unknown injury and client #6's allegation were not reported immediately to the Administrator and to BDDS. -A 10/17/11 BDDS report for client #4's unknown injury discovered on 10/17/11 at 7:20am, indicated client #4's left eye was red and blue over his eye brow with slight swelling. An investigation into the 10/17/11 incident for client #6 indicated staff noticed client #4's unknown black eye on 10/15/11 and 10/16/11 and did not report it until 10/17/11. GHS #3's witness statement indicated when she left on 10/15/11 at 7am, "there was nothing wrong with [client #4's] eye." The injury was not reported immediately to the Administrator or to BDDS. On 6/1/12 at 10:45am, an interview with the QMRP (Qualified Mental Retardation Professional), the Quality Assurance Manager (QAM), and the QMRP-D (QMRP-Designee) was completed. The QMRP indicated the facility followed the BDDS guidelines to immediately report to the Administrator allegations of abuse, neglect, and/or mistreatment. The QMRP			

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	and the QAM both indicated staff were trained annually for reporting allegations, incidents, and injuries of unknown origin immediately to BDDS. On 6/1/12 at 10:45am, an interview with the QMRP, QAM, and QMRP-D was completed. The QMRP, QAM, and the QMRP-D stated "some" of the allegations had BDDS reports, and "not all" investigations completed had been reported to BDDS. 9-3-2(a)			

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W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, for 4 of 24 BDDS (Bureau of Developmental Disability Services) reports of abuse, neglect, and/or mistreatment and injuries of unknown origin (for clients #3, #6, and #7), the facility failed to complete a thorough investigation for allegations of abuse, neglect, and/or mistreatment and injuries of unknown origin. Findings include: On 5/29/12 at 4pm, the facility's BDDS (Bureau of Developmental Disability Services) reports and on 5/30/12 at 12:30pm, the facility's investigations were reviewed. -A 4/22/12 BDDS report for an incident on 4/22/12 at 8am, indicated client #6 had reported to facility staff to a staff person on 4/21/12 that client #3 hit him in the chest and client #6 complained that his chest was sore. No investigation was available for review. -A 3/31/12 BDDS report for an incident on 3/25/12 at 9am, indicated client #3 went to the kitchen, "grabbed" a knife, threatened to hurt herself, and later handed the knife to staff. No investigation was available for review for this incident. -A 3/27/12 BDDS report for an incident on 3/27/12 at 11:25am, indicated client #3 had gone AWOL (Absent Without Leave) from workshop twice; client #3 left a third time AWOL running into traffic down [street #3] into moving traffic threatening to commit suicide. No investigation	W0154	**CORRECTION:** *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically, Investigations will be completed for Client #7's injury of unknown origin on 10/27/11, client #3's suicidal gesture on 3/25/12, Client #3's elopement incident on 3/27/12 and client to client aggression between Client #3 and Client #6 on 4/21/12. **PREVENTION:** Facility professional staff will receive be provided with clear expectations regarding investigation of incidents. Facility supervisory staff will be retrained regarding agency investigation procedures, with emphasis on timely completion. Retraining will focus on the need to develop and maintain sound time management skills and to request assistance from the Operations Team as needed. Additionally, training will stress the importance of prioritizing facility support tasks to assure that alleged violations are investigated without delay. The Quality Assurance and Operations Teams will monitor compliance with investigation timelines and coordinate corrective measures as needed. Once completed, the facility will turn in investigation packets to the Quality Assurance Team for	07/07/2012

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	was available for review. -A 10/27/11 BDDS report for client #7's unknown injury discovered on 10/27/11 at 10:15pm, indicated staff found an unknown "0.75 inch bruise under" client #7's right eye. The report indicated client #7's unknown bruise was "being investigated" and no investigation was available for review. On 6/1/12 at 10:45am, an interview with the QMRP (Qualified Mental Retardation Professional), the Quality Assurance Manager (QAM), and the QMRP-D (QMRP-Designee) was completed. The QMRP indicated the facility followed the BDDS guidelines to investigate allegations of abuse, neglect, and/or mistreatment and injuries of unknown origin. The QAM and the QMRP both indicated no documented evidence was available for review of the investigations. On 6/1/12 at 10:45am, an interview with the QMRP, QAM, and QMRP-D was completed. The three staff indicated the facility's investigations were not thorough because no outcome information was documented. The QMRP, QAM, and the QMRP-D stated "some" allegations had BDDS reports, "not all" investigations completed had been reported to BDDS. 9-3-2(a)		review and filing. Additionally, the QDDPD will maintain a copy of each investigation at the facility. **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team	

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W0156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview, for 6 of 24 BDDS (Bureau of Developmental Disability Services) reports reviewed and for 2 of 3 investigations reviewed, the facility failed to report the results of investigations according to State Law within 5 working days for clients #1, #2, #3, #4, #5, #6, and #7. Findings include: On 5/29/12 at 4pm, the facility's BDDS (Bureau of Developmental Disability Services) reports and on 5/30/12 at 12:30pm, the facility's investigations were reviewed. -A 5/16/12 BDDS report for an incident on 5/15/12 at 7:30pm, indicated when a "day shift staff reported to work (on 5/16/12) [client #6] told her that on the previous evening when [GHS #6] was transporting he and his housemates home from the library (clients #1, #2, #3, #4, #5, #6, and #7)she detoured into an apartment complex and they observed a man yelling at and hitting a woman who	W0156	**CORRECTION:** *The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.* Specifically, Follow-up reports will be submitted to the BDDS regarding the results of investigations into incidents that occurred on 10/17/11 (2), 10/27/11, 12/27/11, 3/25/12, 3/27/12, 4/21/12 and5/15/12. **PREVENTION:** Facility professional staff will receive be provided with clear expectations regarding follow-up reporting for all required incidents. Facility supervisory staff will be retrained regarding agency reporting procedures, with emphasis on timely completion of follow-up reports. Retraining will focus on the need to develop and maintain sound time management skills and to request assistance from the Operations Team as needed. Additionally, training will stress the importance of prioritizing facility support tasks to assure that alleged the results of investigations are reported without delay. The Quality Assurance and Operations Teams will monitor compliance	07/07/2012

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	was holding a child. [Client #6] alleged that [GHS #6] got out of the van, left the individuals without supervision, and chased after the man. [Client #6's] housemates corroborated his statement. [Clients #1, #2, #3, #4, #5, #6, and #7] indicated the man [GHS #6] was chasing had a firearm." The report indicated staff reported the allegation and GHS #6 was suspended pending an investigation. -The 5/16/12 Investigation into the 5/15/12 at 7:30pm incident indicated "Incident Description:" on 5/16/12 at 7am, clients #1, #3, and #6 told of the incident to the day shift staff. The description of the incident indicated "On 5/15/12 while returning from the library [GHS #6] drove them into an apartment complex in the vicinity of [street #1 and street #2] and them alone on the van while [GHS #6] intervened in a domestic dispute. Additionally, they said that they believed a man involved in the dispute had a firearm. During the initial course of the investigation additional allegations emerged suggesting that on the evening of Tuesday, 5/15/12, (that) [GHS #6] used [client #3's] library card to check out movies for [GHS #6's] personal use and that this resulted in [client #3] incurring late fees of $9.43." The 5/16/12 Investigation "Conclusion		with reporting timelines and coordinate corrective measures as needed. **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team	

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	and Findings" indicated clients #1, #2, #3, #4, #5, #6, and #7 were on the van returning from the library with GHS #6 who took the van into an apartment complex, got out of the van, and left clients unsupervised on the van. The investigation indicated it was verified that client #3 "could not check out items from the library because [client #3] had incurred $9.43 in late fees" checked out by GHS #6 for GHS #6's personal use. The investigation conclusion indicated "The evidence substantiates that the actions [GHS #6] resulted in the individuals who lived [in the group home] experiencing mental anguish." The results of the investigation were not reported to BDDS within five (5) working days. -A 4/22/12 BDDS report for an incident on 4/22/12 at 8am, indicated client #6 had reported to facility staff to a staff person on 4/21/12 that client #3 hit him in the chest and client #6 complained that his chest was sore. No results of the investigation were reported to BDDS. -A 3/31/12 BDDS report for an incident on 3/25/12 at 9am, indicated client #3 went to the kitchen, "grabbed" a knife, threatened to hurt herself, and later handed the knife to staff. The results of the investigation were not reported to			

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	BDDS within five (5) working days. -An investigation into a 12/27/11 incident indicated client #6 "reported to [GHS #1] on Saturday, 12/24/11 he observed [GHS #7] prevent [client #4] from exiting the bathroom by propping a vacuum cleaner against the bathroom door." The investigation indicated GHS #1 reported the allegation on 12/27/11. The investigation indicated GHS #7 had her HR (Human Resource) file reviewed which indicated GHS #7 "received corrective actions: Counseling 8/2/10 for failure to report suspected neglect in a timely manner, on 2/8/11 for failure to work shift as scheduled, and on 10/17/11 "for alleged physical abuse-not substantiated." The investigation indicated "Conclusions: The evidence does not substantiate that [GHS #7] prevented [client #4] from exiting the bathroom by propping a vacuum cleaner against the door." The results of the investigation were not reported to BDDS within five (5) working days. -A 10/27/11 BDDS report for client #7's unknown injury discovered on 10/27/11 at 10:15pm, indicated staff found an unknown "0.75 inch bruise under" client #7's right eye. The report indicated client #7's unknown bruise was "being investigated." The results of the			

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	investigation were not reported to BDDS within five (5) working days. -A 10/17/11 BDDS report for an incident on 10/17/11 at 4:45pm, client #6 reported to the administrative staff that "an unspecified time over the past weekend" GHS #7 "slammed the fire door into his buttocks over the weekend." The report indicated GHS #7 was "suspended pending an investigation." The 10/24/11 investigation completed by the Compliance Coordinator (CC) indicated unsubstantiated abuse and neglect. The CC indicated client #6 and GHS #7's "personalities conflict." The CC indicated client #6 hit, bumped into, or fell into the fire door because "it was unwitnessed" incident. The CC indicated the same weekend client #4's unknown black eye was observed by the facility staff on 10/15/11 and 10/16/11 and client #4's unknown black eye was not reported until 10/17/11. The results of the investigation were not reported to BDDS within five (5) working days. -A 10/17/11 BDDS report for client #4's unknown injury discovered on 10/17/11 at 7:20am, indicated client #4's left eye was red and blue over his eye brow with slight swelling. An allegation investigation into the 10/17/12 incident for client #6 indicated staff noticed client #4's			

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	unknown black eye on 10/15/11 and 10/16/11 and did not report it until 10/17/11. GHS #3's witness statement indicated when she left on 10/15/11 at 7am, "there was nothing wrong with [client #4's] eye." The results of the investigation were not reported to BDDS within five (5) working days. On 6/1/12 at 10:45am, an interview with the QMRP (Qualified Mental Retardation Professional), the Quality Assurance Manager (QAM), and the QMRP-D (QMRP-Designee) was completed. The QMRP indicated the facility followed the BDDS guidelines to investigate and to report the results of the completed investigations to the Administrator within five (5) working days for allegations of abuse, neglect, and/or mistreatment. The QAM and the QMRP both indicated no documented evidence was available for review of reporting the results of the investigations. On 6/1/12 at 10:45am, an interview with the QMRP, QAM, and QMRP-D was completed. The QMRP, QAM, and the QMRP-D stated "some" allegations had BDDS reports, "not all" investigations completed had been reported to BDDS, and no results of investigations had been reported within five (5) working days.			

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W0157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, for 5 of 24 BDDS (Bureau of Developmental Disability Services) reports reviewed and 2 of 3 investigation reports reviewed, the facility failed to complete effective corrective action for injuries of unknown origin and allegations of abuse, neglect, and/or mistreatment to protect clients #1, #2, #3, #4, #5, #6, and #7 from the potential of abuse, neglect, and/or mistreatment. Finding include: On 5/29/12 at 4pm, the facility's BDDS (Bureau of Developmental Disability Services) reports and on 5/30/12 at 12:30pm, the facility's investigations were reviewed. Both reviews indicated the following injuries of unknown origin and allegations of abuse, neglect, and/or mistreatment: -A 5/16/12 BDDS report for an incident on 5/15/12 at 7:30pm, indicated when a "day shift staff reported to work (on 5/16/12) [client #6] told her that on the previous evening when [GHS #6] was transporting he and his housemates home	W0157	**CORRECTION:** *If the alleged violation is verified, appropriate corrective action must be taken.* Specifically, direct support staff #6's employment has been terminated and the facility has added additional direct support staff on evenings and weekends to increase supervision and supplement active treatment services. **PREVENTION:** The Quality Assurance team will review investigation results and interdisciplinary team meeting records, and will follow-up as needed with facility supervisory staff and the Operations Team to assure the facility implements corrective measures as needed. **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team	07/07/2012

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	from the library (clients #1, #2, #3, #4, #5, #6, and #7) she detoured into an apartment complex and they observed a man yelling at and hitting a woman who was holding a child. [Client #6] alleged that [GHS #6] got out of the van, left the individuals without supervision, and chased after the man. [Client #6's] housemates corroborated his statement. [Clients #1, #2, #3, #4, #5, #6, and #7] indicated the man [GHS #6] was chasing had a firearm." The report indicated staff reported the allegation and GHS #6 was suspended pending an investigation. -The 5/16/12 Investigation into the 5/15/12 at 7:30pm incident indicated "Incident Description:" on 5/16/12 at 7am, clients #1, #3, and #6 told of the incident to the day shift staff. The description of the incident indicated "On 5/15/12 while returning from the library [GHS #6] drove them into an apartment complex in the vicinity of [street #1] and [street #2] and left them alone on the van while [GHS #6] intervened in a domestic dispute. Additionally, they said that they believed a man involved in the dispute had a firearm. During the initial course of the investigation additional allegations emerged suggesting that on the evening of Tuesday, 5/15/12, (that) [GHS #6] used [client #3's] library card to check out movies for [GHS #6's] personal use and			

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	that this resulted in [client #3] incurring late fees of $9.43." The 5/16/12 Investigation for the 5/15/12 incident indicated the following witness statements: -Client #3 stated "On our way home, [GHS #6] took us to some apartments. [GHS #6] got out of the van and ran up to the apartment and left us by ourselves. She went after this guy who hit the girl with the baby in her hand. The police came. A ... guy was calling [GHS #6] a b----. She went after him and was cussing at him and yelling. It was a bad neighborhood around [street #1] and [street #2]. Three police came. [GHS #6] said he had a gun but I didn't see any gun. I didn't hear gunshots. [GHS #6] left us alone on the van. The guy called her a b---- and said he would shoot her." -GHS #6 stated "I worked by myself. I always work by myself. We went to the library after dinner. We were there about an hour and a half...I didn't check anything out that day. On my way to the house, I realized I had left one of the library cards on the counter so I had to go back. I turned around in an apartment complex. I saw a man and a lady with a baby fighting. He was actually beating on her and she wasn't fighting back. I did stop and say something to them and told			

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	them I was going to call the police and I did call the police...I got out on the side of the van. I didn't leave the van. I said Hey that is child endangerment and I'm calling the police...Before the police came, they went into the apartment building so the police couldn't go in after them because they didn't know where they lived. The man did not have a weapon. I wouldn't have got out of the van if there was a weapon...The guy was cussing me out saying I'll shoot you. He was mad because I stopped him from doing something he shouldn't have been doing...." The 5/16/12 Investigation "Conclusion and Findings" indicated clients #1, #2, #3, #4, #5, #6, and #7 were on the van returning from the library with GHS #6 who took the van into an apartment complex, got out of the van, and left clients unsupervised on the van. The investigation indicated it was verified that client #3 "could not check out items from the library because [client #3] had incurred $9.43 in late fees" checked out by GHS #6 for GHS #6's personal use. The investigation conclusion indicated "The evidence substantiates that the actions [GHS #6] resulted in the individuals who lived [in the group home] experiencing mental anguish." No corrective action was available for review.			

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	GHS #6 was suspended since 5/16/12. -A 3/31/12 BDDS report for an incident on 3/25/12 at 9am, indicated client #3 went to the kitchen, "grabbed" a knife, threatened to hurt herself, and later handed the knife to staff. No corrective action for incident reporting was available for review. -A 3/27/12 BDDS report for an incident on 3/27/12 at 11:25am, indicated client #3 had gone AWOL (Absent Without Leave) from workshop twice, client #3 left a third time AWOL running into traffic down [street #3] into moving traffic threatening to commit suicide. The corrective action was client #3 had not returned to day services workshop since incident. No documented evidence was available for review of client #3's ISP and BSP regarding client #3's threats of suicide into moving traffic. -An investigation into a 12/27/11 incident indicated client #6 "reported to [GHS #1] on Saturday, 12/24/11 he observed [GHS #7] prevent [client #4] from exiting the bathroom by propping a vacuum cleaner against the bathroom door." The investigation indicated GHS #1 reported the allegation on 12/27/11. The investigation indicated GHS #7 had her HR (Human Resource) file reviewed			

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	which indicated GHS #7 "received corrective actions": Counseling 8/2/10 for failure to report suspected neglect in a timely manner, on 2/8/11 for failure to work shift as scheduled, and on 10/17/11 "for alleged physical abuse-not substantiated." The investigation indicated "Conclusions: The evidence does not substantiate that [GHS #7] prevented [client #4] from exiting the bathroom by propping a vacuum cleaner against the door." No corrective action was available for review for reporting allegations of abuse, neglect, and/or mistreatment immediately to the administrator. -A 10/17/11 BDDS report for an incident on 10/17/11 at 4:45pm, client #6 reported to the administrative staff that "an unspecified time over the past weekend" GHS #7 "slammed the fire door into his buttocks over the weekend." The report indicated GHS #7 was "suspended pending an investigation." The 10/24/11 investigation completed by the Compliance Coordinator (CC) and indicated unsubstantiated abuse and neglect. The CC indicated client #6 and GHS #7's "personalities conflict." The CC indicated client #6 hit, bumped into, or fell into the fire door because "it was unwitnessed" incident. The CC indicated the same weekend client #4's unknown			

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	black eye was observed by the facility staff on 10/15/11 and 10/16/11 and client #4's unknown black eye was not reported until 10/17/12. No corrective action was available for review for reporting allegations of abuse, neglect, and/or mistreatment immediately to the administrator. -A 10/17/11 BDDS report for client #4's unknown injury discovered on 10/17/11 at 7:20am, indicated client #4's left eye was red and blue over his eye brow with slight swelling. An allegation investigation into the 10/17/11 incident for client #6 indicated staff noticed client #4's unknown black eye on 10/15/11 and 10/16/11 and did not report it until 10/17/11. GHS #3's witness statement indicated when she left on 10/15/11 at 7am, "there was nothing wrong with [client #4's] eye." No corrective action was available for review for reporting allegations of abuse, neglect, and/or mistreatment immediately to the administrator. On 6/1/12 at 10:45am, an interview with the QMRP (Qualified Mental Retardation Professional), the Quality Assurance Manager (QAM), and the QMRP-D (QMRP-Designee) was completed. The QAM stated corrective "action was not always completed" because he was not			

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	able to substantiate the allegation. The QMRP and the QAM both indicated staff were trained annually for reporting allegations and injuries of unknown origin. The QAM and the QMRP both indicated no documented evidence was available for review of completed corrective action for staff to immediately report to the administrator allegations of abuse, neglect, and/or mistreatment. On 6/1/12 at 10:45am, an interview with the QMRP, QAM, and QMRP-D was completed. The QMRP, QAM, and the QMRP-D stated "some" allegations had BDDS reports, "not all" investigations completed had been reported to BDDS, no results of investigations had been reported, and no documented corrective action to ensure staff immediately reported to the administrator allegations of abuse, neglect, and/or mistreatment and injuries of unknown origin. The QAM stated GHS #6 "was still suspended at this time (6/1/12)." QAM indicated client #3 was reimbursed the $9.43 for late fees from her library card exploitation and indicated no documented receipt was available for review. 9-3-2(a)			

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W0159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, interview, and record review, for 4 of 4 sample clients (clients #1, #2, #3, and #4) and for three additional clients (clients #5, #6, and #7), the facility's Qualified Mental Retardation Professional (QMRP) failed to integrate, coordinate, and monitor the development of training programs to ensure the Individual Support Plans (ISPs) were based on identified needs, assessments, comprehensive functional assessments (CFAs), and program data recorded. The QMRP failed to ensure each client's ISP was implemented when opportunities existed. Findings include: 1. Please refer to W225. The facility failed to complete an accurate reassessment of client #3's vocational needs for 1 of 1 sample client (client #3) with no current workshop services. 2. Please refer to W227. The facility	W0159	**CORRECTION:** *Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.* Specifically, the QDDPD will receive additional training on the following topics: 1.Completion of accurate reassessments of client's vocational needs for upon changes in employment status. 2.The need to develop behavior supports across environments to address all behavioral needs. 3.Development of appropriate training objectives for clients based on their needs. 4.Encouraging and including client choices for food. 5.Implementation of client #3's behavior plan and providing supervision during formal and informal opportunities for training. 6.Ensuring accurate behavior data is recorded for Client #3. 7.Obtaining approval from the facility's Human Rights Committee (HRC) for all restrictive practices 8.Encouraging clients to use adaptive equipment and training and monitoring staff to assure adaptive equipment learning objectives are implemented consistently, as well as the need	07/07/2012

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	failed for 1 additional client (client #5) to address his behaviors of theft of money, pop, and food at the workshop. 3. Please refer to W242. The facility failed to develop a training objective/goal based on client #2's toileting need for 1 of 4 sample clients (client #2). 4. Please refer to W247. The facility failed to encourage and include client choices for food for 7 of 7 clients (clients #1, #2, #3, #4, #5, #6, and #7) who lived in the group home. 5. Please refer to W249. The facility failed to implement client #3's behavior plan and provide supervision during formal and informal opportunities when opportunities existed for 1 of 4 sample clients (client #3). 6. Please refer to W252. The facility failed to ensure accurate behavior data was recorded for 1 of 3 sample clients (client #3) who had a Behavior Support Plan (BSP). 7. Please refer to W264. The facility failed obtain approval from the facility's Human Rights Committee (HRC) for		to maintain adaptive equipment including, but not limited to walkers, in good repair. 9.Conducting monthly/quarterly review of ISP/BSP data. 10.Assuring staff collects behavioral data as needed. **PREVENTION:** Members of the Operations and Quality Assurance Teams will conduct periodic audits of facility support documents and conduct active treatment observations on an ongoing basis to assure the QDDPD integrates, coordinates and monitors, the active treatment program effectively and will provide guidance, mentorship and corrective measures as needed. **RESPONSIBLE PARTIES:** QDDPD, Operations Team, Quality Assurance Team	

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	restrictive practices employed for 7 of 7 clients (clients #1, #2, #3, #4, #5, #6, and #7) who lived in the group home. 8. Please refer to W436. The facility failed to teach and encourage client #1 to wear his prescribed eye glasses, client #2 to wear her hearing aid and prescribed eye glasses, client #3 to wear her prescribed eye glasses, and failed to provide client #6's walker repair for 3 of 4 sample clients (clients #1, #2, and #3) and 1 additional client (client #6) who had adaptive equipment prescribed. 9. On 5/31/12 at 11am, client #1's 3/22/12 ISP (Individual Support Plan) and record for the current year were reviewed. Client #1's record did not indicate a quarterly review of client #1's record or ISP by the QMRP. Client #1's record did not indicate program data reviews and did not indicate behavioral data. On 5/31/12 at 1:50pm, client #2's 10/2/11 ISP and record for the current year were reviewed. Client #2's record did not indicate a quarterly review of client #2's record or ISP by the QMRP. Client #2's record did not indicate program data			

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	reviews and did not indicate behavioral data. On 5/31/12 at 11:20am, client #3's 4/27/12 ISP and record were reviewed and did not indicate a quarterly review of client #3's record by the QMRP, did not indicate program data, and did not indicate behavioral data. On 5/31/12 at 12:35pm, client #4's 8/28/11 ISP and record for the current year were reviewed. Client #4's record did not indicate a quarterly review of client #4's record or ISP by the QMRP. Client #4's record did not indicate program data reviews and did not indicate behavioral data. On 6/1/12 at 10:45am, an interview with the QMRP (Qualified Mental Retardation Professional) was completed. The QMRP indicated no quarterly QMRP reviews for clients #1, #2, #3, and #4 were available for review. The QMRP indicated no program data was available for review of client #1, #2, #3, and #4's programs. The QMRP indicated no additional information was available for review. 9-3-3(a)			

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W0186	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 7 of 7 clients (clients #1, #2, #3, #4, #5, #6, and #7) who lived in the group home, the facility failed to provide enough staff on duty to supervise clients based on their identified needs. Findings include: On 5/29/12 from 5:25pm until 7:15pm, and on 5/30/12 from 5:25am until 8:20am, observations and interview were completed at the group home. During both periods two large butcher knives were observed in the kitchen. On 5/29/12 from 6:50pm until 7:15pm, the two large butcher knives were placed into the dish wash utensil rack, the dishwasher door was open/down, and the utensil rack was extended outward fully exposed. From 6:50pm until 7:15pm, client #3 was unsupervised by the facility staff and observed to load dishes from the sink into the rack, accessed the kitchen, and was	W0186	**CORRECTION:** *The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.* Specifically, the facility has added additional direct support staff on evenings and weekends to increase supervision and supplement active treatment services. **PREVENTION:** The Operations Team will monitor facility staff schedules to assure adequate direct support staff are assigned to all shifts. Additionally, on an ongoing basis, members of the Operations and Quality Assurance Teams will spot check time and attendance records to assure hours worked match the facility schedule. **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team	07/07/2012

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	alone in the kitchen four (4) times. On 5/30/12 from 5:25am until 8:20am, the two large butcher knives were observed in the open dishwasher with the utensil rack extended and exposed. From 5:25am until 8:20am, client #3 had unsupervised independent access to the two large butcher knives in the utensil rack. On 5/29/12 at 6:20pm, client #3 ran into her bedroom in the front of the house near the front door from the kitchen and the bedroom door slammed. Just as the door slammed, it reopened and client #3 was out the front door into the front yard alone and no facility staff followed her. The facility van was parked in front of the windows to the front living room blocking the view from the living room windows into the front yard. Client #3 walked across the front yard to the swing near the road in front of the group home and sat down. Client #3 pulled out her cigarettes and lighter and began to smoke. At 6:30pm, the Residential Manager (RM) came to the door. The RM stated client #3 "goes out there to smoke" independently. The RM stated "she only leaves AWOL from workshop." At 6:35pm, the RM walked outside and spoke with client #3 who sat smoking on the swing. At 6:40pm, the RM and client #3 returned inside the group home. At 6:40pm, the RM stated client #3's level of			

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	supervision was "we just keep track of her every so often." Client #3's record was reviewed on 5/31/12 at 11:20am. Client #3's record indicated client #3 was admitted to the facility on 2/2012. Client #3's 3/13/12 BSP (behavior support plan) indicated targeted behaviors of verbal aggression, physical aggression, non compliance, "AWOL defined as This occurs when [client #3] is very frustrated or upset about an issue or when things do no go her way. [client #3] will leave the premises unsupervised, Suicidal Threats (which is) any time [client #3] starts implicating that nobody cares about her and that she has nothing to live for, therefore she wants to kill herself." Client #3's 3/13/12 BSP indicated for AWOL and Suicidal Threats behaviors staff were to "Keep [client #3] in your sight at all times when she leaves the home/property," offer activity, and document AWOL incident and behaviors. The plan did not indicate how one staffperson was to monitor client #3 in line of sight while still supervising clients #1, #2, #4, #5, #6 and #7. On 5/31/12 at 11am, the facility's 5/2012, 4/2012, and 3/2012 "Staff Schedule Sheet" were reviewed. The staff schedules indicated for Mondays through			

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	Fridays: one staff person 7am until 3pm, one staff person 2pm until 10pm, one staff person 10pm until 8am. The staff schedules indicated for Saturdays and Sundays: one staff person 6am until 10pm and one staff person from 10pm until 8am. On 5/30/12 at 12:45pm, an interview with the Quality Assurance Manager (QAM) and the QMRP-D (Qualified Mental Retardation Professional-Designee) was completed. Both indicated one staff was scheduled for seven clients (clients #1, #2, #3, #4, #5, #6, and #7). The QAM stated "the state funds this house at 6.0 hours" which was one staff on duty for seven clients. The QMRP-D and the QAM both stated clients #1, #2, #3, #4, #5, #6, and #7 "required" staff supervision for cooking, active treatment, transportation, and clients #1, #2, #4, #5, and #7 "required" assistance in bathing and dressing. Both the QAM and the QMRP-D stated clients #2 and #7 "required" assistance with toileting needs. The QAM and QMRP-D both stated client #3 was "eye sight supervision at all times." On 6/1/12 at 10:45am, an interview with the QMRP (Qualified Mental Retardation Professional), the Quality Assurance Manager (QAM), and the QMRP-D			

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	(QMRP-Designee) was completed. The QAM stated there was "always one staff" for seven clients in the group home. The QMRP and the QAM stated the agency had reviewed their staffing plan for the group home and was "going to add" staff. 9-3-3(a)			

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	15G422	A. BUILDING 00 B. WING	06/07/2012

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W0225	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on record review and interview, for 1 of 1 sample client (client #3) with no current workshop services, the facility failed to complete a reassessment of client #3's vocational needs. Findings include: On 5/29/12 from 5:25pm until 7:15pm, and on 5/30/12 from 5:25am until 8:20am, observations and interview were completed at the group home. During both periods client #3 indicated she did not currently attend work services. Client #3 indicated during both observation periods she had not attended workshop since March, 2012. Client #3's record was reviewed on 5/31/12 at 11:20am. Client #3's record indicated client #3 was admitted to the facility on 2/2012. Client 3's 4/22/12 Individual Support Plan (ISP) included an active treatment schedule which indicated Mondays through Fridays "from 7:30am - 9am ride to workshop, from 7:30am to 4pm [Workshop name]...from 4pm to 5pm ride home from workshop." Client #3's 2/24/12 "Vocational Skills" assessment indicated client #3 was	W0225	**CORRECTION:** The comprehensive functional assessment must include, as applicable, vocational skills. Specifically, the team will complete a re-assessment of Client #3's vocational skills and needs. **PREVENTION:** Professional staff will be retrained regarding the need to assure that, in additional to annual reassessment, the team must reassess vocational needs when a client's vocational or day service status changes unexpectedly. Members of the Operations and Quality Assurance Teams will periodically review facility support documents on an ongoing basis to assure that the team meets clients' vocational training needs **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team	07/07/2012

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	independent in the areas of "Toileting, In-seat behavior, Attention Span, Dexterity Skills, Discrimination Skills, Eye-Hand Coordination, Follows Instructions, Uses Pincher Grasp, Matches colors, (and) Concept on One." Additional record review indicated no reassessment for client #3's vocational needs was completed after client #3 was suspended from workshop. On 6/1/12 from 8:45am until 10:15am, Workshop Site #3 was observed and client #3 was not present at the workshop. At 8:55am, WKS (Workshop Staff) #1 was interviewed. WKS #1 indicated he was client #3's supervisor before client #3's workshop services were suspended in 3/2012. WKS #1 stated client #3 was "a great worker, great skills, when [client #3] was not having behaviors." WKS #1 indicated client #3's workshop services were suspended because of client #3's behaviors of AWOL (Absent without Leave) and running into traffic. WKS #1 stated "we have to keep her safe" and the workshop could not keep client #3 safe. At 9:15am, WKS #2 stated the "last time" client #3 left AWOL was in 3/2012 when she was "manic" and ran into traffic stating "she wanted to kill herself." At 9:45am, WKS #1 stated the workshop would like client #3 to return "if the [group home agency] can develop a plan			

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	with us to keep" client #3 safe at work. WKS #1 stated when client #3 "gets like she was, [client #3] does not recognize danger. We believe she was not safe at work." WKS #1 indicated no plan was available for review and had not been developed to keep client #3 safe at work. WKS #1 provided the following team meeting minutes without client #3 present: On 4/26/12, "Team met to discuss what plans can be put into [client #3's] safety while not providing one on one supervision beyond a reasonable amount of time. Self Harm, Elopement, [client #3's statements of] Nobody Cares, Result in contacting home, [client #3] will go home." WKS #1 indicated the workshop leadership reviewed this plan and the workshop leadership did not believe this went far enough to keep client #3 safe and the workshop employees safe. WKS #1 stated "She's not coming until something can be figured out." Client #3's workshop behavior data and incident records were requested from 2/2012 through 5/31/12. WKS #1 stated client #3's behavioral data from workshop was not available for review. WKS #1 provided client #3's workshop data sheets for program documentation dated 2/2012, 3/2012, 4/2012, and 5/2012. All four (4) months did not document client #3's behaviors and the information indicated client #3 had not attended workshop since			

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	3/20/12. On 6/1/12 at 10:45am, an interview with the Qualified Mental Retardation Professional (QMRP) was completed. The QMRP indicated client #3 had suicidal threats and leaving the workshop AWOL in 3/2012. The QMRP indicated client #3's workshop services had been suspended. The QMRP indicated client #3 had no reassessment for her vocational needs completed since 2/2012. 9-3-4(a)			

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W0227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview, for 1 additional client (client #5), the facility failed to address client #5's behaviors of theft of money, pop, and food at the workshop. Findings include: On 5/20/12 from 10:10am until 11:02am, client #5 was observed at workshop site #1. From 10:10am until 10:40am, client #5 watched a movie, walked around the program area independently, and at 10:40am, left the program area to go to the rest room. At 10:40am, client #5's workshop supervisor indicated client #5's ISP (Individual Support Plan) goal/objective was to use money in the vending machine to obtain his desired items. The workshop supervisor stated "He never has any money to run this goal." The workshop supervisor stated client #5 "will take other clients' food, pop, snacks, and money on a regular basis." The workshop supervisor indicated client #5 had no documented Behavior Support Plan. The workshop supervisor stated "This behavior is not new." Client #5 has been doing this "a long time. We let the group home know about the behaviors." The workshop supervisor indicated no documented record of client #5's behaviors of taking money, food, pop, and snacks was available for review. At 10:40am, client #5 was observed to leave the bathroom after entering, walked through the workshop building to the front break area, and client #5 began to check the change return slots in the pop and snack machines. The workshop	W0227	**CORRECTION:** *The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment.* Specifically, the team will develop appropriate behavior supports to address Client #5's stealing money,soft drinks and food at the workshop. **PREVENTION:** Facility professional staff will be retrained regarding the need to develop comprehensive behavior supports across environments for all clients. Members of the Operations and Quality Assurance Teams will periodically review incident documentation and support documents, on an ongoing basis to assure the team addresses client behavioral support needs as appropriate. (**Addendum, 6/29/12:** The Home Manager and QDDPD will conduct on-site observations at day service and workshop facilities no less than monthly. Additionally, the facility has begun using communication notebooks for each client to enable residential and day service staff to communicate about issues as they arise on a daily basis.) **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support	07/07/2012

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	supervisor stated client #5 "will go through the trash and lunch boxes to get pop or money." Client #5 located three workshop clients sitting in the break area, walked around to circle their tables, and eyed their snacks and pop on the tables. Client #5 opened the trash can lids, looked inside, removed a empty can, and was observed to shake it. On 5/31/12 at 1:50pm, client #5's record was reviewed and no Behavior Support Plan (BSP) was available for review. Client #5's 10/14/11 ISP (Individual Support Plan) did not indicate the behaviors of the theft of money, pop, or food at the workshop. On 5/31/12 at 10:45am, an interview was completed with the QMRP. The QMRP indicated client #5 had no Behavior Support Plan available for review. 9-3-4(a)		Associates, Operations Team, Quality Assurance Team	

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W0242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. Based on observation, record review, and interview, for 1 of 4 sample clients (client #2), the facility failed to develop a training objective/goal based on client #2's toileting need. Findings include: On 5/29/12 from 5:25pm until 7:15pm, and on 5/30/12 from 5:25am until 8:20am, client #2 walked throughout the group home and was not observed to use the bathroom. During both observation periods client #2 had adult incontinent briefs sitting inside her shared bedroom on the floor beside her dresser. On 5/30/12 at 6:30am, client #2 was observed to wear slacks and the incontinent brief stuck out from the waist. Client #2's record was reviewed on 5/31/12 at 1:50pm. Client #2's 10/2/11 ISP indicated a goal/objective to wash her	W0242	**CORRECTION:** *The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.* Specifically, the team has initiated a learning objective that addresses Client #2's toileting needs **PREVENTION:** The QDDPD will be retrained regarding the need to review the comprehensive functional assessment, incident documentation and progress notes to assure each client receives training in needed personal skills. Members of the Quality Assurance and Operations Teams will periodically compare current support documents to assessment data to assure	07/07/2012

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	hands independently after toileting. Client #2's 4/15/12 "Physician Orders" indicated "May use Depends type undergarments as needed." Client #2's 10/2/11 entry from her vocational location indicated "depends at work due to incontinence." No toileting goal was available for review. On 6/1/12 at 10:45am, an interview with the QMRP (Qualified Mental Retardation Professional), the QMRP-D (Qualified Mental Retardation Professional-Designee), and the Director of Quality Assurance (DQA) was completed. The three professional staff indicated client #2 was incontinent and wore incontinent briefs for client #2's dignity. The QMRP indicated client #2 did not have a specific objective which taught client #2 to use the toilet. 9-3-4(a)		training needs are addressed in each client's individual support plan. **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team	

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W0247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. Based on observation, record review, and interview, for 7 of 7 clients (clients #1, #2, #3, #4, #5, #6, and #7) who lived in the group home, the facility failed to encourage and include client choices for food. Findings include: On 5/29/12 at 6pm, clients #1, #2, #3, #4, #5, #6, and #7 sat down to eat the evening meal which included salad and one salad dressing "Zesty Italian." On 5/30/12 at 7:50am, clients #1, #2, #3, #4, #5, #6, and #7 sat down to eat the breakfast meal which included one cereal "Frosted Cheerios." On 6/1/12 at 10:45am, an interview with the QMRP (Qualified Mental Retardation Professional) was completed. The QMRP indicated clients #1, #2, #3, #4, #5, #6, and #7 should have the choice of cereal and salad dressing. 9-3-4(a)	W0247	**CORRECTION:** *The individual program plan must include opportunities for client choice and self-management.* Specifically, direct support staff will be retrained regarding the need to offer appropriate mealtime choices including but not limited to condiments. **PREVENTION:** Facility professional staff will be expected to observe no less than two morning and two evening active treatment sessions per week to assure staff support dietary choices. Additionally members of the Operations and Quality Assurance Teams will periodically monitor active treatment on an ongoing basis to assure quality meal time service delivery. **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team	07/07/2012

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W0249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview, for 1 of 4 sample clients (client #3), the facility failed to implement client #3's behavior plan as written. Findings include: On 5/29/12 from 5:25pm until 7:15pm, and on 5/30/12 from 5:25am until 8:20am, observations and interview were completed at the group home. During both periods two large butcher knives were observed in the kitchen. On 5/29/12 from 6:50pm until 7:15pm, the two large butcher knives were placed into the dish wash utensil rack, the dishwasher door was open/down, and the utensil rack was extended outward fully exposed. From 6:50pm until 7:15pm, client #3 was unsupervised by the facility staff and observed to load dishes from the sink into the rack, accessed the kitchen, and was alone in the kitchen four (4) times. On 5/30/12 from 5:25am until 8:20am, the two large butcher knives were observed in	W0249	**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, direct support staff have been retrained regarding proper implementation of Client #3's Behavior Support Plan. Additionally, the facility has added additional direct support staff on evenings and weekends to increase supervision and assure adequate staff are in place to implement behavior supports as needed. **PREVENTION:** Facility professional staff will be expected to observe no less than two morning and two evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training toward proper implementation of Individual and	07/07/2012

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	the open dishwasher with the utensil rack extended and exposed. From 5:25am until 8:20am, client #3 had unsupervised independent access to the two large butcher knives in the utensil rack. On 5/29/12 at 6:20pm, client #3 ran into her bedroom in the front of the house near the front door from the kitchen and the bedroom door slammed. Just as the door slammed, it reopened and client #3 was out the front door into the front yard alone and no facility staff followed her. The facility van was parked in front of the windows to the front living room blocking the view from the living room windows into the front yard. Client #3 walked across the front yard to the swing near the road in front of the group home and sat down. Client #3 pulled out her cigarettes and lighter and began to smoke. At 6:30pm, the Residential Manager (RM) came to the door. The RM stated client #3 "goes out there to smoke" independently. The RM stated "she only leaves AWOL from workshop." At 6:35pm, the RM walked outside and spoke with client #3 who sat smoking on the swing. At 6:40pm, the RM and client #3 returned inside the group home. At 6:40pm, the RM stated client #3's level of supervision was "we just keep track of her every so often."		Behavior Support Plans. Additionally members of the Operations and Quality Assurance Teams will periodically monitor active treatment on an ongoing basis to assure quality service delivery. **RESPONSIBLE PARTIES:** QDDPD, Home Manager, Support Associates, Operations Team, Quality Assurance Team.	

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	On 5/29/12 at 4pm, the facility's investigations were reviewed and indicated the following for client #3's behaviors of AWOL and Suicidal Threats. -A 3/27/12 BDDS report for an incident on 3/27/12 at 11:25am, indicated client #3 had gone AWOL (Absent Without Leave) from workshop twice; client #3 left a third time running into traffic down [street #3] into moving traffic threatening to commit suicide. Client #3's Interdisciplinary Notes (IDT) were reviewed on 5/31/12 at 12noon and indicated the following: -A 4/26/12 IDT indicated incidents on 3/27/12 and 3/20/12 at 1:16pm. The IDT note indicated on 3/20/12 at 1:16pm, client #3 became upset, agreed to sit in her chair at the workshop, then client #3 "jumped from her chair," became upset, left AWOL outside the building. The IDT note indicated the workshop staff walked with client #3, client #3 calmed, and group home staff came to the workshop to pick her up. -A 5/4/12 IDT entry from the QMRP-D (Qualified Mental Retardation Professional-Designee) indicated Workshop Supervisor "called 5/4/12 stating that the safety board (at workshop) felt that it would be best if [client #3] didn't return to [Workshop name] due to the severity of her suicidal tendencies, [client #3] puts staff and herself at risk and [workshop name] states it's too much of a risk." Client #3's record was reviewed on 5/31/12 at 11:20am. Client #3's record indicated client #3 was admitted to the facility on 2/2012. Client #3's 3/13/12 BSP indicated targeted behaviors of verbal aggression, physical aggression,			

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	non compliance, "AWOL defined as This occurs when [client #3] is very frustrated or upset about an issue or when things do no go her way. [client #3] will leave the premises unsupervised, Suicidal Threats (which is) any time [client #3] starts implicating that nobody cares about her and that she has nothing to live for, therefore she wants to kill herself." Client #3's 3/13/12 BSP indicated for AWOL and Suicidal Threats behaviors staff were to "Keep [client #3] in your sight at all times when she leaves the home/property," offer activity, and document AWOL incident and behaviors. On 6/1/12 at 10:45am, an interview with the Qualified Mental Retardation Professional (QMRP) was completed. The QMRP indicated client #3 had suicidal threats and leaving the workshop AWOL in 3/2012. The QMRP indicated client #3 was to be within eye sight of facility staff for supervision. The QMRP stated the facility had "locked up all the sharps which included knives." The QMRP stated client #3 "is not safe with knives unless supervised." 9-3-4(a)			

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W0252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on observation, record review, and interview, for 1 of 3 sample clients (client #3) who had a Behavior Support Plan (BSP), the facility failed to ensure accurate behavior data was recorded for client #3. Findings include: On 5/29/12 at 6:20pm, client #3 ran into her bedroom in the front of the house near the front door from the kitchen and the bedroom door slammed. Just as the door slammed, it reopened and client #3 was out the front door into the front yard alone and no facility staff followed her. The facility van was parked in front of the windows to the front living room blocking the view from the living room windows into the front yard. Client #3 walked across the front yard to the swing near the road in front of the group home and sat down. Client #3 pulled out her cigarettes and lighter and began to smoke. At 6:30pm, the Residential Manager (RM) came to the door. The RM stated client #3 "goes out there to smoke" independently. The RM stated "she only	W0252	**CORRECTION:** *Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.* Specifically, direct support staff have been retrained regarding facility expectations for documentation of behavioral episodes including but not limited to Client #3. **PREVENTION:** Professional staff will be retrained regarding the need to monitor behavior documentation each time they are present in the home in order to provide guidance and corrective measures to direct support staff in a timely manner to assure appropriate documentation of behavioral situations occurs. Additionally, members of the Quality Assurance and Operations Teams will periodically compare incident data and recorded behavior documentation to assure behavioral episodes are recorded and tracked to provide the team with needed assessment data. **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team	07/07/2012

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	leaves AWOL from workshop." At 6:35pm, the RM walked outside and spoke with client #3 who sat smoking in the swing. At 6:40pm, the RM and client #3 returned inside the group home. At 6:40pm, the RM stated client #3's level of supervision was "we just keep track of her every so often." On 5/29/12 at 4pm, the facility's investigations were reviewed and indicated the following for client #3's behaviors of AWOL and Suicidal Threats: -A 3/27/12 BDDS report for an incident on 3/27/12 at 11:25am, indicated client #3 had gone AWOL (Absent Without Leave) from workshop twice and left a third time AWOL running into traffic down [street #3] into moving traffic threatening to commit suicide. Client #3's Interdisciplinary Notes (IDT) were reviewed on 5/31/12 at 12noon and indicated the following: -A 4/26/12 IDT indicated incidents on 3/27/12 and 3/20/12 at 1:16pm. The IDT note indicated on 3/20/12 at 1:16pm, client #3 became upset, agreed to sit in her chair at the workshop, then client #3 "jumped from her chair," became upset, left AWOL outside the building. The IDT note indicated the workshop staff walked with client #3, client #3 calmed, and group home staff came to the workshop to			

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	pick her up. No behavior data was documented on client #3's record. Client #3's record was reviewed on 5/31/12 at 11:20am. Client #3's record indicated client #3 was admitted to the facility on 2/2012. Client #3's 3/13/12 BSP indicated targeted behaviors of "AWOL defined as This occurs when [client #3] is very frustrated or upset about an issue or when things do no go her way. [Client #3] will leave the premises unsupervised, Suicidal Threats (which is) any time [client #3] starts implicating that nobody cares about her and that she has nothing to live for, therefore she wants to kill herself." Client #3's 3/13/12 BSP indicated for AWOL and Suicidal Threats behaviors staff were to "Keep [client #3] in your sight at all times when she leaves the home/property," offer activity, and document AWOL incident and behaviors. Client #3's record did not indicate behavioral data. On 6/1/12 at 10:45am, an interview with the Qualified Mental Retardation Professional (QMRP) was completed. The QMRP indicated client #3 had suicidal threats and leaving the workshop AWOL in 3/2012. The QMRP indicated no behavior data was documented and no data was available for review.			

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W0264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE 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, record review, and interview, for 7 of 7 clients (clients #1, #2, #3, #4, #5, #6, and #7) who lived in the group home, the facility failed obtain approval from the facility's Human Rights Committee (HRC) for restrictive practices employed. Findings include: On 5/29/12 at 4pm, the facility's BDDS (Bureau of Developmental Disability Services) reports were reviewed and indicated the following for client #3's behaviors: -A 3/31/12 BDDS report for an incident on 3/25/12 at 9am, indicated client #3 went to the kitchen, "grabbed" a knife, threatened to hurt herself, and later handed the knife to staff. The report indicated a corrective action of the facility's HRC (Human Rights Committee) approved a verbal emergency restriction on 3/30/12 to lock up knives.	W0264	**CORRECTION:** *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 address*ed. Specifically for Clients#1 – #7, the team has obtained Human Rights Committee approval for securing knives and other sharp objects. **PREVENTION:** Professional staff will be retrained regarding the need to obtain prior written informed consent and Human Rights Committee approval for all restrictive programs prior to implementation. (**Addendum, 6/29/12:** retraining will focus on assuring that the QDDPD has a clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications to the Human Rights Committee.The	07/07/2012

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	The report indicated the staff "reminded [client #3] that when she acted in a similar manner in the past that the police came when she could not calm down and was a risk to herself." Client #3's record was reviewed on 5/31/12 at 11:20am. Client #3's record indicated client #3 was admitted to the facility on 2/2012. Client #3's 3/13/12 BSP indicated targeted behaviors of verbal aggression, physical aggression, non compliance, "AWOL defined as This occurs when [client #3] is very frustrated or upset about an issue or when things do no go her way. [client #3] will leave the premises unsupervised, Suicidal Threats (which is) any time [client #3] starts implicating that nobody cares about her and that she has nothing to live for, therefore she wants to kill herself." Client #3's 3/13/12 BSP indicated for AWOL and Suicidal Threats behaviors staff were to "Keep [client #3] in your sight at all times when she leaves the home/property," offer activity, and document AWOL incident and behaviors. Client #3's plan did not include the HRC restriction for sharps and no written documented approvals were available for review. On 6/1/12 at 10:45am, an interview with the Qualified Mental Retardation		training will also focus on helping professional staff develop adequate record keeping practices to assure that HRC approval records are available for review.) Additionally, the agency has established a separate Quality Assurance Department to assist with auditing facility systems. Members of the Quality Assurance and Operations Teams will periodically review support documents and Human Rights Committee Records on an ongoing basis to assure prior written informed consent and HRC approval occurs for all restrictive programs. (**Addendum 6/28/12:** The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to due process and prior written informed consent. Administrative staff will conduct visits to the facility as needed but no less than monthly. **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team	

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	Professional (QMRP) was completed. The QMRP stated the facility was to have "locked up all the sharps which included knives." The QMRP stated client #3 "is not safe with knives unless supervised." The QMRP indicated HRC gave verbal consent for locked sharps on 3/30/12 and stated "No written approvals" were available for review. The QMRP indicated clients #1, #2, #4, #5, #6, and #7 did not have an identified need for the locked sharps, however to keep client #3 safe the sharps should be locked up. 9-3-4(a)			

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W0436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, interview, and record review, for 3 of 4 sample clients (clients #1, #2, and #3) and 1 additional client (client #6) who had adaptive equipment prescribed, the facility failed to teach and encourage client #1 to wear his prescribed eye glasses, client #2 to wear her hearing aid and prescribed eye glasses, client #3 to wear her prescribed eye glasses, and failed to provide client #6's walker repair. Findings include: 1. On 5/29/12 from 5:25pm until 7:15pm, and on 5/30/12 from 5:25am until 8:20am, client #1 walked throughout the group home, had medication administered, and did not wear his prescribed eye glasses. On 5/29/12 at 5:40pm, the Residential Manager (RM) prompted client #1 to wear his eye glasses	W0436	**CORRECTION:** The facility must furnish,maintain in good repair, *and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.* Specifically, direct support staff will be retrained regarding the need to implement Client #1,Client #2 and Client #3's adaptive equipment goals as needed, at every reasonable opportunity. Additionally the facility will expedite repairs of Client #6's walker. **PREVENTION:** Facility professional staff will be expected to observe no less than two morning and two evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training toward proper implementation of learning objectives including but not limited to adaptive equipment goals. Additionally, members of the Operations and Quality Assurance Teams will conduct	07/07/2012

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	and client #1 stated "I lost them." Client #1 was prompted to watch television, read a book, set the table, and rinse dishes without his prescribed eye glasses encouraged or found. Client #1's record was reviewed on 5/31/12 at 11am. Client #1's 3/22/12 ISP (Individual Support Plan) indicated a goal/objective "will make informed choices about adaptive equipment/eyeglasses." Client #1's 8/8/11 vision evaluation indicated client #1 wore prescribed eye glasses. 2. On 5/29/12 from 5:25pm until 7:15pm, and on 5/30/12 from 5:25am until 8:20am, client #2 walked throughout the group home, had medication administered, and did not wear her hearing aid and did not wear her prescribed eye glasses. During both observation periods client #2 was prompted to watch television, read a book, set the table, and rinse dishes without her prescribed eye glasses and her hearing aid. Client #2's record was reviewed on		periodic active treatment observations on an ongoing basis to assure that clients are utilizing adaptive equipment as recommended. **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team	

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	5/31/12 at 1:50pm. Client #2's 10/2/11 ISP did not indicate a goal/objective to wear her prescribed hearing aid and did not indicate a goal/objective to wear her prescribed eye glasses. Client #2's 10/26/11 hearing evaluation indicated she wore a hearing aid because of bilateral hearing loss. Client #2's 7/7/11 vision evaluation indicated she wore prescribed eye glasses. 3. On 5/29/12 from 5:25pm until 7:15pm, and on 5/30/12 from 5:25am until 8:20am, client #3 walked throughout the group home, had medication administered, and did not wear her prescribed eye glasses. During both observation periods client #3 was prompted to watch television, read a book, take a walk outside, smoke outside, read the newspaper, and rinse dishes without her prescribed eye glasses. Client #3's record was reviewed on 5/31/12 at 11:20am. Client #3's 4/22/12 ISP indicated a goal/objective to clean her prescribed eye glasses. Client #3's 4/6/11 vision evaluation indicated she wore prescribed eye glasses.			

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	4. On 5/29/12 from 5:25pm until 7:15pm, and on 5/30/12 from 5:25am until 8:20am, client #6 walked throughout the group home and did not use his walker for walking. On 5/30/12 at 6am, client #6 stated his walker was kept in his bedroom. Client #6 showed his walker with worn wheels. Client #6 indicated his walker wheels with the padding grips were missing and exposed the metal finish of the walker to contact with the floor. Client #6 stated "I was to get a new one. Don't have it yet." Client #6's record was reviewed on 5/31/12 at 12:15pm. Client #6's 7/15/11 ISP did not indicate a goal/objective to use his walker. Client #6's 11/5/09 physical therapy assessment indicated he used a walker. Client #6's 5/2012 "Adaptive Equipment Cleaning/Maintenance" record indicated "Walkers: Surface clean, rubber stops in place" and were initialed off by the group home staff three times a day for thirty-one days in May, 2012. On 6/1/12 at 10:45am, an interview with			

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	the QMRP (Qualified Mental Retardation Professional), the QMRP-D (Qualified Mental Retardation Professional-Designee), and the Director of Quality Assurance (DQA) was completed. The three professional staff indicated client #1 wore prescribed eye glasses and should have worn his eye glasses. The three professional staff indicated client #2 wore prescribed eye glasses, wore a hearing aid, and should have been taught and encouraged to use her adaptive equipment. The three professional staff indicated client #3 wore prescribed eye glasses and should have worn her eye glasses. The QMRP indicated client #6's walker was worn and provided an inservice held on 5/31/12 which indicated that client #6's walker was not record on the data information correctly. The QMRP indicated client #6's walker was in need of repair. 9-3-7(a)			

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W0454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation and interview, for 7 of 7 sampled clients (clients #1, #2, #3, #4, #5, #6, and #7) who lived in the group home, the facility failed to ensure a clean area for medication administration. Findings include: On 5/30/12 at 6:32am, client #5 entered the medication administration room with Group Home Staff (GHS) #4 and tested his blood sugar. Client #5 dripped blood from his fingers onto the medication administration counter and on the handle and lid to the sharps container. No teaching and no encouragement to clean up the blood was observed. At 6:36am, client #4 had his medications administered by GHS #4; client #4 laid his hands on the counter where the smeared blood from client #5 was. At 6:50am, client #2 had medication administration completed with GHS #1 and GHS #4; client #2 touched the same counter with blood smears, handled her medications with her fingers, and no redirection was taught or encouraged. At 7:10am, client #1 entered the medication room with GHS #1; client #1 had his	W0454	**CORRECTION:** *The facility must provide a sanitary environment to avoid sources and transmission of infections.* Specifically, the facility has replaced its sharps disposal container with a new container that is less likely to be contaminated with blood or body fluids. Additionally staff have been retrained regarding bloodborne pathogens and cleaning of contaminated materials and the need to maintain universal precautions. **PREVENTION:** Facility professional staff will be expected to observe no less than two morning and two evening active treatment sessions per week to assess direct support staff to provide hands on coaching and training toward proper implementation of universal precautions and maintaining a sanitary training environment. Additionally, members of the Operations and Quality Assurance Teams will conduct periodic active treatment observations on an ongoing basis to assure that the team supports universal precautions and a sanitary training environment. **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team	07/07/2012

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	medications administered after client #5's blood smears were still on the counter, and no redirection was taught or encouraged. At 7:30am, GHS #1 was shown the blood smears on the medication administration counter and GHS #1 stated "I didn't see it." GHS #1 stated "I didn't clean it" between clients. At 7:30am, GHS #1 retrieved the sharps container and stated "yes, there was blood" around the handle and access point to place sharp needles into the jug. On 6/1/12 at 10:45am, an interview with the QMRP (Qualified Mental Retardation Professional) was completed. The QMRP indicated the facility followed core A/core B for medication administration which included to wipe and clean the medication administration area free of spills before medication administration was completed for each client. The QMRP indicated clients #1, #2, #3, #4, #5, #6, and #7 used the medication administration area. 9-3-7(a)			

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	15G422	A. BUILDING 00 B. WING	06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	5843 N SHERMAN AVE INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on record review, observation, and interview, for 1 of 2 sampled clients (client #6) who was to receive a modified diet, the facility failed to ensure client #6 received his prescribed diet. Findings include: On 5/29/12 at 6pm, client #6 received one serving of a one foot long by six inch wide slice of pizza. Client #6 cut the pizza with a rocker knife into four pieces and consumed it. No redirection was observed and no double portions were encouraged. On 5/30/12 at 7:50am, client #6 received a slice of toast. Client #6 cut the toast in half and consumed it. No redirection was observed and no double portions were encouraged. On 5/31/12 at 12:15pm, client #6's record was reviewed and indicated a 4/15/12 "Physician's Order" for "Diet, Encourage at least 75% intake at meals with supplements, Encourage 100% consumption of protein foods and dairy, offer double portions of meat items,	W0460	**CORRECTION:** *Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.* Specifically, staff have been retrained on Client #6's dining plan, and his diet is being prepared and served as prescribed. **PREVENTION:** Professional staff will be retrained regarding the need to provide ongoing supervision during meal preparation and during family style dining to assure foods are prepared and served in an appropriate texture. Additionally, members of the Operations and Quality Assurance Teams will periodically observe active treatment sessions at the facility, on an ongoing basis, to assure food is prepared and served prescribed diets. **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team	07/07/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G422	A. BUILDING 00 B. WING	06/07/2012

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	Ensure Plus Supplement give one can daily, suggest small frequent meals, softer foods and foods chopped into pea size pieces." On 6/1/12 at 10:45am, an interview was completed with the QMRP (Qualified Mental Retardation Professional). The QMRP indicated client #6 should have had his food cut up into pea size pieces and client #6 should have been offered and encouraged double portions of food. 9-3-8(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G422	A. BUILDING 00 B. WING	06/07/2012

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W0488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, record review, and interview, for 6 of 7 clients (clients #1, #2, #4, #5, #6, and #7) who lived in the group home, the facility failed to encourage, teach, and include clients to shop for food. Findings include: On 5/29/12 from 5:25pm, until 7:15pm, and on 5/30/12 from 5:25am until 8:20am, clients #1, #2, #3, #4, #5, #6, and #7 were observed at the group home. During both observation and interview periods clients #1, #2, #4, #5, #6, and #7 indicated they were not offered the opportunity to shop for groceries and clients #1, #2, #4, #5, #6, and #7 wanted to go to the store to shop. On 5/30/12 at 8:15am, client #3 indicated she was going to stay home with GHS (Group Home Staff) #1 and go grocery shopping with GHS #1. GHS #1 indicated GHS #1 completed the grocery shopping every week. On 6/1/12 at 10:45am, an interview with the QMRP (Qualified Mental Retardation Professional) was completed. The QMRP indicated clients #1, #2, #4, #5, #6, and #7 should have the choice of shopping for groceries. The QMRP indicated no documented evidence was available for review for grocery shopping outings. 9-3-8(a)	W0488	**CORRECTION:** *The facility must assure that each client eats in a manner consistent with his or her developmental level.* Specifically, professional and direct support staff will be retrained regarding the need to include all clients in the grocery shopping process. **PREVENTION:** Facility supervisors will provide oversight to assure all clients receive the opportunity to participate in grocery shopping on an ongoing basis. Members of the Quality Assurance and Operations Teams will periodically review facility progress notes to confirm that all clients are participating in grocery shopping and follow up with facility professional staff as needed. **RESPONSIBLE PARTIES:** QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team **Corrections completed by**: 7/7/12	07/07/2012