STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G656	A. BUILDING 00 B. WING	04/12/2013

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JAY-RANDOLPH DEVELOPMENTAL SERVICES	227 E UNION ST PORTLAND, IN 47371

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W000000	This visit was for a predetermined full recertification and state licensure survey. This visit was in conjunction with the PCR to the investigation of complaint #IN00123819 investigated on 2/27/13. Dates of Survey: April 2, 3, 4 and 12, 2013. Provider number: 15G656 Facility number: 001193 AIM number: 100446910 Surveyor: Vickie Kolb, RN, BSN, Public Health Nurse Surveyor III These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/22/13 by Ruth Shackelford, Medical Surveyor III.	W000000		

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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W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 3 of 3 sampled clients (#1, #2 and #3) and for 3 additional clients (#4, #5 and #6), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure: __The clients' dining dishes were not stained, warped and/or peeling. __The facility owned DP (Day Program) followed the clients' dining plans, provided the clients with their dining equipment and labeled the clients' food containers with name, date and contents. __Clients #1, #2, #3 #4, #5 and #6 were not restricted from the food and/or snacks and client #3 was not restricted from the sippy cups. __The facility reported all allegations of abuse/neglect/mistreatment immediately to the administrator and to BDDS (Bureau of Developmental Disabilities Services) and to APS (Adult Protective Services) within 24 hours of acknowledgment of the abuse/neglect/mistreatment for clients #1 and #2. __The facility implemented its policy and procedures to conduct thorough investigations for clients #1, #2, #3, #5 and #6.	W000104	Now, and in the future, the JRDS governing body will exercise the general policy and operating direction over each facility. All dishes in need of being replaced have been replaced. All food containers are now labeled. All locks have been removed. All staff will be trained and retrained by the Dietician and QMRP with routine monitoring by the Home Manager, Dietician and QMRP. Now, and in the future, all staff will be trained on the JRDS Protection Policy to ensure all allegations of abuse/neglect/mistreatment are immediately reported to the administrator and to BDDS and APS; as well as investigated per the JRDS policy. DSP, Home Manager and Residential Department Head responsible. At least annually all JRDS staff are trained and tested on the JRDS Protection Policy (5/1/13 and 5/10/13). Testing results indicate it was understood. Usage of the new investigative form has shown proficiency among staff.	05/12/2013

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	Findings include: 1. Observations were conducted at the group home on 4/2/13 between 3:30 PM and 6 PM and on 4/3/13 between 5:30 AM and 8:30 AM and at the facility owned DP (Day Program) on 4/3/13 between 11:15 AM and 11:45 AM. The clients used plastic high sided divided plates to eat their meals in the morning, afternoon and evening. The afternoon meal was packed from the group home and taken to the DP. During the evening observation, there were 10 divided plastic plates in the cupboard at the group home and 6 on the counter. Every plastic divided plate was stained, warped and/or peeling. At the DP, the staff unpacked client #1's, #2's and #3's lunches. The lids were taped to the top of the plates with masking tape. Interview with DP staff #1 on 4/3/13 at 11:30 AM stated clients #1's, #2's and #3's lunches were packed from the home and "always" came in the high sided plastic plates with the lid taped to the top. When asked why was it taped, DP staff #1 stated, "Because it doesn't fit on the plate anymore." DP staff #1 indicated the dishes that were sent to the DP were stained, warped and peeling. DP staff #1 stated, "They need to be replaced."			

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	Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM indicated the divided plastic plates used by the clients (#1, #2, #3, #4, #5 and #6) were in need of being replaced. 2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to ensure client #1's, #2's, #3's, #4's, #5's and #6's rights in regard to restricting the clients from the food and/or snacks and restricting client #3 from the sippy cups. Please see W125. 3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to ensure all allegations of neglect/abuse/mistreatment were immediately reported to the administrator and thoroughly investigated with a reproducible system of investigation for clients #1, #2, #3, #5 and #6, all allegations of neglect/abuse/mistreatment were reported to BDDS and to APS per state law for clients #1 and #6 and to ensure the IDT (Interdisciplinary Team) reviewed and/or approved client #3's			

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	practice of playing with shoestrings in regard to client #1's and #3's health and safety. Please see W149. 4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to ensure all allegations of abuse/neglect and/or client to client abuse were reported immediately to the administrator in regard to client #6 and to ensure all allegations of abuse/neglect were reported to BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for clients #1 and #2. Please see W153. 5. The governing body failed to exercise general policy and operating direction over the facility to provide evidence of and/or to conduct thorough investigations for clients #1, #2, #3, #5 and #6. Please see W154. 9-3-1(a)			

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W000125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to ensure client #1's, #2's, #3's, #4's, #5's and #6's rights in regard to restricting the clients from the food and/or snacks and restricting client #3 from the sippy cups. Findings include: Observations were conducted at the group home on 4/2/13 between 3:30 PM and 6 PM and on 4/3/13 between 5:30 AM and 8:30 AM. During both observations, 3 of the kitchen cabinets had infant locks on the doors, preventing clients #1, #2, #3, #4, #5 and#6 from opening the doors without maneuvering the plastic locking devices. One of the cabinets contained client #3's sippy cups and the other two contained snack items (cookies, crackers and chocolate). Client #1's record was reviewed on 4/4/13 at 1 PM. Client #1's BSP (Behavior Support Plan) of 11/10/12 indicated client	W000125	Now, and in the future, clients will not be restricted from food and/or snacks and sippy cups (unless contraindicated per assessment). Staff have been trained by the Dietician and QMRP on client rights. Random/unannounced visits by the QMRP, Dietician, LPN and Home Manager will occur to ensure client rights are protected. Home Manager, DSPs and QMRP responsible.	05/12/2013

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	#1 displayed the behaviors of excessive eating and obsessing about food. The BSP indicated client #1's behaviors had gotten to the point of "stealing others food, pulling items out of the trash, and taking uncooked food from the pantry." Client #1's BSP indicated client #1 "cannot be allowed free access to all food and drink items within her household. She [client #1] has shown that she cannot be trusted to be safe, and could eat uncooked, unsafe, or unhealthy amounts of food." The BSP indicated food and/or snacks were to be placed out of client #1's eyesight and/or out of her reach. The BSP did not indicate the food and/or snacks were to be locked due to client #1's behaviors. Client #1's record indicated client #1 had a legal guardian. Client #1's record did not indicate client #1's guardian had given verbal and/or written consent to lock the food and/or snacks in the group home. Client #2's record was reviewed on 4/3/13 at 12 PM. Client #2's ISP of 11/9/12 did not indicate a need for client #2 to be restricted from food and/or snacks. Client #2's ISP indicated client #2 had a legal guardian. Client #2's record did not indicate client #2's guardian had given verbal and/or written consent to lock the food and/or snacks at the group home.			

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	Client #3's record was reviewed on 4/3/13 at 2 PM. Client #3's ISP of 4/13/12 did not indicate a need for client #3 to be restricted from food, snacks and/or his sippy cups. Client #3's record indicated client #3 had a legal guardian. Client #3's record did not indicate client #3's guardian had given verbal and/or written consent to lock the food, snacks and/or client #3's sippy cups at the group home. The facility's HRC (Human Rights Committee) notes for 2012/2013 were reviewed on 4/3/13 at 1 PM. The HRC notes did not indicate the approval to place a lock on the kitchen cabinets to restrict any of the clients in the group home from food and/or snacks in the home. The HRC notes indicated no approval to restrict client #3 from his sippy cups. Interview with staff #2 and #4 on 4/3/13 at 6:30 PM indicated the baby locks were on one of the kitchen cabinets because client #3 "Will get in the cabinet and mess with his sippy cups, getting them all out." Staff #2 and #4 indicated the baby locks were on the snack cabinet because clients #3 and #6 would not leave the snacks alone if they were not locked or hard to get to. When asked if any of the clients were able to independently open the 3 cabinets with the baby locks on them,			

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	staff #2 stated, "No, we [the staff] have to open it and get them whatever they need." During interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM, the QIDP indicated she did not know the clients were being restricted from the food and/or snack items. The QIDP indicated she was not aware client #3 was being restricted from his sippy cups. The QIDP stated, "To my knowledge, there shouldn't be any locks on any of the kitchen cabinets." 9-3-2(a)			

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W000149	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 record review and interview for 3 of 3 sampled clients (clients #1, #2 and #3) and #2 additional clients (clients #5 and #6), the facility neglected to implement its policy and procedures to ensure: __All allegations of neglect/abuse/mistreatment were immediately reported to the administrator and thoroughly investigated with a reproducible system of investigation for clients #1, #2, #3, #5 and #6. __All allegations of neglect/abuse/mistreatment were reported to BDDS (Bureau of Developmental Disabilities Services) and to APS (Adult Protective Services) per state law for clients #1 and #2. Findings include: The facility's reportable incident reports, BDDS (Bureau of Developmental Disabilities Services) reports and investigative records were reviewed on 4/2/13 at 1:30 PM and again on 4/4/13 at 10 AM. The facility's records indicated the following: __Incident Report dated 2/16/13 at 12:30	W000149	Now, and in the future, all allegations of incidents of abuse will be reported to DDARS and APS within 24 hours of the incident. Investigation of the allegations of incidents of abuse will be investigated by JRDS within 24 hours of the alleged incidents of abuse, per our attached policy. Home Manager, Residential Department Head responsible. *The attached JRDS Procedures for Reporting Reportable Incidents to the State have been implemented. All investigations are reviewed by members of the JRDS Quality Review Team.	05/12/2013

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	PM indicated "[Client #2] was sitting on the couch and turned and grabbed [client #1] who was sitting in a recliner beside [client #2]." The facility records did not indicate BDDS and/or APS were notified of the client to client abuse in regard to clients #1 and #2. The facility records did not indicate an investigation was conducted. __Incident Report dated 2/16/13 at 5 PM indicated "[Client #6] came out of her room and into the living room and grabbed [client #1] by the hair and started hitting her [client #1] in the face. Staff stopped her [client #6] and told her [client #6] to go to her room." __BDDS report of 2/17/13 indicated on 2/16/13 at 5 PM client #2 "who is basically nonverbal, got upset that [client #1] was sitting in his chair. While grabbing at [client #1], [client #2] scratched [client #1's] left arm resulting in a 2 inch mark. [Client #2] had been resistive with staff throughout the day. It was decided to send [client #2] to the ER [Emergency Room] to rule out any medical issues. He [client #2] was taken to the ER at 5:30 PM. Within 10 minutes of [client #2] leaving, [client #6] walked over the (sic) [client #1] and hit her on the right side of her face. [Client #1's] right cheek is slightly swollen." A Follow Up BDDS report of 2/28/13 indicated "The			

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	incident occurred because [client #1] was sitting in the aggressor's chair. Staff rearranged the furniture and put [client #1's] rocker in the place where the aggressor's chair had been sitting." The facility records did not indicate an investigation was conducted. __Incident Report dated 2/16/13 at 5:30 PM indicated "It was reported that when [client #6] became aggressive towards a housemate that a staff had taken [client #6] to her room and that another staff held [client #6's] door closed on at least 2 occasions not allowing [client #6] out of her room." The report indicated the house manager and the facility nurse were notified of the allegations of abuse. The facility records did not indicate the administrator was immediately notified and/or BDDS and APS were notified of the allegation of abuse/mistreatment. The facility records did not indicate an investigation was conducted in regard to the allegations of abuse/mistreatment. __BDDS report of 2/20/13 indicated at 7 PM "The residents had just finished supper when [client #6] who was sitting at the table, reached over and slapped [client #3] on the right side of his face." The staff asked client #6 to leave the room and as client #6 was leaving, client #6 slapped client #5 on the left side of his			

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	face. The HM (Home Manager) was called and instructed the staff to call the police. The police arrived and talked to client #6, telling her it was against the law to hit someone else and asked client #6 to apologize. The facility records did not indicate an investigation was conducted. __BDDS report of 2/23/13 indicated on 2/22/13 at 5:30 PM "Today at supper [client #2] turned his plate of food over on the table. [Name of staff] took [client #2] to his bedroom. She put items on his bed to keep him off his bed and closed his bedroom door. She [the staff] told the other working staff something like, "we can't let him have his way." Saturday [name of staff] phoned the QMRP [Qualified Mental Retardation Professional] (this reporter) and stated that [client #2] appeared to be in a bad mood and was noncompliant. As we discussed what had occurred this morning, [name of staff] told of the incident at supper last night. Also, during a later conversation another staff, [name of staff] stated that last Saturday when [client #6] became aggressive towards a housemate [name of staff] had taken [client #6] to her room and that [name of staff] held [client #6's] door closed on at least 2 occasions not allowing [client #6] out of her room. The Residential Department Head was contacted who			

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	suspended [name of staff] until an investigation is completed. [Name of staff] also suspended until an investigation is completed**."** __The follow up BDDS report of 3/5/13 indicated the Residential Department Head investigated the incident of 2/22/13. "The outcome from the investigation was that [name of staff] held [client #6's] door closed in an attempt to keep [client #6] from hurting someone else. As reported by staff [client #6] was upset that the door was held closed but did calm down within a few minutes. Restricting [client #6] to her room is not part of HRC [Human Rights Committee] approved plan. [Name of staff] received a written warning and was retrained on 2/28 by the Residential Department Head on the JRDS (Jay Randolph Developmental Services) Individual Protection Plan." The report indicated the staff did restrict client #2 to his room and from lying on his bed. "They (the report did not indicate who they was) also reported that [name of staff] also called him [client #2] an "a-----" and confirmed that she said "we can't let him have his way." [Name of staff's] employment was terminated on 2/25. Restricting [client #2] from his room is not part of his HRC approved plan." __The follow up BDDS report of 3/15/13			

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	indicated "...After numerous interviews were completed, there were no findings/reports of other incidents of this type of seclusion...." The facility investigative records did not indicate staff/client interviews, record reviews, investigative results and/or actions taken in regard to the allegations of abuse in regard to clients #2 and #6. __Incident report of 3/3/13 at 8:30 PM indicated client #6 was sitting in the living room on the couch beside client #3. Client #6 was "staring at people and gazing at the television." Client #6 was asked not to stare, "...it wasn't nice. When she [client #6] reached over and smacked [client #3] on the arm." The facility investigative records indicated one written statement from staff #4. The investigative records did not indicate staff/client interviews, record reviews, investigative results and/or actions taken in regard to the client to client abuse for clients #6 and #3. __BDDS report of 3/12/13 indicated on 3/9/13 client #6 was asked to slow her pace of eating down. Client #6 put her spoon down and "smacked" client #3 on his right arm. The facility investigative records indicated one written statement from staff #4. The investigative records did not indicate staff/client interviews,			

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	15G656	A. BUILDING 00 B. WING	04/12/2013

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	record reviews, investigative results and/or actions taken in regard to the client to client abuse for clients #6 and #3. __BDDS report of 3/12/13 indicated on 3/11/13 while at the facility owned day program at 11:50 AM client #6 ran to the table client #1 was sitting at and hit client #1 on the right side of her face and in the back of the neck. The facility records did not indicate an investigation was conducted. __Incident report of 3/12/13 at 5:40 PM indicated "Staff had prompted her [client #6] to sit up straight in her chair and not to lean over her plate per her dietary management plan.... [Client #6] looked up at the staff, then hit the housemate [client #3] sitting next to her with her open hand. Staff asked [client #6] to stop, she then hit the housemate [client #3] again with her open hand before the staff could get between them. Staff asked [client #6] to leave the area, she then hit another housemate [client #5] with her open hand on the way out of the dining room...." The facility records did not indicate an investigation was conducted. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 4/4/13 at 3 PM indicated all allegations of abuse/mistreatment and client to client			

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	abuse were to be immediately reported to the administrator at the time of the incident and/or when the allegation was made. The QIDP indicated BDDS and APS were to be notified within 24 hours of the incident and/or knowledge of the abuse/mistreatment. The QIDP indicated all allegations of abuse/mistreatment were to be thoroughly investigated. The QIDP indicated the RDH (Residential Department Head) conducted the facility investigations for the client to client abuse of 3/3/13 and 3/9/13 in regard to clients #3 and #6 and for the allegation of abuse made on 2/22/13 in regard to clients #2 and #6. The QIDP indicated the RDH had provided all of the facility investigative reports for review and the QIDP was unable to provide any additional documentation of investigative records. The QIDP indicated the facility investigative folder provided for review did not indicate staff/client interviews, records reviewed, investigative results and/or actions taken in regard to the investigative results. The QIDP indicated the results of the investigations were reported in the BDDS reports. Review of the revised facility policy "Individual Protection Policy" of 5/12 on 4/2/12 at 2 PM indicated "JRDS [Jay-Randolph Developmental Services] personnel are required to preserve an			

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	individual's rights, dignity, health, and safety. As such JRDS prohibits the abuse, neglect, exploitation, mistreatment of an individual served or the violation of the individual's rights." The policy defines abuse to be the "use of unreasonable physical force such as spanking, pinching, shoving, shaking and other punitive acts.... actions, verbal statements or commands, or other procedure that result in a detrimental outcome for the individual involved (i.e. tone of voice, derogatory statement, facial expressions, isolation, demeaning gestures, name calling, and other damaging acts.)" The policy indicated "Individuals served must not be subjected to abuse by anyone, including, but not limited to, JRDS staff, other consumers, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals." The facility policy indicated the staff were to report abuse/neglect/mistreatment immediately to the Executive Director or a designee. The policy indicated the Case Coordinator or designee was to file a report with BDDS within 24 hours of being made aware of an incident of abuse/neglect/mistreatment and then the Program Head or designee would initiate an investigation. 9-3-2(a)			

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W000153	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 interview and record review for 2 of 8 incidents of alleged abuse/neglect and/or client to client abuse reviewed, the facility failed to immediately report to the administrator allegations of abuse in regard to client #6 and to report allegations of abuse/neglect to BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for clients #1 and #2. Findings include: The facility's reportable incident reports and BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 4/2/13 at 1:30 PM and again on 4/4/13 at 10 AM. The facility's records indicated the following: __Incident Report dated 2/16/13 at 12:30 PM indicated "[Client #2] was sitting on the couch and turned and grabbed [client #1] who was sitting in a recliner beside [client #2]." The facility records indicated no BDDS report and APS was not	W000153	Now, and in the future, all alleged incidents of abuse will be reported immediately to the Administrator and to DDARS, BDDS and APS within 24 hours of the allegation in accordance with state law. In accordance with the JRDS incident reporting policy all allegations will be reported to the administrator immediately and an investigation will be completed with 24 hours of the alleged incidents of abuse. JRDS DSP, Home Manager, QMRP and Residential Department Head responsible. The attached JRDS Procedures for Reporting Reportable Incidents to the State have been implemented. All investigations are reviewed by members of the JRDS Quality Review Team.	05/12/2013

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	notified of the client to client abuse in regard to clients #1 and #2. __Incident Report dated 2/16/13 at 5:30 PM indicated "It was reported that when [client #6] became aggressive towards a housemate that a staff had taken [client #6] to her room and that another staff held [client #6's] door closed on at least 2 occasions not allowing [client #6] out of her room." The facility records did not indicate the administrator was immediately notified and BDDS and APS were not notified of the allegation of abuse/mistreatment. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 4/4/13 at 3 PM indicated all allegations of abuse/mistreatment and client to client abuse were to be immediately reported to the administrator at the time of the incident and/or when the allegation was made. The QIDP indicated BDDS and APS were to be notified within 24 hours of the incident and/or knowledge of the abuse/mistreatment. 9-3-2(a)			

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W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 8 of 8 incidents of alleged abuse/neglect and/or client to client abuse reviewed, the facility failed to provide evidence of an investigation and/or evidence a thorough investigation was conducted for clients #1, #2, #3, #5 and #6. Findings include: The facility's reportable incident reports, BDDS (Bureau of Developmental Disabilities Services) reports and investigative records were reviewed on 4/2/13 at 1:30 PM and again on 4/4/13 at 10 AM. The facility's records indicated the following: __Incident Report dated 2/16/13 at 12:30 PM indicated "[Client #2] was sitting on the couch and turned and grabbed [client #1] who was sitting in a recliner beside [client #2]." The facility records indicated no investigation was conducted. __Incident Report dated 2/16/13 at 5 PM indicated "[Client #6] came out of her room and into the living room and grabbed [client #1] by the hair and started hitting her [client #1] in the face. Staff	W000154	Now, and in the future, there will be evidence that all alleged violations are thoroughly investigated. The Client Incident Report (see attached) contains a section for the Department Head or Health Care Coordinator's report. This report must be completed within 24 hours of an incident. Residential Department Head Responsible *The attached JRDS Procedures for Reporting Reportable Incidents to the State have been implemented. All investigations are reviewed by members of the JRDS Quality Review Team.	05/12/2013

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	stopped her [client #6] and told her [client #6] to go to her room." The BDDS report of 2/17/13 indicated on 2/16/13 at 5 PM client #2 "who is basically nonverbal, got upset that [client #1] was sitting in his chair. While grabbing at [client #1], [client #2] scratched [client #1's] left arm resulting in a 2 inch mark. [Client #2] had been resistive with staff throughout the day. It was decided to send [client #2] to the ER [Emergency Room] to rule out any medical issues. He [client #2] was taken to the ER at 5:30 PM. Within 10 minutes of [client #2] leaving, [client #6] walked over the (sic) [client #1] and hit her on the right side of her face. [Client #1's] right cheek is slightly swollen. A Follow Up BDDS report of 2/28/13 indicated "The incident occurred because [client #1] was sitting in the aggressor's chair. Staff rearranged the furniture and put [client #1's] rocker in the place where the aggressor's chair had been sitting." The facility records indicated no investigative records in regard to the incident of 2/16/13. __Incident Report dated 2/16/13 at 5:30 PM indicated "It was reported that when [client #6] became aggressive towards a housemate that a staff had taken [client #6] to her room and that another staff held [client #6's] door closed on at least 2 occasions not allowing [client #2] out of			

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	her room." The report indicated the house manager and the facility nurse were notified at the time of the allegations of abuse were made. The facility records indicated an investigation was initiated on 2/22/13. The facility investigative records indicated no staff/client interviews, record reviews, investigative results and/or actions taken in regard to the incident. __BDDS report of 2/20/13 indicated at 7 PM "The residents had just finished supper when [client #6] who was sitting at the table, reached over and slapped [client #3] on the right side of his face." The staff asked client #6 to leave the room and as client #6 was leaving, client #6 slapped client #5 on the left side of his face. The HM (Home Manager) was called and instructed the staff to call the police. The police arrived and talked to client #6, telling her it was against the law to hit someone else and asked client #6 to apologize. The facility records indicated no investigative records in regard to the incident of 2/20/13. __BDDS report of 2/23/13 indicated on 2/22/13 at 5:30 PM "Today at supper [client #2] turned his plate of food over on the table. [Name of staff] took [client #2] to his bedroom. She put items on his bed to keep him off his bed and closed his bedroom door. She [the staff] told the			

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	other working staff something like, "we can't let him have his way." Saturday [name of staff] phoned the QMRP [Qualified Mental Retardation Professional] (this reporter) and stated that [client #2] appeared to be in a bad mood and was noncompliant. As we discussed what had occurred this morning, [name of staff] told of the incident at supper last night. Also, during a later conversation another staff, [name of staff] stated that last Saturday when [client #6] became aggressive towards a housemate [name of staff] had taken [client #6] to her room and that [name of staff] held [client #6's] door closed on at least 2 occasions not allowing [client #6] out of her room. The Residential Department Head was contacted who suspended [name of staff] until an investigation is completed. [Name of staff] also suspended until an investigation is completed." __The follow up BDDS report of 3/5/13 indicated the Residential Department Head investigated the incident of 2/22/13. The outcome from the investigation was that [name of staff] held [client #6's] door closed in an attempt to keep [client #6] from "hurting" someone else. As reported by staff. [client #6] was upset that the door was held closed but did calm down within a few minutes. Restricting [client			

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	#6] to her room is not part of HRC [Human Rights Committee] approved plan. [Name of staff] received a written warning and was retrained on 2/28 by the Residential Department Head on the JRDS (Jay Randolph Developmental Services) Individual Protection Plan." The report indicated the staff did restrict client #2 to his room and from lying on his bed. "They (the report did not indicate who they was) also reported that [name of staff] also called him [client #2] an "a-----" and confirmed that she said "we can't let him have his way." [Name of staff's] employment was terminated on 2/25. Restricting [client #2] from his room is not part of his HRC approved plan." __The follow up BDDS report of 3/15/13 indicated "...After numerous interviews were completed, there were no findings/reports of other incidents of this type of seclusion...." The facility investigative records indicated no staff/client interviews, record reviews, investigative results and/or actions taken in regard to the allegations of abuse in regard to clients #2 and #6. __Incident report of 3/3/13 at 8:30 PM indicated client #6 was sitting in the living room on the couch beside client #3. Client #6 was "staring at people and gazing at the television." Client #6 was			

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	asked not to stare, "...it wasn't nice. When she [client #6] reached over and smacked [client #3] on the arm." The facility investigative records indicated one written statement from staff #4. The investigative records indicated no staff/client interviews, record reviews, investigative results and/or actions taken in regard to the client to client abuse for clients #6 and #3. __BDDS report of 3/12/13 indicated on 3/9/13 client #6 was asked to slow her pace of eating down. Client #6 put her spoon down and "smacked" client #3 on his right arm. The facility investigative records indicated one written statement from staff #4. The investigative records indicated no staff/client interviews, record reviews, investigative results and/or actions taken in regard to the client to client abuse for clients #6 and #3. __BDDS report of 3/12/13 indicated on 3/11/13 while at the facility owned day program at 11:50 AM client #6 ran to the table client #1 was sitting at and hit client #1 on the right side of her face and in the back of the neck. The facility records indicated no investigation was conducted. __Incident report of 3/12/13 at 5:40 PM indicated "Staff had prompted her [client #6] to sit up straight in her chair and not			

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	to lean over her plate per her dietary management plan.... [Client #6] looked up at the staff, then hit the housemate [client #3] sitting next to her with her open hand. Staff asked [client #6] to stop, she then hit the housemate [client #3] again with her open hand before the staff could get between them. Staff asked [client #6] to leave the area, she then hit another housemate [client #5] with her open hand on the way out of the dining room...." The facility records indicated no investigation was conducted. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 4/4/13 at 3 PM indicated all allegations of abuse/mistreatment were to be thoroughly investigated. The QIDP indicated the RDH (Residential Department Head) conducted the facility investigations for the client to client abuse of 3/3/13 and 3/9/13 in regard to clients #3 and #6 and for the allegation of abuse made on 2/22/13 in regard to clients #2 and #6. The QIDP indicated the RDH had provided all of the facility investigative reports for review and the QIDP was unable to provide any additional documentation of investigative records. The QIDP indicated the facility investigative folder provided for review did not indicate staff/client interviews, records reviewed, investigative results			

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	and/or actions taken in regard to the investigative results. The QIDP indicated the results of the investigations were reported in the BDDS reports. 9-3-2(a)			

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W000210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, interview, and record review for 3 of 3 sampled clients (#1, #2 and #3) and 2 additional clients (#5 and #6), the facility failed to ensure the Interdisciplinary Team (IDT) assessed/re-assessed: __Client #3 in regard to the use of shoelaces and the client's ambulatory needs. __Clients #1, #2, #3, #5 and #6 for the need for a clothing protector. Findings include: 1. Observations were conducted at the group home on 4/2/13 between 3:30 PM and 6 PM. __At 4:20 PM client #1 walked through the living room with an orange shoe lace in her mouth. The HM verbally and physically prompted client #1 to give up the shoe lace and throw it in the trash. __At 4:22 PM client #3 was sitting in the dining room by the window, looking out the window and playing with a purple shoe lace. Client #3 was pulling the shoe lace through his hands and putting it in his mouth.	W000210	Now, and in the future, the Home Manager, LPN and QMRP will ensure all assessments are complete within 30 days after admission. All recommendations will be identified and addressed within 30 days. The IDT has re-evaluated each individual's need for a clothing protector and only those needing clothing protectors will wear them. * The QMRP and LPN will make random unannounced visits to ensure all plans are followed. The Dietician visits randomly and unannounced to ensure compliance.	05/12/2013

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	__At 5 PM client #3 had black, yellow and white shoe laces. The laces were tied together in a knot. Client #3 dropped the shoe laces on the floor in the kitchen, picked them up and put a portion of them in his mouth and then pulled them out. __At 5:15 PM a pair of red shoe laces was lying on the floor in the dining room. During the morning observation on 4/3/13 between 5:30 AM and 8:30 AM, client #3 carried around a black and white shoe lace. Client #3 was observed to drop the shoe laces on the floor and put them in his mouth twice during the observation. Interview with staff #1 and #2 on 4/2/13 at 6:15 AM indicated client #3 carried shoe laces and played with them. Staff #2 stated, "I think his mom gives them to him to play with." When asked where are they stored, staff #2 stated "I think he keeps them in the dining room," and staff #1 indicated she did not know where client #3 stored the shoe laces. When asked how are the shoelaces monitored and cleaned, staff #2 indicated she had seen some of the shoelaces on top of the washer and sometimes they would throw them in the wash with the other clothes if they saw them. Interview with the QIDP (Qualified Intellectual Disabilities Professional) and			

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	the RM (Residential Manager) on 4/4/13 at 3 PM indicated client #3 liked to play with shoelaces. The QIDP indicated the IDT had not assessed and/or reviewed the practice of client #3's having and/or "playing with" shoe laces in regard to the client's safety and health issues. 2. During observations at the group home on 4/2/13 between 3:30 PM and 6 PM and on 4/3/13 between 5:30 AM and 8:30 AM, clients #1, #2, #3, #5 and #6 wore clothing protectors over their clothes while eating their meals. Client #1's record was reviewed on 4/4/13 at 1 PM. Client #1's record did not indicate client #1 had been assessed for food spillage and the need to wear a clothing protector while dining. Client #2's record was reviewed on 4/3/13 at 12 PM. Client #2's record did not indicate client #2 had been assessed for food spillage and the need to wear a clothing protector while dining. Client #3's record was reviewed on 4/3/13 at 2 PM. Client #3's record did not indicate client #3 had been assessed for food spillage and the need to wear a clothing protector while dining. Client #5's record was reviewed on 4/4/13			

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	at 12 PM. Client #5's record did not indicate client #5 had been assessed for food spillage and the need to wear a clothing protector while dining. Client #6's record was reviewed on 4/4/13 at 12:15 PM. Client #6's record did not indicate client #6 had been assessed for food spillage and the need to wear a clothing protector while dining. During interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM, the RM indicated the clients wore clothing protectors to keep their clothes clean. When asked if the clients had been assessed for the need for the use of clothing protectors, the QIDP stated, "No, not that I'm aware of." The QIDP indicated clients #1, #2, #3, #5 and #6 had not been assessed for excessive food spillage and the need to wear a clothing protector while dining. 3. During observations at the group home on 4/2/13 between 3:30 PM and 6 PM and on 4/3/13 between 5:30 AM and 8:30 AM and at the facility owned DP (Day Program) on 4/3/13 between 11:15 AM and 11:45 AM, client #3 walked with an unsteady gait.			

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	Client #3's record was reviewed on 4/3/13 at 2 PM. Client #3's record indicated a diagnosis of, but not limited to, CP (Cerebral Palsy). Client #3's March 2013 Monthly/Quarterly Health Summary notes indicated client #3 "Has awkward gait with flexed knees bilat (bilateral)." Client #3's nursing note of 3/15/13 indicated "Observed [client #3] in the group home environment. [Client #3] ambulating unassisted with his flexed knee awkward gait." Client #3's ISP of 4/13/12 indicated client #3 was at risk for "falls, slips and trips: potentially, due to CP dx. (diagnosis)." Client #3's record indicated client #3 had a PT (Physical Therapy) evaluation on 12/30/08 with recommendations for client #3 to use the stairs when available, to incorporate walking often into his regular activities and to perform the provided exercises of seated hamstring stretch, seated stretch and heel cord stretches. Client #3's record indicated no further PT evaluations since 12/30/08. Interview with the facility LPN on 4/4/13 at 11 AM indicated client #3 had CP and was at risk for falls due to his uneven gait. The LPN indicated client #3's most current PT evaluation and/or ambulatory assessment was 12/30/08. 9-3-4(a)			

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W000220	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development. Based on observation, interview and record review for 3 of 3 sample clients (#1, #2 and #3), the facility failed to assess the clients in regard to their communication skills and/or needs. Findings include: During observations at the group home on 4/2/13 between 3:30 PM and 6 PM and on 4/3/13 between 5:30 AM and 8:30 AM, clients #1, #2 and #3 did not speak. Client #1's record was reviewed on 4/4/13 at 1 PM. Client #1's CFA (Comprehensive Functional Assessment) of 10/22/12 indicated client #1 vocalized, but was unable to speak in complete sentences and to maintain a conversation. Client #1's CFA indicated client #1 required verbal/physical intervention from the staff for all her communication needs. Client #1's ISP (Individual Support Plan) of 11/9/12 contained no information regarding functional speech/language skills. Client #2's record was reviewed on 4/3/13 at 12 PM. Client #2's CFA of 10/17/12 indicated client #2 did not maintain a	W000220	Now, and in the future, all residents will be assessed regarding communication skills/needs at least annually; upon entry into the group home, each client will be assessed regarding his/her communication skills/needs; his/her needs and programs will be determined by the speech therapist as well as the schedule for follow-up. Annual assessments will be conducted to determine needs. Implementation of recommendations will be addressed by the IDT. QMRP responsible for assessment. The Home Manager and DSP are responsible for providing programming as prescribed by the therapist.	05/12/2013

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	conversation and verbal/physical intervention was needed from the staff for all communication needs. Client #2's ISP of 11/9/12 contained no information regarding functional speech/language skills. Client #3's record was reviewed on 4/3/13 at 2 PM. Client #3's record indicated client #3 had a diagnosis of, but not limited to, Speech Impairment. Client #3's CFA of 3/12 indicated client #3 did not maintain a conversation and verbal/physical intervention was needed from the staff for all communication needs. Client #3's ISP of 4/13/12 contained no information regarding functional speech/language skills. Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM stated clients #1, #2 and #3 had not had speech/language evaluations to evaluate their communication needs "To my knowledge." During interview with the facility LPN on 4/4/13 at 11 AM, the LPN indicated clients #1 and #2 were non-verbal. The LPN indicated client #3 was verbal, but difficult to understand. The LPN indicated clients #1, #2 and #3 had not had speech/language evaluations to			

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	evaluate their communication needs. 9-3-4(a)			

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W000227	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 3 of 3 sampled clients (#1, #2 and #3), the ISPs (Individual Support Plans) failed to include objectives to address the clients' food preparation needs. Findings include: 1. Observations were conducted at the group home on 4/2/13 between 3:30 PM and 6 PM and on 4/3/13 between 5:30 AM and 8:30 AM. During both observations, clients #1, #2 and #3 were verbally and physically prompted by the staff to come to the kitchen and assist with the meal preparation. Client #1's record was reviewed on 4/4/13 at 1 PM. Client #1's CFA (Comprehensive Functional Assessment) of 10/2012 indicated client #1 required step by step cues with kitchen safety, to use a table knife, to make a sandwich, to prepare a simple dessert and/or snack. Client #1's ISP dated 11/9/12 indicated no objectives to assist client #1 with meal preparation.	W000227	Now, and in the future, all ISPs will include objective to address the clients' food preparation needs. New goals have been created for each client and address his/her functioning ability. Progress on each goal is monitored by the QMRP on the individual's program monthly summary. DSPs, Home Manager and QMRP responsible.	05/12/2013

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	Client #2's record was reviewed on 4/3/13 at 12 PM. Client #2's CFA (Comprehensive Functional Assessment) of 11/2012 indicated client #2 required step by step cues with kitchen safety, to use a table knife, to make a sandwich, to prepare a simple dessert and/or snack. Client #2's ISP dated 11/9/12 indicated no objectives to assist client #2 with meal preparation. Client #3's record was reviewed on 4/3/13 at 2 PM. Client #3's CFA (Comprehensive Functional Assessment) of 3/2012 indicated client #3 required step by step cues with kitchen safety, to use a table knife, to make a sandwich, to prepare a simple dessert and/or snack. Client #3's ISP dated 11/9/12 indicated no objectives to assist client #3 with meal preparation. Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM indicated clients #1, #2 and #3 were not independent in food preparation and required verbal and physical prompting from the staff. The QIDP indicated clients #1, #2 and #3 did not have any objectives in place to assist them with food preparation.			

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W000242	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 record review and interview for 2 of 3 sample clients (#2 and #3), the facility failed to ensure the clients' ISPs (Individual Support Plans) included the clients' identified training needs in regards to toilet training. Findings include: Observations were conducted at the group home on 4/3/13 between 5:30 AM and 8:30 AM. At 6:10 AM client #2 was sitting in the rocker in the living room. Staff #4 asked client #2, "Are you wet?" Staff #4 prompted client #2 to get up from the rocker and go to the bathroom to get cleaned up. Client #2's record was reviewed on 4/3/13 at 12 PM. Client #2's 2012/2013 Quarterly/Monthly Health Summary notes from the nurse indicated client #2 was incontinent of urine and wore an adult depends. Client #2's ISP of 11/9/12 did	W000242	Now, and in the future, all residents' individual needs will be assessed at least 20 days prior to an individual's Annual IPP meeting, where the needs will be prioritized. Goals and objectives will be developed and implemented to address an individual's identified needs, at least annually. Home Manager and QMRP responsible	05/12/2013

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	not indicate a toileting plan or any training objectives in place to assist client #2 with his toileting needs. Client #3's record was reviewed on 4/3/13 at 2 PM. Client #3's 2012/2013 Quarterly/Monthly Health Summary notes from the nurse indicated client #3 was incontinent of urine and "Wears depends 24/7." Client #3's ISP (Individualized Support Plan) of 4/13/12 did not indicate a toileting plan or any training objectives in place to assist client #3 with his toileting needs. Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM indicated clients #2 and #3 did not have a toileting plan or training objectives in place to assist the clients with their toileting needs. 9-3-4(a)			

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W000249	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 3 of 3 sampled clients (#1, #2 and #3) and 2 additional clients (#5 and #6), the facility failed: __To provide the clients' medication training during formal and informal training opportunities. __To offer client #1 an alternate activity when sucking her thumb. __To ensure the facility owned DP (Day Program) followed client #1's dining plan. Findings include: 1. During observations of the medication pass at the group home on 4/3/13 between 5:30 AM and 8:30 AM the following was observed: _____At 5:34 AM, staff #4 gave client #1 a Multi-Vitamin. _____At 5:37 AM staff #4 gave client #3 Doxycycline (an antibiotic) 100 mg (milligrams). _____At 5:42 AM, staff #4 gave client #6 a Multi-Vitamin and Levothyroxine (for	W000249	Now, and in the future, all clients will receive continuous active treatment programming consistent with his/her needs. All staff will be trained and retrained on providing medication training formally and informally; to follow the written guidelines addressing thumb sucking and to ensure Day Programming follows dining plans for all individuals. QMRP, specific program Lead Staff and DSPs responsible Routinely the Home Manager will monitor staffs' implementation of all training opportunities both formally and informally. The QMRP will monitor randomly/unannounced. Client #1 is offered alternate activities to replace thumb sucking. Results are monitored by staff. Day Program staff will be trained on individual dining plans as they are developed/changed to meet an individual's needs. Implementation will be monitored by random visits from both Dietician and Home Manager.	05/12/2013

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	hypothyroidism) 25 mcg (micrograms). _____At 5:45 AM, staff #4 gave client #2 a Multi-Vitamin and Levothyroxine 100 mcg. _____At 5:50 AM, staff #4 placed 30 ml (milliliters) of Sorbitol (for constipation) in a sippy cup with prune juice. Staff #4 took the sippy cup with the Sorbitol and prune juice to the dining room, handed it to client #3 and walked away from him. _____At 7:35 AM staff #1 gave client #1 Claritin (for allergy relief) 10 mg, Keppra (for seizures) 50 mg, Luvox (for depression). 100 mg, Vitamin E 400 mg and Zantac (an antacid) 150 mg. _____At 7:45 AM staff #1 gave client #3 Oyster shell supplement, Colace (a stool softener) 100mg, Detrol (for urinary incontinence related to an overactive bladder) 4 mg, Claritin 10 mg, Dulcolax (a laxative) 5 mg, and Depakote ER (for seizures) 500 mg. _____At 7:50 AM staff #1 gave client #5 Trileptal (for mood stabilization & seizures) 300 mg, Lamictal 600 mg and Bactrim (an antibiotic) 1/2 tablet. ____At 8 AM staff #1 gave client #6 Lamictal 100 mg, Trimpex (an antibiotic) 100 mg, Risperdal (an antipsychotic medication) 5 mg, Provera (a hormone) 10 mg, Zyrtec 10 mg and Nasonex 2 sprays in each nostril (for allergies) _____At 8:10 AM staff #1 gave client #2			

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	Colace 200 mg, Zyrtec 10 mg, Luvox 100 mg and Risperdal 1 mg. During the AM medication pass staff #4 prepared the medications and took them to the clients. Staff #1 and #4 did not offer the clients any training in regards to their medications. Client #1's record was reviewed on 4/4/13 at 1 PM. Client #1's ISP of 11/9/12 indicated after staff has prepared her medications, client #1 will take them. Client #2's record was reviewed on 4/3/13 at 12 PM. Client #2's ISP of 11/9/12 indicated client #2 had an objective when offered a choice of two medication cards, client #2 will correctly point to his Luvox card. Client #3's record was reviewed on 4/3/13 at 2 PM. Client #3's ISP of 4/13/12 indicated client #3 had an objective to locate the Sorbitol in the medication drawer. Client #5's record was reviewed on 4/4/13 at 2 PM. Client #3's ISP of 11/19/12 indicated client #3 had an objective to come to the medication site for his medications. Client #6's record was reviewed on 4/4/13			

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	at 1:30 PM. Client #6's ISP of 11/9/12 indicated client #3 had an objective to state the name of her Lexapro. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 4/4/13 at 3 PM indicated the staff were to offer the clients formal and informal medication training with every medication pass and at every opportunity available. 2. During observations at the group home on 4/2/13 between 3:30 PM and 6 PM and on 4/3/13 between 5:30 AM and 8:30 AM, client #1 was observed sucking her thumb throughout the observation. Staff observed client #1 sucking her thumb and did not redirect client #1 when sucking her thumb and/or hand her something to occupy her hands. Client #1's record was reviewed on 4/4/13 at 1 PM. Client #1's BSP (Behavior Support Plan) of 11/10/12 indicated "When she [client #1] is observed sucking her thumb, hand her something fun and appealing to hold or play with, so as to occupy her hands and reinforce than behavior." Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 4/4/13 at 3 PM indicated the staff were to implement client #1's BSP whenever			

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	client #1 was observed sucking her thumb. 3. Observations were conducted at the facility owned DP (Day Program) on 4/3/13 between 11:15 AM and 11:45 AM. Client #1 ate her meal with a short handled toddler spoon. The bolus of the spoon was as large as an adult teaspoon. Client #1 ate large bites of food and the staff did not prompt client #1 to put her spoon down between bites and/or to take a drink between bites. DP staff #1 was sitting beside client #1 when client #1 began eating. After a few minutes, DP staff #1 got up and left client #1. Client #1 began eating her food with her fingers until DP staff #1 returned and prompted client #1 to use her spoon. When asked if client #1 should be unattended while eating, DP staff #1 stated, "No." Client #1's record was reviewed on 4/4/13 at 1 PM. Client #1's Choking Management Plan of 11/2/12 indicated client #1 was to use a small spoon and was to put her spoon down between bites and take a drink. The plan indicated "Consider small presentation of food items as [client #1] is not compliant when 1:1 is not available. Cueing does not work well without 1:1." Interview with the QIDP (Qualified			

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	Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM indicated staff were to sit with client #1 whenever eating to ensure she did not choke and took appropriate size bites. 9-3-4(a)			

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W000250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to ensure the clients' active treatment schedules were individualized and failed to develop an active treatment schedule for client #6 for the days she stayed home from the facility owned DP (Day Program). Findings include: Client #1's, #2's, #3's, #4's, #5's and #6's daily ATSs (Active Treatment Schedules) were reviewed on 4/4/13 at 1:30 PM. Client #1's, #2's, #3's, #4's, #5's and #6's daily ATSs were identical with fixed daily regimens of activities. The ATS indicated Monday - Friday the clients were to: 6 AM - wake 7 AM - Breakfast 8 AM - Meds 9 AM - 4 PM Vocational Programming at the facility owned day program 4 PM - Meds 5 PM - Personal hygiene, toileting, dinner, goals, outside outings	W000250	Now, and in the future, an Active Treatment schedule will be developed and is be implemented by assigned staff that outlines the current individualized Active Treatment program for each resident. The implementation will be monitored by the Home Manager. Home Manager and DSPs responsible	05/12/2013

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	6 PM - bathing 7 PM - blank 8 PM - Meds 9 PM - Bed The ATS indicated Saturday and Sunday the clients were to: 6 AM - Sleep 7 AM - Breakfast 8 AM - Meds 9 AM - TV 10 AM - Goals 11 AM - TV/goals NOON - Lunch 1 PM - Clean up 2 PM - Leisure 3 PM - Blank 4 PM - Meds 5 PM - Afternoon choice 6 PM - Goals 7 PM - blank 8 PM - Meds 9 PM - Bed Interview with the DPS (Day Program Supervisor) on 4/4/13 at 12 PM indicated client #6 has had increased behaviors and due to the increase the IDT (Interdisciplinary Team) decided to let client #6 pick and choose when she wanted to go to the DP. The DPS indicated client #6 doesn't like the winter months and gets angry and will hit whoever is close by her. The DPS stated,			

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	"Lately she doesn't come much at all and if she does it is usually just for a half day or so." During interview with staff #6 on 4/4/13 at 1 PM, staff #6 indicated client #6 chose when she would go to the day program. When asked what did client #6 do on the days she chose not to go, staff #6 stated, "Watch TV, do chores, run errands with us if we have any." When asked if client #6 had a specific active treatment schedule to inform the staff of the training and activities client #6 was to be provided when staying at home and not going to the day program, staff #6 stated, "No, we just do whatever." Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM indicated active treatment schedules should be individualized for each client. The QIDP indicated due to an increase in aggressive behaviors the IDT decided client #6 could choose which days she wanted to go to the day program. The QIDP indicated client #6 did not have a specific active treatment schedule in place to include those days and/or time she did not go to the day program. 9-3-4(a)			

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W000289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on record review and interview for 1 of 2 sample clients requiring a BSP (Behavior Support Plan) (#2), the facility failed to incorporate proactive interventions to manage client #2's inappropriate behaviors of aggression and OCD (Obsessive Compulsive Disorder). Findings include: Client #2's record was reviewed on 4/3/13 at 12 PM. Client #2's BSP of 11/9/12 indicated client #2 had targeted behaviors of OCD behaviors "Such as: Repeating the same action over and over (attempting to put a coin in the pop machine), items placed in certain spots and extended lying on the bathroom floor." The BSP indicated physical aggression to include pinching, grabbing, kicking, hitting, throwing things and shoving. The BSP indicated previously used methods were verbal counseling and informal positive reinforcement "have been use (sic) to redirect the behavior." The BSP indicated "When [client #2] begins to become aggressive staff should reflect his feelings	W000289	Now, and in the future, all behavior programs will include pro-active strategies in accordance with identified behaviors. All behavior programs are reviewed, at least annually, by the Human Rights Committee and the IDT for effective content. QMRP, HRC and IDT responsible	05/12/2013

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	and encourage him to go to his room. If [client #2] refuses to go to another area, all interaction with him should stop until he has calmed down for a period of time. Once [client #2] has calmed down staff should praise [client #2] and encourage him to participate in activity. If [client #2] does not want to interact, staff should offer interaction at least every 15 minutes. When [client #2] is found lying on the bathroom floor staff will go to him and tell him it is time to get up off the floor. If he [client #2] refuses to get up staff should approach him at least every 15 minutes stating it is time to get up off the floor. Praise [client #2] when he is off the floor and encourage him to another room and sit in a chair." Client #2's BSP indicated no pro-active strategies for the staff in regard to client #2's identified behaviors. During interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) the QIDP was asked what pro-active strategies were the staff to use in regard to client #2's behaviors, the QIDP indicated client #2's BSP did not include pro-active strategies, only reactive strategies. 9-3-5(a)			

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W000312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 2 sampled clients receiving medications to control behaviors (#2), the facility failed to implement a plan of reduction the client could achieve to reduce and eventually eliminate the behaviors for which client #2 received psychoactive medications. Findings include: Client #2's record was reviewed on 4/3/13 at 12 PM. Client #2's 2012/2013 physician's orders indicated client #2 took Risperdal 2 mg (milligrams) a day for aggression and Luvox 200 mg a day for OCD (Obsessive Compulsive Disorder). Client #2's BSP (Behavior Support Plan) of 11/9/12 indicated client #2 had targeted behaviors of obsessive compulsive behaviors and physical aggression. Client #2's BSP indicated "If [client #2] shows 0 incidents of aggression or OCD in a 12 month period a decrease of one of the medications will be considered." Interview with the QIDP (Qualified	W000312	Now, and in the future, all residents' behavior plans will include reduction of targeted inappropriate behaviors in correlation to the planned reduction of the behaviorally-specific, psychoactive prescribed medication. Behavioral tracking will be documented by direct care staff, the Home Manager, and monitored monthly by the QMRP.	05/12/2013

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	Intellectual Disabilities Professional) on 4/4/13 at 3 PM stated client #2's criteria for reduction needed to be reviewed and revised as 0 behaviors for 12 months "might be a bit much to expect." 9-3-5(a)			

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W000315	483.450(e)(4)(i) DRUG USAGE Drugs used for control of inappropriate behavior must be monitored closely for desired responses and adverse consequences by facility staff. Based on record review and interview, the facility failed to provide evidence of preventive screening for EPS (extrapyramidal side effects - a group of side effects associated with the use of anti-psychotic medications including, but not limited to, restlessness and involuntary muscle movements) for 2 of 2 sampled clients (#1 and #2) who received psychotropic medications. Findings include: Client #1's record was reviewed on 4/4/13 at 1 PM. Client #1's 2013 physician's orders indicated client #1 was taking Risperdal 1 mg (milligram) and Luvox 200 mg a day for depression. Client #1's record did not indicate client #1 was being screened for EPS. Client #2's record was reviewed on 4/3/13 at 12 PM. Client #2's 2013 physician's orders indicated client #2 was taking Risperdal 2 mg a day for aggression and Luvox 200 mg a day for OCD behaviors. Client #2's record did not indicate client #2 was being screened for EPS.	W000315	Now, and in the future, the facility staff will use the attached AIMS Test at least annually or as needed to monitor for EPS. If any EPS is noted, a doctor will be contacted for an examination in regard to the symptoms. Staff will contact the nurse when a different behavior or unusual physical characteristic/reaction is observed. Staff are trained upon hire and at least annually to consult the MAR for listed side effects. Home Manager, QMRP, RN and Health Care Coordinator responsible.	05/12/2013

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	Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM indicated clients #1 and #2 had not been screened for EPS. 9-3-6(a)			

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W000323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 2 of 3 sampled clients (#2 and #3), the facility failed to ensure the clients' vision and hearing were evaluated annually. Findings include: Client #2's record was reviewed on 4/3/13 at 12 PM. Client #2's Appointment Form dated 9/29/11 from the optometrist indicated client #2 had "Compound Hyperopic Astigmatism OU (both eyes). Client #2's record indicated no hearing evaluation for review. Client #2's annual History and Physical Examination of 1/2/13 indicated no vision and/or hearing evaluation by the physician. Client #2's record indicated no vision and/or hearing evaluation for 2012. Client #3's record was reviewed on 4/3/13 at 2 PM. The record indicated the client's last hearing evaluation was conducted on 9/6/11. Client #3's Appointment Form of 11/18/12 indicated client #3 saw his medical doctor due to bleeding from both ears. The client was given a diagnosis of, but not limited to, bilateral otitis externa (ear infection both ears). Client #3's	W000323	Now, and in the future, to ensure that vision and hearing screenings are conducted at all client annual physical examinations the following will be done: Staff will be trained regarding an annual physical exam procedure including the responsibility of staff to ensure that the attending physician addresses all areas on the annual form and is aware of SDH regulations re hearing and vision screenings to be done annually. After the appointment the Home Manager and the LPN will review each annual physical form to ensure all areas have been addressed. The Home Manager, DSP, and LPN are responsible.	05/12/2013

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	record indicated no further hearing evaluation since 9/6/11. Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM indicated client #2's most current visual evaluation was 9/29/11. The QIDP indicated clients #2 and #3 had not had a hearing evaluation within the past year. 9-3-6(a)			

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility nursing services failed: __To ensure client #1 received physical therapy exercises as prescribed by the physician. __To ensure client #1's, #2's, #3's, #5's and #6's medications instructions on the clients' pill packs from the pharmacist, the MARs (Medication Administration Records) and the physician's orders were reconciled to indicate the same instructions for the clients' medications. __To ensure the staff thickened all of client #6's liquids. Findings include: 1. During observations at the group home on 4/2/13 between 3:30 PM and 6 PM and on 4/3/13 between 5:30 AM and 8:30 AM, client #1 ambulated with an uneven gait. Client #1's record was reviewed on 4/4/13 at 1 PM. Client #1's record indicated client #1 had a diagnosis of, but not limited to, Osteoporosis. Client #1's Monthly/Quarterly Heath Summary for March 2013 indicated client #1 "Walks with an uneven gait." Client #1's	W000331	Now, and in the future, nursing services will assess and monitor client specific medical needs. The IDT will determine need for necessary evaluations for ensuring all clients' medical needs are recognized and met. The Residential Nurse and Home Manager will reconcile each pill pack and MAR as new meds arrive and monthly to ensure all instructions are the same. Staff have been retrained on specific dietary orders. IDT and Residential Nurse responsible.	05/12/2013

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	Appointment Form of 8/27/12 indicated client #1 saw her physician for "Unsteady gait" and "Bruised frontal left knee." Client #1 received a diagnosis of, but not limited to, "Mild gait disturbance associated with behaviors." The form indicated physician's orders for physical therapy to include "generalized strengthening of bilateral lower extremities, quadriceps, gluteal muscles and calf muscles." The client's record indicated the physician's orders for physical therapy were not addressed. Interview with the facility LPN on 4/4/13 at 11 AM indicated she was not aware of orders for physical therapy in regards to client #1. During interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM, the RM stated she had taken client #1 to the appointment and client #1's physician told the RM client #1 would "more than likely" not cooperate with doing the exercises. The RM indicated the physician demonstrated the type of exercises the client should be doing. The RM indicated she was the one that made medical appointments for the clients in the group home and she did not schedule client #1 to go to physical therapy because			

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	of what the doctor had told her. 2. During observations of the medication pass at the group home on 4/3/13 between 5:30 AM and 8:30 AM the following was observed: _____At 5:34 AM, staff #4 placed a Multi-Vitamin in 30 ml (milliliters) of applesauce and approached client #1 in the living room and said, "Here, take this" and fed client #1 the applesauce with the medication in it. The medication package indicated client #1 was to take the Multi-Vitamin on an empty stomach and with lots of water. _____At 5:37 AM staff #4 placed a Doxycycline (an antibiotic) 100 mg (milligrams) in 30 ml of applesauce and walked to client #3's bedroom, woke client #3 and fed him the applesauce with the medication in it with a disposable plastic spoon. The medication package indicated client #3 was to take the Doxycycline on an empty stomach. _____At 5:42 AM, staff #4 placed a Multi-Vitamin and Levothyroxine (for hypothyroidism) 25 mcg (micrograms) in 30 ml of applesauce and walked to client #6's bedroom, woke client #6 by pulling back her covers and prompting her to sit up to take her medications. Client #6 sat up on the side of her bed, the staff handed her the medication cup with applesauce			

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	and medication and stated, "Here, take this." Client #6 proceeded to feed herself the applesauce/medication. The medication package indicated client #6 was to take the Multi-Vitamin on an empty stomach. _____At 5:45 AM, staff #4 placed a Multi-Vitamin and Levothyroxine 100 mcg in 30 ml of applesauce, walked to client #2 in the living room and said, "Here, take this" and fed client #2 the applesauce with the medication in it. The medication package indicated client #2 was to take the Multi-Vitamin and Levothyroxine on an empty stomach. _____At 7:35 AM, staff #1 gave client #1 the remainder of her AM medications in 30 ml of applesauce with a plastic disposable spoon. Client #1 fed herself the applesauce, taking large bites. _____At 7:45 AM, staff #1 gave client #3 the remainder of his AM medications in 30 ml of applesauce with a plastic disposable spoon. _____At 7:50 AM, staff #1 gave client #5 his AM medications in 30 ml of applesauce with a plastic disposable spoon. _____At 8 AM, staff #1 gave client #6 her AM medications with water. The water was not thickened. _____At 8:10 AM, staff #1 gave client #2 the remainder of his AM medications in 30 ml of applesauce with a plastic			

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	disposable spoon. Client #1's record was reviewed on 4/4/13 at 1 PM. Client #1's April 2012 MAR indicated client #1 was to take her Multi-Vitamin on an empty stomach, 1 hour prior to meals and/or 2 - 3 hours after a meal. Client #1's 2012/2013 Physician orders indicated no specific orders for client #2 to take her Multi-Vitamin with or without food. Client #1's Quarterly Nutritional Review of 1/7/13 indicated client #1 was to use a "small spoon" to decrease the size of bites she takes. Client #2's record was reviewed on 4/3/13 at 12 PM. Client #2's April 2012 MAR indicated client #2 was to take his Multi-Vitamin on an empty stomach, 1 hour prior to meals and/or 2 - 3 hours after a meal. Client #2's MAR indicated client #2 was to take his Levothyroxine on an empty stomach. Client #2's 2012/2013 Physician orders indicated no specific orders for client #2 to take his Multi-Vitamin and/or his Levothyroxine with or without food and/or on an empty stomach. Client #3's record was reviewed on 4/3/13 at 2 PM. Client #3's MAR indicated client #3 was to take his Doxycycline 2 hours before a meal or 2 hours after antacids,			

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	iron, vitamins and minerals. Client #3's 2012/2013 Physician orders indicated no orders for client #3 to take his Doxycycline 2 hours before a meal or 2 hours after antacids, iron, vitamins and minerals. Client #6's record was reviewed on 4/4/13 at 1 PM. Client #6's MAR indicated client #6 could take her Mult-Vitamin with or without food. Client #6's MAR indicated client #6 was to take the Levothyroxine on an empty stomach. Client #6's 2012/2013 Physician orders indicated no orders for client #6 to take her Mult-Vitamin with or without food and her Levothyroxine on an empty stomach. Client #6's Quarterly Nutritional Review of 1/7/13 indicated client #6 was to have all her liquids thickened to honey consistency. Interview with staff #1 and #2 on 4/4/13 at 8:15 AM indicated it was staffs' choice to give the clients their medications with applesauce. Staff #2 stated, "We just do because they are all on special diets so we just thought it would be better for them." Staff #1 indicated client #6's liquids should be thickened prior to her getting them. Interview with the facility LPN on 4/4/13 at 11 AM indicated the staff were to give			

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	the medications as ordered by the physician, as indicated on the MAR and as instructed by the pharmacist on the clients' individual pill packs. The LPN stated, "They should all be the same and I'm working on that." The LPN indicated the group home staff "should notify me" if there is a discrepancy in the physician's orders, the MAR and/or the directions on the label from the pharmacist. The LPN indicated staff were not to give the clients their medication in applesauce unless the nurse and/or physician instructs the staff to do so and it would be designated on the MAR if the client was to get their medications in applesauce. When asked how client #3 was to get his Sorbitol, the LPN indicated the staff were to pour the 30 ml of Sorbitol into a medication cup and give it to the client. The LPN indicated the staff were never to give a client medication and then walk away from the client. The LPN indicated the staff were to stay with the clients until they took their medications. The LPN indicated all of client #6's liquids were to be thickened to honey consistency. The LPN indicated that included liquids given at medication time. 9-3-6(a)			

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W000346	483.460(d)(4) NURSING STAFF If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse. Based on observation, interview and record review for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to ensure a registered nurse was available for verbal or onsite consultation to the facility LPN (Licensed Practical Nursing). Findings include: Client #1's record was reviewed on 4/4/13 at 1 PM. Client #1's record indicated client #1 had diagnoses of, but not limited to, Osteoporosis, Seizure Disorder and GERD. Client #2's record was reviewed on 4/3/13 at 12 PM. Client #1's record indicated client #1 had diagnoses of, but not limited to, Hypothyroidism, High Cholesterol and a history of constipation. Client #3's record was reviewed on 4/3/13 at 2 PM. Client #3's record indicated client #3 had a history of constipation and allergies.	W000346	Now, and in the future, JRDS will have a formal arrangement with a contracted Registered Nurse to be available for verbal and/or onsite consultation to the LPN/Healthcare Coordinator. Residential Department Head, Healthcare Coordinator responsible. Client needs and concerns will be addressed by the LPN with the RN on a monthly basis or as needed. Any recommendations by the RN will be considered by the IDT and acted upon accordingly.	05/07/2013

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	Interview with the facility LPN on 4/4/13 at 11 AM indicated she would go to the clients' home once a month to do the monthly assessments, but if clients #1, #2, #3, #4, #5 and #6 did not feel well, the RM (Resident Manager) would call the clients' doctor for instructions. When asked if the facility had a Registered Nurse available for oversight and/or consultation, the LPN stated "No, I have just always worked with the doctors." The LPN indicated the facility is in the process of looking for an RN to hire for consultation. 9-3-6(a)			

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W000369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, interview and record review, the facility failed to ensure all medications were administered without error for 7 of 33 doses administered for clients #1, #2, #3 and #6. Findings include: During observations of the medication pass at the group home on 4/3/13 between 5:30 AM and 8:30 AM the following was observed: _____At 5:34 AM, staff #4 gave client #1 a Multi-Vitamin in 30 ml (milliliters) of applesauce. The medication package indicated client #1 was to take the Multi-Vitamin on an empty stomach and with lots of water. _____At 5:37 AM staff #4 gave client #3 Doxycycline (an antibiotic) 100 mg (milligrams) in 30 ml of applesauce. The medication package indicated client #3 was to take the Doxycycline on an empty stomach. _____At 5:42 AM, staff #4 gave client #6 a Multi-Vitamin and Levothyroxine (for hypothyroidism) 25 mcg (micrograms) in 30 ml of applesauce. The medication	W000369	Now, and in the future, all drugs will be administered according to the doctor's order on the medication. Staff will be trained/retrained regarding the individual needs per client's medication administration. The LPN will randomly monitor each clients' medication administration in order to teach and ensure quality care for each client. Healthcare Coordinator, Home Manager and DSPs responsible	05/12/2013

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	package indicated client #6 was to take the Multi-Vitamin on an empty stomach. _____At 5:45 AM, staff #4 gave client #2 a Multi-Vitamin and Levothyroxine 100 mcg in 30 ml of applesauce. The medication package indicated client #2 was to take the Multi-Vitamin and Levothyroxine on an empty stomach. _____At 5:50 AM, staff #4 placed 30 ml of Sorbitol in a sippy cup with prune juice. When asked how much prune juice was in the sippy cup, staff #4 stated, "Probably about 6 ounces." Staff #4 took the sippy cup with the Sorbitol and prune juice to the dining room, handed it to client #3 and walked away from the client to continue the medication pass. Client #3 carried the sippy cup with prune juice with him until 6:50 AM when client #3 sat his sippy cup down on the dining room table and staff #2 picked it up and placed it in the kitchen sink to be washed. Staff #2 indicated the sippy cup was client #3's and he had not finished drinking the prune juice, there was still 1/3 of the prune juice/Sorbitol mixture in the sippy cup. Client #3 did not get all of his prescribed dose Sorbitol. Client #1's record was reviewed on 4/4/13 at 1 PM. Client #1's April 2012 MAR (Medication Administration Records) indicated client #1 was to take her Multi-Vitamin on an empty stomach, 1			

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	hour prior to meals and/or 2 - 3 hours after a meal. Client #1's 2012/2013 Physician orders indicated no specific orders for client #1 to take her Multi-Vitamin with or without food. Client #2's record was reviewed on 4/3/13 at 12 PM. Client #2's April 2012 MAR indicated client #2 was to take his Multi-Vitamin on an empty stomach, 1 hour prior to meals and/or 2 - 3 hours after a meal. Client #2's MAR indicated client #2 was to take his Levothyroxine on an empty stomach. Client #2's 2012/2013 Physician orders indicated no specific orders for client #2 to take his Multi-Vitamin and/or his Levothyroxine with or without food and/or on an empty stomach. Client #3's record was reviewed on 4/3/13 at 2 PM. Client #3's MAR indicated client #3 was to take his Doxycycline 2 hours before a meal or 2 hours after antacids, iron, vitamins and minerals. Client #3's 2012/2013 Physician orders indicated no orders for client #3 to take his Doxycycline 2 hours before a meal or 2 hours after antacids, iron, vitamins and minerals. Client #6's record was reviewed on 4/4/13 at 1 PM. Client #6's MAR indicated client #6 could take her Mult-Vitamin with or			

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	without food. Client #6's MAR indicated client #6 was to take the Levothyroxine on an empty stomach. Client #6's 2012/2013 Physician orders indicated no orders for client #6 to take her Mult-Vitamin with or without food and her Levothyroxine on an empty stomach. Interview with the facility LPN on 4/4/13 at 11 AM indicated the staff were to give the medications as ordered by the physician, as indicated on the MAR and as instructed by the pharmacist on the clients' individual pill packs. The LPN stated, "They should all be the same and I'm working on that." The LPN indicated the group home staff "should notify me" if there is a discrepancy in the physician's orders, the MAR and/or the directions on the label from the pharmacist. The LPN indicated staff were not to give the clients their medication in applesauce unless the nurse and/or physician instructs the staff to do so. When asked how client #3 was to get his Sorbitol, the LPN indicated the staff were to pour the 30 ml of Sorbitol into a medication cup and give it to the client. The LPN indicated the staff were never to give a client medication and then walk away from the client. The LPN indicated the staff were to stay with the clients until they took their medications. 9-3-6(a)			

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W000426	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. Based on observation and interview for 3 of 3 sampled clients (#1, #2 and #3) and 2 additional clients (#4 and #5), the facility failed to ensure the water temperatures within the group home did not exceed 110 degrees. Findings include: Observations were conducted at the group home on 4/3/13 between 5:30 AM and 8:30 AM. At 6:20 AM client #6 was washing her hands in the kitchen sink and stated, "Hot." The water temperature was tested in the kitchen sink and was found to be 116.5 degrees Fahrenheit. The water temperature was taken at 7:20 AM in the shower/bath and found to be 118.9 degrees Fahrenheit. The water temperature was taken at 7:25 AM in the tub/bath and found to be 119.7 degrees Fahrenheit. Interview with staff #2 on 4/3/13 at 6:30 AM indicated the staff did not monitor the water temperatures. Staff #2 indicated a maintenance person came in the home	W000426	Now, and in the future, the hot water temperature will be monitored on at least a monthly basis by the Home Manager and documented. The temperature is not to exceed 110 degrees Fahrenheit. The JRDS maintenance department will be called if temperatures are documented above 110 degrees Fahrenheit and need to be adjusted. Home Manager, Maintenance responsible	05/01/2013

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	and tested the water temperatures. Staff #2 stated, "The water has been hot lately." Staff #2 indicated clients #1, #2, #3, #4 and #5 could not adjust the water temperatures independently and required staff assistance. Staff #2 indicated client #6 could adjust her own water temperatures. Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM indicated clients #1, #2, #3, #4 and #5 could not adjust the water temperatures independently and required staff assistance. The HM indicated client #6 could adjust her own water temperatures. The QIDP indicated the water temperature was not to exceed 110 degrees Fahrenheit. 9-3-7(a)			

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W000436	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 1 of 3 sample clients (#3), the facility failed to ensure client #3 was provided with the recommended adaptive dining equipment. Findings include: Observations were conducted at the group home on 4/2/13 between 3:30 PM and 6 PM and on 4/3/13 between 5:30 AM and 8:30 AM, and at the facility owned DP (Day Program) on 4/3/13 between 11:15 AM and 11:45 AM. Client #3 used a long handled teaspoon to eat his morning and evening meals and used a disposable plastic spoon for his afternoon meal. Client #3 was not provided a non skid mat for his afternoon meal. Client #3 was not provided built up silverware while eating. Client #3's record was reviewed on 4/3/13 at 2 PM. Client #3's record indicated client #3 had a diagnosis of, but not limited to, Cerebral Palsy. Client #3's CFA (Comprehensive Functional Assessment) of 3/2012 indicated client #3	W000436	Now, and in the future, all clients will be assessed for the need for assistive devices. Devices will be provided in all settings and for each individual, as needed. QMRP, Home Manager responsible Upon entry into the group home, and as needed in the future, each client's needs will be assessed for the need of assistive devices by specialists. All recommendations will be followed as indicated by the specialists' assessments. Results of the assessments will be shared with the IDT and the implementation of said devices will be monitored by the QMRP, Home Manager, Day Program Supervisor and LPN.	05/12/2013

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	required verbal and physical cues from the staff to use regular eating utensils. Client #3's 2/4/13 Quarterly Nutritional Assessment indicated client #3 was to use built up silverware while eating. During interview with DP staff #1 on 4/3/13 at 11:30 AM, DP staff #1 stated client #3 "usually" used a long handled spoon "like a tea spoon" provided for him from the group home staff. DP staff #1 indicated she was not aware client #3 was to use built up silverware. Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM indicated client #3 was to be provided silverware with a built up handle. The RM indicated client #3 used a long handled spoon to eat his meals and was not aware client #3 was to have built up silverware. 9-3-7(a)			

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W000454	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 2 of 3 sampled clients (#1 and #3), the facility failed to monitor client #3's use of shoe laces. Findings include: Observations were conducted at the group home on 4/2/13 between 3:30 PM and 6 PM. __At 4:20 PM client #1 walked through the living room with an orange shoe lace in her mouth. The HM verbally and physically prompted client #1 to give up the shoe lace and throw it in the trash. __At 4:22 PM client #3 was sitting in the dining room by the window, looking out the window and playing with a purple shoe lace. Client #3 was pulling the shoe lace through his hands and putting it in his mouth. __At 5 PM client #3 had black, yellow and white shoe laces. The laces were tied together in a knot. Client #3 dropped the shoe laces on the floor in the kitchen, picked them up and put a portion of them in his mouth and then pulled them out. __At 5:15 PM a pair of red shoe laces was lying on the floor in the dining room.	W000454	Now, and in the future, all items in the home that are touched by clients with the potential of germ transmission will be monitored and a system for sanitizing and cleanliness will be in place and maintained. To ensure that clean sensory items are in use, a system to place soiled items out of reach, and soiled items replaced with clean items, is in place and is being monitored by all staff as well as the client. The staff and client have been trained on this procedure. Home Manager and DSP of home and day program responsible	05/12/2013

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	During the morning observation on 4/3/13 between 5:30 AM and 8:30 AM, client #3 carried around a black and white shoe lace. Client #3 was observed to drop the shoe laces on the floor and put them in his mouth twice during the observation. Interview with staff #1 and #2 on 4/2/13 at 6:15 AM indicated client #3 carried shoe laces and played with them. Staff #2 stated, "I think his mom gives them to him to play with." When asked where are they stored, staff #2 stated "I think he keeps them in the dining room," and staff #1 indicated she did not know where client #3 stored the shoe laces. When asked how are the shoelaces monitored and cleaned, staff #2 indicated she had seen some of the shoelaces on top of the washer and sometimes they would throw them in the wash with the other clothes if they saw them. Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM indicated client #1 would put things in her mouth she shouldn't. The RM indicated client #3 liked to play with shoelaces. The QIDP indicated the facility did not have a system in place to monitor and/or sanitize the shoe laces and/or to ensure the client's health in regards to the shoe laces.			

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W000484	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation, record review and interview for 3 of 3 sample clients (#1, #2 and #3) and 2 additional clients (#5 and #6), the facility failed to provide the clients the opportunity to use a knife to prepare their food. Findings include: Observations were conducted at the group home on 4/2/13 between 3:30 PM and 6 PM. The evening meal consisted of barbeque chicken, macaroni and cheese, cooked cabbage, baked apples and bread. Staff #1 cut up some of the food and placed it in the food processor to puree and then placed the pureed food in divided plates, one plate for client #3 and one plate for client #5. Staff #1 then began cutting up bread slices into cubes and placing the cubes into individual plastic high sided plates for clients #1, #2 and #6. Once all the food was dipped up and the plates were filled, clients #1, #2, #3, #5 and #6 were prompted to come to the kitchen to wash their hands and to pick up their plates. The HM (Home Manager) escorted clients #1 and #5 to the dining room with their plates. Clients	W000484	Now, and in the future, JRDS will equip areas with tables, chairs, eating utensils and dishes designed to meet the developmental needs of each client. Clients will be equipped with utensils that, based upon individual assessments, will meet their needs. Utensils have been purchased and training is in progress to enable staff to utilize the proper approach to meet the needs of each individual's plan. At least annually each client will be assessed to determine his/her developmental needs. Implementation will be monitored by the Home Manager, QMRP and Dietician.	05/12/2013

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	#1 and #5 sat down and immediately started eating. The HM returned to the kitchen to assist other clients to the dining room, leaving clients #1 and #5 unsupervised while they ate. Individually with staff assistance, each client washed their hands, picked up their plate, walked to the dining room and sat down and began eating their food. The staff stood behind them as they ate. Observations were conducted on 4/3/13 between 5:30 AM and 8:30 AM. The morning meal consisted of cooked cereal, cottage cheese, toast, milk, juice and coffee. Staff #1 cut up the toast and placed it in the food processor with the cooked cereal for clients #3 and #5. Staff #2 cut client #1's, #2's and #6's toast into cubes and placed the cubed toast into dishes. The clients were prompted to come to the kitchen, pick up their pre-filled plate and take it to the dining room. During both observations the clients did not assist in cutting their food. During both observations the clients were provided only spoons to eat their meals. During both observations, client #3 used a long handled spoon (an ice tea stirring spoon) to eat his meals. During interview with staff #2 on 4/3/13			

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	at 6:35 AM, staff #2 stated, "We don't let them (the clients) use sharp knives. I don't really trust any of them with a knife." During interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM, the RM stated the staff "usually" cuts the clients' food for them. The QIDP stated, "I never really thought about it. I guess they should be helping cut their food." 9-3-8(a)			

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W000488	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 and interview for 3 of 3 sample clients (#1, #2 and #3) and 2 additional clients (#5 and #6), the facility failed to provide the clients training in family style dining. Findings include: Observations were conducted at the group home on 4/2/13 between 3:30 PM and 6 PM. The evening meal consisted of barbeque chicken, macaroni and cheese, cooked cabbage, baked apple and bread. Once the food was prepared, staff #1 pureed the food and placed each item into plastic high sided divided plates, one for client #3 and one for client #5. Staff #1 then began cutting up bread slices into cubes and placing the cubes into individual plastic high sided plates for clients #1, #2 and #6. Staff #2 placed a serving of food into the divided dishes and began setting out glasses and filling them with liquids. Once all the food was dipped up and the plates were filled, clients #1, #2, #3, #5 and #6 were prompted to come to the kitchen to wash their hands and to pick up their plates. The HM (Home Manager) escorted clients #1 and #5 to the dining room with	W000488	Now, and in the future, each client will eat in a manner consistent with his or her developmental level per the functional assessment. A staff training re individual developmental levels and needs will be conducted. If appropriate, eating programs will be implemented in accordance with an individual's needs and family style dining will be implemented. Goals have been created and are being implemented for each individual to teach the expectations of that person for effective family style dining. Progress for each goal will be monitored on the individual's monthly summary. Modifications will be made as needed. Home Manager, DSP and QMRP responsible. The Dietician will randomly monitor techniques.	05/12/2013

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	their plates. Clients #1 and #5 sat down and immediately started eating. The HM returned to the kitchen to assist other clients to the dining room, leaving clients #1 and #5 unsupervised while they ate. Individually with staff assistance, each client washed their hands, picked up their plate, walked to the dining room and sat down and began eating their food. The staff stood behind them as they ate. Observations were conducted on 4/3/13 between 5:30 AM and 8:30 AM. The morning meal consisted of cooked cereal, cottage cheese, toast, milk, juice and coffee. Staff #1 pureed client #3's and #5's food and placed it into a divided plate. Client #1's, #2's and #6's food was also prepared and dipped into the dishes. Staff #2 filled the glasses and placed them on the dining room table for the clients. Clients were prompted to come to the kitchen to wash their hands. and to pick up their pre-filled plates and take it to the dining room. During both observations the staff did not provide the clients with training in regard to family style dining. Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 4/4/13 at 3 PM stated what was seen in			

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	observation was how the clients "usually" had their meals. The HM indicated food was not brought to the table and the clients did not assist and/or serve themselves, the plates were filled in the kitchen and the clients carried their plates to the dining room with assistance from the staff. The QIDP indicated the clients were to be provided training in regard to family style dining. 9-3-8(a)			