Compliance Summary Report

Compliance Summary Report of **ICF/ID Review Tool 2/28/14** on **Trans Health Care, Inc.**

Reviewer: ***Anne Oconnell-Null***
Provider: ***Trans Health Care, Inc.***
County Name: ***Richland County***

Total Cites: ***23***
Total POCs: ***23***

CITE #1

Question	Explanation	
Were there rights restrictions or aversives in place which were not addressed in the IP?	The ICF/DD did not ensure that aversive interventions/behavior support methods were being employed with sufficient safeguards and in a safe manner. The behavioral assessment for ID #2 indicates “no hands on”. Nursing notes and staff interviews verify that physical holds, escorts, and in room time out are utilized.	
POC	**Status**	**Comments**
Action: ID #2 - The IP and BSP for individual #2 have been revised and the use of physical intervention has been eliminated from the plan. The facility has revised its Behavior Support Policies and Practices to ensure resident health and welfare. Facility staff have been trained on this policy. On 3/11-12/14 staff received training in Crisis Prevention/Intervention provided by the County Board of DD. New employees are to attend the Crisis Intervention training offered by the County Board of DD. All employees will receive annual crisis prevention/intervention training.Completion Timeline: 4/11/14 Responsible Person: Carrie Kegley is to ensure that behavior support methods are being utilized with sufficient safeguards and in a safe manner. Carrie Kegley or Designee will audit IPs and nursing notes monthly for six months and then randomly to ensure that behavior support methods are being utilized with sufficient safeguards and in a safe manner.	Approved	

CITE #2

Question	Explanation	
Was the IP revised based on the changes in the individuals needs/wants?	ID #5 was due to be seen by her dentist on 6/12/13 but refused treatment at that time. Her dentist ordered a 90 Day follow up for “scaling” and a 180 day follow up for “prophy”. No evidence was noted at the time of review that these follow up recommendations were implemented.	
POC	**Status**	**Comments**
Action: ID #5 – The dental exam was rescheduled for 2/21/14. Recommendations from that examination have been followed. Additionally an IHP addendum has been completed with guardian approval/consent which addresses this individual’s choice to refuse recommended care. Other Individuals dental exam appointment schedules were reviewed on 2/21/14 and found to be in compliance. Refusal of dental exams will be addressed in the IHP with guardian approval/consent.Completion Timeline: 4/11/14 Responsible Person: Janet Husty has a Health Tracking Sheet and a tickler sheet that tracks and identifies all appointments to ensure Individuals receive dental care and medical appointments. Carrie Kegley is to ensure refusal is addressed in the IHP. Carrie Kegley or Designee will audit the dental schedule monthly for six months and then randomly to ensure Individuals receive dental care and refusal is addressed in the IHP.	Approved	

CITE #3

Question	Explanation
Upon identification of an unusual incident, is there evidences that the provider took the following immediate actions as appropriate:- Report was made to the designated person-Report was made within 24 hours of the incident-Appropriate actions were taken to protect the health and safety of the at-risk individual	The ICF/DD did not ensure that a UI report was made within 24 hours. The unusual incident system did not provide evidence that the ICF took appropriate actions to ensure health and safety (December 2013 unusual incidents # 58, 62, 64 and 71). Many of the incident reports lack detail about what occurred in Peer to Peer Physical Acts and there is no clarification sought during the investigation. While the facility did ensure that individuals were assessed by Nursing staff, it did not indicate that anything was done to ensure that individuals were further protected from injury. There were multiple incidents of Peer to Peer Physical Acts were an individual kicked his peers in the stomach and yet the reports did not address how safety would be ensured for all those at risk. Several individuals had bruises of unknown origin and there was no indication that the individual was asked about this or that staff were interviewed to see if there could be an explanation for bruising.

POC	Status	Comments
Action: The QIDP previously responsible for oversight of this system is no longer employed by the facility as of 1/14/2014. Interim staff are in place with Administrative and Corporate oversight. The facility UI reporting system has been revised to include daily monitoring of the nursing notes by the Janet Husty or Carrie Kegley. Staff have been trained in these practices. Completion Timeline: 4/11/14 Responsible Person: Carrie Kegley and Leslie Archibald are to ensure UI reports are made within 24 hours and that they provide evidence to ensure health and safety of the at-risk Individual. Linda Lamson or Designee will audit UI reports for six months and then randomly to ensure the reports are made within 24 hours and that they provide evidence to ensure health and safety of the at-risk Individual.	Approved	

CITE #4

Question	Explanation
Is there evidence that a prevention plan was identified, that the prevention plan addressed the causes and contributing factors identified in the investigation and that the individual's IP was revised if necessary?	The prevention plan did not address the causes and contributing factors identified during the investigation. The prevention plans do not address the causes and contributing factors to the MUIs nor were there any indication that the IP's were revised as necessary to include this information. The causes and contributing factors were often a restatement of the incident. Causes and contributing factors should attempt to identify the primary cause (s) of incident (I.e. supervision was not provided, adaptive equipment was not available, control issues with staff, environmental issues, individual had verbal altercation with peer at work, etc.). Many of the prevention plans indicated that the individual would be monitored or redirected by staff, which would appear not to be effective because similar incidents kept occurring. Additionally, the ICF's system does not show that prevention plans are being implemented (2013-070-0203). The cause and contributing factors should address supervision levels, behaviors, peer interactions, and any other relevant criteria to help determine the best plan to prevent re-occurrence.n.

POC	Status	Comments
Action: Linda Lamson has taken over the revisions to the MUI/UIR policies and practices. The QIDP previously responsible for oversight of this system is no longer employed by the facility as of 1/14/2014. Interim staff are in place with Administrative and Corporate oversight. The new practice has been in place as of 1/14/14. Completion Timeline: 4/11/14 Responsible Person: Carrie Kegley is to develop a prevention plan for each MUI that addresses the causes and contributing factors identified in the investigation and then revise the Individual's IP if necessary. Linda Lamson or Designee will audit MUIs and IHPs for six months and then randomly to ensure a prevention plan is developed that addresses the causes and contributing factors identified in the investigation and that the Individual's IHP is revised if necessary.	Approved	

CITE #5

Question	Explanation	
Is the plan being implemented as written?	The Provider failed to implement the Individual plans as required. The IP for ID #3 indicates that staff need to accompany him to ensure that the pop is thickened. Direct Care Staff and the QDDP indicate that he obtains his pop from the vending machine without staff present.	
POC	**Status**	**Comments**
Action: ID #3 - Assessed on 2/19/14 regarding the implementation of thickened liquids, specifically carbonated beverages. Those recommendations have been incorporated into the IHP and implemented after guardian consent was obtained.Completion Timeline: 4/11/14 Responsible Person: Carrie Kegley is to ensure Individuals' plans are implemented as written. This will be accomplished by direct observation by supervisory staff. Linda Lamson or Designee will audit IPs and CFAs monthly for six months and then randomly to ensure Individuals' plans are implemented as written.	Approved	

CITE #6

Question	Explanation	
If the service plan includes assistance with money management, are the individuals' funds being managed as indicated in the plan?-Bill paying-Banking-Shopping	The ICF/DD did not provide assistance with money management as indicated in the IP. The savings accounts of IDs #1 and #2 are routinely accessed and managed by the individuals. These accounts are not monitored with the use of a ledger and are not consistently verified with receipts. ID #1 can manage up to $20.00 independently per IP, and the balance of this account at the end of Dec 2013 was $107.44. ID #2 can manage up to $5.00 independently per IP,and the balance at the end of Dec 2013 was $244.23.Additionally, ID #5 is routinely given cash withdrawals from her resident funds account in amounts that exceed the $5.00 that she can carry independently per IP. In example:11/4/13 $10, 11/22/13 $10, 12/21/13 $10.17, 1/23/14 $7.25, 1/30/14 $30.	
POC	**Status**	**Comments**
Action: ID #1 – IHP and CFA revised to reflect cash handling for bill paying, banking and shopping. Action: ID #2 – IHP and CFA revised to reflect cash handling for bill paying, banking and shopping.Action: ID #5 – IHP and CFA revised to reflect cash handling for bill paying, banking and shopping.Revisions to the Individual's IHP including assessments to the CFA will reflect the differing levels of need for consumers in regards to handling cash and completing banking transactions.Completion Timeline: 4/11/14 Responsible Person: Carrie Kegley is to ensure Individual's IHP and CFA are revised to accurately reflect cash handling for bill paying, banking and shopping. Linda Lamson or Designee will audit IPs and CFAs monthly for six months and then randomly to ensure Individual's IHP and CFA are revised to accurately reflect cash handling for bill paying, banking and shopping.	Approved	

CITE #7

Question	Explanation	
If the IP includes aversive interventions, are the interventions being implemented only when the identified behaviors are destructive to the individual or others?	The ICF/DD did not ensure that aversive interventions were being implemented only when behaviors are destructive to self or others. The behavior support plan for ID #2 identifies the use of a physical intervention for sexual behavior, a behavior was not defined within the plan to be destructive to the individual or others.	
POC	**Status**	**Comments**
Action: ID #2 - The IP and BSP for individual #2 have been revised and the use of physical intervention has been eliminated from the plan. The facility additionally has re-written the Behavior Support policies to ensure that aversive interventions are implemented only when behaviors are of risk of physical harm to self or others. Facility staff have been trained on this policy. On 3/11-12/14 staff received training in Crisis Prevention/Intervention provided by the County Board of DD. New employees are to attend the Crisis Intervention training offered by the County Board of DD. All employees will receive annual crisis prevention/intervention training.Completion Timeline: 4/11/14 Responsible Person: Carrie Kegley is to ensure aversive interventions are implemented only when behaviors are of risk of physical harm to self or others. Linda Lamson or Designee will audit IPs and BSPs monthly for six months and then randomly to ensure aversive interventions are implemented only when behaviors are of risk of physical harm to self or others.	Approved	

CITE #8

Question	Explanation	
If the IP includes aversive interventions (including rights restrictions), was informed consent obtained prior to implementation?	The ICF/DD did not ensure that the individual/guardian gave consent to the IP prior to implementation. The informed consent for ID #5's formal BSP (initiated 2/3/14) was signed by her guardian on 2/4/14. Additionally, the consent did not address the risks, benefits, alternatives, or consequences specific to the use of Trileptal 900mg BID for "anger outbursts".	
POC	**Status**	**Comments**
Action: ID #5 – The informed consent was revised and includes the risks, benefits, alternatives or consequences to the use of Trileptal. HRC approval obtained 3/17/14 and guardian consent obtained prior to implementation. The facility has revised BSPs and Informed Consent forms for all Individuals to include the risks, benefits, alternatives or consequences to the use of specific medications prescribed for behavior purposes. This was completed by 3/27/14.Completion Timeline: 4/11/14 Responsible Person: Carrie Kegley is to ensure IPs are implemented only after guardian informed consent is obtained. Linda Lamson or Designee will audit IPs monthly for six months and then randomly to ensure IPs are implemented only after guardian informed consent is obtained.	Approved	

CITE #9

Question	Explanation	
If the individual(s) being served are unable to self-medicate, was a self-medication assessment completed?	The ICF/DD did not complete the self medication assessment in it's entirety. The self-medication assessments for ID's #1, #2, #3, #4, & #5 are silent as to results because the last two questions of the assessment were not completed.	
POC	**Status**	**Comments**
Action: ID's 31, #2, #3, #4, #5 – Individuals' self-administration of medication assessments have been reviewed by Deb Ditmyer. The final statement on the assessment has been accurately completed. All Individuals' self-administration of medication assessments were reviewed by Deb Ditmyer. She has assured that the final statement on the assessment has been accurately completed. Additionally Carrie Kegley has assured that these are coordinated with the day program provider. Completion Timeline: 4/11/14 Responsible Person: Janet Husty is to ensure Individuals' self-administration of medication assessments are complete. Linda Lamson or Designee will audit self-administration of medication assessments monthly for six months and then randomly to ensure they are complete.	Approved	

CITE #10

Question	Explanation	
During the review, was there evidence of any unreported incidents that should have been reported as either an Unusual Incident or a Major Unusual Incident?	The ICF/DD did not evidence that all Major Unusual Incidents, and unusual incidents were reported. A review of MUI and UI records found that there were multiple allegations of Peer to Peer Physical Acts, Unapproved Behavior Supports and potential neglect that should have been reported. For example incidents on 1/8, 1/9, 1/15, and 1/20/14, mention physical interventions, such as escorts and holds that are not in approved plans. Three interventions for ID #2 should have been reported as MUI's. There is no mention that the individual has a plan for aversive hands on intervention or that it was properly utilized. The incidents on 1/8, 1/9, and 1/20/14 did not have a completed UI form.	
POC	**Status**	**Comments**
Action: ID #2 - The IP and BSP for individual #2 have been revised and the use of physical intervention has been eliminated from the plan. The facility has reviewed the noted incidents and assured appropriate reporting has occurred. The facility MUI policy and reporting system has been revised to maintain regulatory compliance. Staff have been trained in these practices.Completion Timeline: 4/11/14 Responsible Person: Carrie Kegley is to ensure appropriate MUI and UI reporting has occurred. Linda Lamson or Designee will audit MUIs and UIRs monthly for six months and then randomly to ensure appropriate reporting has occurred.	Approved	

CITE #11

Question	Explanation	
Does the plan address the individual's assessed needs in the area of vocational/day programming?	The IP did not address vocational/day programming needs. The individual has unassessed needs in the area of vocational/day programming. ID #3's daily schedule includes day programming at a vocational workshop. He often refuses to go, he is 80 years old and has not been given the opportunity to choose retirement instead of daily refusals.	
POC	**Status**	**Comments**
Action: ID #3 - A special team meeting was held to establish choices for vocational/day programming activities. These have been incorporated into the IHP and Active Treatment plan with guardian consent/approval. A section was added to the CFA to address the vocational/day programming needs for individuals. Completion Timeline: 4/11/14 Responsible Person: Carrie Kegley is to ensure Individuals are given the choice to retire. Linda Lamson or Designee will audit IHPs and CFAs monthly for six months and then randomly to ensure Individuals are given the choice to retire.	Approved	

CITE #12

Question	Explanation	
Does the plan address the individual's assessed needs in the area of personal care?	The IP did not address personal care needs. The individual has unassessed needs in the area of personal care. ID #5 expressed during the individual interview that she does not have access to a stylist (at the facility or in the community) she can trust with her hair texture and cannot complete these tasks herself. The individual's IP is silent on her hair washing and styling needs. She currently wears a wig over her natural hair.	
POC	**Status**	**Comments**
Action: ID #5 - The CFA, (dated 1-18-14) was reviewed and it does include and reflect an accurate assessment of her abilities and needs in the area of hair care. It is additionally noted in the CFA and IP that individual #5 does embellish comments and seeks attention through making false statements. It has been the individual's choice to wear the wig and she requested that the facility stylist cut her hair short for comfort while wearing the wig. This information was available at the time of survey. It is further assured that she does have access to the stylist of her choice and she has been provided with additional hair products. The in-house stylist is available for appointment on Fridays. Individual #5 may schedule an appointment with the in-house stylist or ask Carrie Kegley to help with the appointment. For other Individuals, the CFA will be reviewed for accuracy regarding hair care needs. Completion Timeline: 4/11/14 Responsible Person: Carrie Kegley is to ensure accurate assessments are completed in the area of hair care. Linda Lamson or Designee will audit CFAs monthly for six months and then randomly to ensure hair care assessments are accurate.	Approved	

CITE #13

Question	Explanation	
Does the IP address the individual's assessed needs in the area of supervision?	The provider failed to have documented evidence that the IP's addressed the individuals needs in the area of supervision. ID #3's IP identifies a supervision level of every two hour checks in the facility, which contradicts his oral intake supervision needs as identified in physician orders and reconfirmed by a speech therapist on 1/29/14. ID # 6's IP indicated " Home staff will make routine attempts to engage in active treatment and daily activities and rotate attention when he is involved in group activities. He must be accompanied by family, home staff, or approved personnel/staff when in the community." This does not make supervision clear for staff.	
POC	**Status**	**Comments**
Action: ID #3 – Supervision levels were reviewed 3/18/14 and approved by the HRC. Action: ID #6 – Supervision levels were reviewed 3/17/14 and approved by the HRC. The facility has established individualized supervision levels for all Individuals which clearly identify required supervision per Individual. These have been reviewed and approved by the HRC and written guardian consent has been obtained. Staff received training on updated supervision levels on 3/24/14. Supervision levels are available to all staff. Completion Timeline: 4/11/14 Responsible Person: Carrie Kegley is to ensure individualized supervision levels for all Individuals clearly identify required supervision. Linda Lamson or Designee will audit CFAs monthly for six months and then randomly to ensure to ensure individualized supervision levels for all Individuals clearly identify required supervision.	Approved	

CITE #14

Question	Explanation	
Does the ICF/ID maintain receipts as required by the individual's IP?	The ICF/DD did not maintain receipts for all purchases as required by the IP. Not all ledger line items could be verified with receipt. Examples:ID #2: Ledger indicates 12/2/13 $30 spent at "Walmart". ID #5: Ledger indicates 1/30/14 $30 spent on "shopping/outing", 11/22/13 $10 spent on "check withdrawal RNI"Receipts did not verify these withdrawal amounts. IDs #2 and #5 have both been assessed as being able to independently carry and manage $5.	
POC	**Status**	**Comments**
Action: ID #2 – The facility has reviewed the ledger expenses noted.Action: ID #5 – The facility has reviewed the ledger expenses noted.Additionally the facility has established a receipting process and form which will identify the specific expenditures made. Individuals' CFAs have been reviewed by the team to assure that they accurately reflect the dollar amount which each individual is able to manage independently. Completion Timeline: 4/11/14 Responsible Person: Traci Selmon to ensure ledger line items are verified with a receipt. Linda Lamson or Designee will audit CFAs monthly for six months and then randomly to ensure ledger line items are verified with a receipt.	Approved	

CITE #15

Question	Explanation	
Does the ICF/ID ensure that the account transaction records/ledgers include Individual or staff signatures for withdrawals?	The ICF/DD did not include signatures for staff or individuals on the transaction ledger for withdrawals. The provider was not able to evidence account ledgers for ID #1 and #2's savings accounts. While the provider did have a bank-printed balance book for these accounts, there were no signatures to accompany withdrawals.	
POC	**Status**	**Comments**
Action: ID #1 – Bank withdrawal slips will be signed by the Individual and staff member assisting during banking transactions.Action: ID #2 - Bank withdrawal slips will be signed by the Individual and staff member assisting during banking transactions.The facility has established the practice for the individual and staff member assisting during banking transactions to both sign withdrawal slips which are then maintained on the resident's behalf along with the bank printed balance book.Completion Timeline: 4/11/14 Responsible Person: Traci Selmon is to ensure Individuals and staff both sign withdrawal slips. Linda Lamson or Designee will audit monthly for six months and then randomly to ensure Individuals and staff both sign withdrawal slips.	Approved	

CITE #16

Question	Explanation	
Does the ICF/ID ensure that the account transaction records/ledgers include Individual or staff signatures for deposits?	The ICF/DD did not include signatures for staff or individuals on the transaction ledgers for deposits. The provider was not able to evidence account ledgers for ID #1 and #2's savings accounts. While the provider did have a bank-printed balance book for these accounts, there were no signatures to accompany deposits.	
POC	**Status**	**Comments**
Action: ID #1 - Bank deposit slips will be signed by the Individual and staff member assisting during banking transactions.Action: ID #2 - Bank deposit slips will be signed by the Individual and staff member assisting during banking transactions.The facility has established the practice for the individual and staff member assisting during banking transactions to both sign deposit slips which are then maintained on the resident's behalf along with the bank printed balance book.Completion Timeline: 4/11/14 Responsible Person: Traci Selmon is to ensure Individuals and staff both sign deposit slips. Linda Lamson or Designee will audit monthly for six months and then randomly to ensure Individuals and staff both sign deposit slips.	Approved	

CITE #17

Question	Explanation	
Does the ICF/ID ensure that the account transaction records/ledgers include Descriptions for each withdrawal and deposit?	The ICF/DD did not include descriptions of the withdrawals and deposits on the account transaction ledger. The provider was not able to evidence account ledgers for ID #1 and #2's savings accounts. While the provider did have a bank-printed balance book for these accounts, there were no descriptions to accompany each deposit/withdrawal.Additionally, the account ledger for ID #5 did not consistently include descriptions of withdrawals. In example:On 11/04/13 $10 spent on "cash w/d".	
POC	**Status**	**Comments**
Action: ID #1 – Account transaction records/ledgers include descriptions for each withdrawal and deposit.Action: ID #2 – Account transaction records/ledgers include descriptions for each withdrawal and deposit.The practice regarding private bank accounts for residents have been revised to include the practice of providing descriptions of withdrawals and deposits and the facility will maintain an account ledger for these accounts along with the bank printed balance book.Completion Timeline: 4/11/14 Responsible Person: Traci Selmon is to ensure account transaction records/ledgers include descriptions for each withdrawal and deposit.Linda Lamson or Designee will audit monthly for six months and then randomly to ensure account transaction records/ledgers include descriptions for each withdrawal and deposit.	Approved	

CITE #18

Question	Explanation	
Does the ICF/ID ensure that cash accounts, savings accounts, and checking accounts are reconciled at least every 60 days by someone who does NOT handle the individual funds?	The ICF/DD did not ensure that each type of account was reconciled. The provider was not able to evidence that reconciliations had been completed of ID #1 and #2's savings accounts.	
POC	**Status**	**Comments**
Action: ID #1 – The savings account was reconciled on 2/6/14.Action: ID #2 – The savings account was reconciled on 2/6/14.The facility has established practices to enable the reconciliation of all resident accounts and cash records. Cash records for routine expenditures by and for Individuals are reconciled every 60 days by a facility staff member not involved in handling the finances. Individual bank accounts held in individuals' names are reconciled by the bank and reviewed as part of the facility reconciliation on the resident fund account. The facility resident fund account is reconciled and signed at least every 60 days by the off-site corporate billing specialist who does not manage resident funds on site. Completion Timeline: 4/11/14 Responsible Person: Traci Selmon to ensure the reconciliation of all resident accounts and cash records at least every 60 days. Linda Lamson or Designee will audit monthly for six months and then randomly to ensure the reconciliation of all individuals' accounts and cash records.	Approved	

CITE #19

Question	Explanation	
Does the facility policy address the following: 1) use of time-out rooms, 2) use of physical restraints, 3) use of drugs to manage behaviors, 4) application of painful or noxious stimuli, 5) the staff members who may authorize the use of interventions, and 6) a system for monitoring the use of interventions?	The provider failed to have a behavior support policy that addressed the following: 1) use of time-out rooms, 2) use of physical restraints, 3) use of drugs to manage behavior, 4) application of painful or noxious stimuli, 5) the staff members who may authorize teh use of interventions, and 6) a system for monitoring the use of interventions. The policy does not include information about what staff members are authorized to use interventions, what the monitoring system for interventions is, or information on physical interventions. Changes were made to the policy on the date of review to remove any physical restraints from the policy. However, staff implement restraints and ID #2 has restraint written into his plan. The provider shall assure consistency between the policy and what actually occurs at the facility.	
POC	**Status**	**Comments**
Action: ID #2 - The IP and BSP for individual #2 have been revised and the use of physical intervention has been eliminated from the plan.The Behavior Support policy does now include facility practice related to time-out, use of physical restraints, use of drugs to manage behavior, application of painful or noxious stimuli, staff that may authorize the use of interventions and a system for monitoring those interventions. As noted above, the staff have been trained in this policy and it has been shared with appropriate parties.Completion Timeline: 4/11/14 Responsible Person: Carrie Kegley is to ensure policies and procedures are followed in practice. Linda Lamson is to ensure policies and procedures follow current regulation and facility practice.	Approved	

CITE #20

Question	Explanation	
Did the ICF/ID maintain a log of unusual incidents which includes:-Name of individual-Description of incident-Identification of injuries-Time/date of incident-Location of incident-Preventative measures	Theprovider failed to maintain a log of unusual incidents which included the required items. The facility was utilizing a form that contained the required elements but parts of the forms were incomplete or inaccurately completed. In the prevention plan section, there were several entries with a “?” and no prevention plan was provided, the location was marked as home but did not provide the room or level of specification to complete a through trends and patterns review, and the causes and contributing factors were not incident specific and often a restatement of the incident. UI reports #82 and #83 were not completed but instead stated, “see other paper,” No other papers were attached.	
POC	**Status**	**Comments**
Action: The QIDP previously responsible for oversight of this system is no longer employed by the facility as of 1/14/2014. Interim staff are in place with Administrative and Corporate oversight. The MUI/UIR system revisions include changes to the log format to be in compliance with regulatory requirements. Completion Timeline: 4/11/14 Responsible Person: Carrie Kegley is to ensure the UI log is completed according to regulatory requirements. Linda Lamson or Designee will audit the UI log monthly for six months and then randomly to ensure the UI log is completed according to regulatory requirements.	Approved	

CITE #21

Question	Explanation	
Did the ICF/ID conduct a monthly review of unusual incidents?	The ICF/DD did not conduct a monthly review of Unusual Incidents. There was evidence that the ICF did complete a monthly review of unusual incidents but no indication that this review prompted any action like ensuring incidents were properly coded and subsequent follow up was completed	
POC	**Status**	**Comments**
Action: A monthly review of UIs will be completed by Carrie Kegley. The information will be analyzed for trends and patterns. This will be reported to the Quality Assurance Committee. Action plans will be developed if needed. Completion Timeline: 4/11/14 Responsible Person: Carrie Kegley is to conduct a monthly review of unusual incidents. Linda Lamson or Designee will audit the UI review monthly for six months and then randomly to ensure follow up is completed.	Approved	

CITE #22

Question	Explanation	
Are medication, treatments and dietary orders being followed?	The provider failed to show documented evidence of medications, treatments and dietary orders being following. The MAR for ID #3's physician ordered foot lotion was blank for November 2014 and December 2014. The MAR for ID #3's physician order for double meat portion and nectar thick liquid was incomplete. There was no system in place to ensure that thickened liquid for pop was provided as ordered.ID #4 was due to return to the dentist in December 2013 and at the time of review ID #4 had not yet been seen. ID #4 was also due to be seen by her podiatrist in November 2013 and was not seen until 1/08/14.	
POC	**Status**	**Comments**
Action: ID #3 - Assessed on 2/19/14 regarding the implementation of thickened liquids, specifically carbonated beverages. Those recommendations have been incorporated into the IHP and implemented after guardian consent was obtained. The physician order for double meat was completed on 2/7/14. Foot lotion has been applied in January 2014, February 2014, and March 2014 per physician order.Action: ID #4 – Dental visit occurred on 2/21/14. Podiatry visit occurred 3/10/14Janet Husty reviews orders, and tracks and schedules appointments. Completion Timeline: 4/11/14 Responsible Person: Janet Husty is to ensure medication, treatment, and dietary orders are being followed by daily audits of the MAR and TAR. Linda Lamson or Designee will audit MARs monthly for six months and then randomly to ensure medication, treatment, and dietary orders are being followed.	Approved	

CITE #23

Question	Explanation	
Does the facility have behavior support policies and procedures in place?	The provider failed to have in place a behavior support policy and procedure. The behavior support policy & procedure does not specify appropriate conduct, and is not available to staff, clients, parents or guardians. The provider made many adjustments to the policy during the compliance review to remove parts. The facility administrator acknowledged that staff actions do not always follow policy guidelines as staff are not aware of what the policy includes.	
POC	**Status**	**Comments**
Action: The facility has revised its Behavior Support Policies and Practices to ensure resident health and welfare. Facility staff have been trained on this policy. The above noted revised policy has been provided to staff, Individuals, parents and guardians. Completion Timeline: 4/11/14 Responsible Person: Carrie Kegley is to ensure policies and procedures are followed in practice. Linda Lamson is to ensure policies and procedures follow current regulation and facility practice.	Approved	