

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G663	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2015
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5662 N CRESTVIEW AVE INDIANAPOLIS, IN 46220
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W000000	<p>This visit was for a pre-determined full annual recertification and state licensure survey.</p> <p>Survey dates: 1/13, 1/14, 1/15, 1/20, 1/21, 1/22, and 1/23/2015.</p> <p>Facility Number: 001216 Provider Number: 15G663 AIMS Number: 100233690</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/3/15 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, for 3 of 3 sampled clients (clients #1, #2, and #3) and 2 additional clients (clients #4 and #5), the governing body failed to exercise operating direction over the facility to complete maintenance and repairs for client #1, #2, #3, #4, and #5's group home and failed to ensure client #5 had a mattress which fit his body type.</p>	W000104	<p>The House Manager and Program Director will work with the maintenance crew to ensure that the lights are repair and/or replaced as needed. This will be completed throughout the house to ensure that no other lights are broken or missing. The Home Manager and/or Program Director will purchase a new bed for</p>	02/22/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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	<p>Findings include:</p> <p>1. On 1/13/15 from 3:50pm until 6:00pm, and on 1/14/15 from 6:00am until 7:50am, observations were conducted and clients #1, #2, #3, #4, and #5 walked and accessed each room throughout the group home independently. During both observation periods the following maintenance items were observed with Residential Manager (RM):</p> <ul style="list-style-type: none"> -The kitchen had 8 of 8 light covers which were broken, damaged, and had dried debris between the light bulb and the inside of each light cover. -The kitchen had 2 of 8 overhead lights burned out. The burned out overhead lights were over the kitchen sink, the food prep counter, and the stove. -Client #1's bedroom closet door was missing. On 1/13/15 at 4:15pm, client #1 indicated his closet door was broken. <p>On 1/23/15 at 1:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director). Both staff indicated they were not aware of the need for the repairs of client #1's closet door or for the kitchen light covers before the survey. Both staff indicated the repairs were now in process of being completed</p>		<p>client #5.</p> <p>The House Manager and Program Director will work with the maintenance crew to ensure that the closet door is replaced and/or repaired. This will be completed throughout the house to ensure that no other doors are broken or missing.</p> <p>The Home Manager and Program Director will be retrained on ensuring that all maintenance issues are addressed in a timely manner and followed up on, if remaining incomplete.</p> <p>Ongoing, the Program Director will complete a monthly walk thru of the group home to ensure that no issues are noted.</p> <p>Ongoing, the Area Director will ensure that a quarterly walk-thru is completed to ensure that all maintenance issues are taken care of in a timely matter and do not remain incomplete.</p> <p>Completion Date: 2-22-2015 Responsible Party: Home Manager and Program Director, and Area Director</p>				

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	<p>by the maintenance department.</p> <p>2. On 1/14/15 from 6:00am until 7:50am, observation and interview were conducted at the group home with client #5. At 6:15am, client #5 was observed in his bedroom in his bed with the light on. Client #5 lay on his side on top of the mattress and client #5's body was within inches from each side of the mattress. At 6:15am, GHS (Group Home Staff) #1 stated client #5 "hung off the edges of his bed. [Client #5] might need a bigger bed (and mattress)." GHS #1 stated client #5 "sleeps on the floor a lot of the time." At 6:30am, client #5 stated to GHS #1 "I fell out of bed again." From 6:20am until 7:20am, client #5 walked throughout the group home, ate breakfast, and returned to his bedroom. At 7:20am, client #5 was located by GHS #2 laying between his bed and the wall on the floor sleeping. At 7:20am, GHS #2 prompted client #5 to get up and lay in his bed. Client #5 lay on his bed and GHS #2 stated client #5's body was within "inches" from each edge of the bed. GHS #2 stated client #5 "looks too big for that bed." At 7:40am, when asked if his bed was comfortable, client #5 did not respond.</p> <p>On 1/13/15 at 3:00pm, client #5's record indicated he was admitted on 12/30/14 from his home.</p>			

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W000125	<p>On 1/23/15 at 1:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director). Both staff indicated they were unaware client #5's mattress/bed did not fit client #5's body type. The QIDP stated client #5 was "a big guy" and "probably a twin bed" was too small for client #5.</p> <p>9-3-1(a)</p> <p>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.</p> <p>Based on observation, record review, and interview, for 3 of 3 sampled clients (clients #1, #2, and #3) and 2 additional clients (clients #4 and #5) who lived in the group home, the facility failed to ensure unimpeded access to the locked sharp objects, locked glass cups and dishes, locked food, and locked chemicals for clients #1, #2, #3, #4, and #5 who did not have documented assessments for the restricted access to the locked items.</p>	W000125	<p>QIDP will complete team meetings, to decide if keeping the extra food and sharps locked is best for the health and safety of the clients. If it is decided for the items to remain locked, the Program Director, in conjunction with the IDT's will work to put goals in place for each client to gain access to the restricted items.</p> <p>The Program Director and Home Manager are going through the Interdisciplinary Team and Human Right's Committee to ensure that the correct approvals are retrieved</p>	02/22/2015

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	<p>Findings include:</p> <p>On 1/13/15 from 3:50pm until 6:00pm, and on 1/14/15 from 6:00am until 7:50am, observations were conducted and clients #1, #2, #3, #4, and #5 walked and accessed each room throughout the group home independently. During both observation periods the group home had three locked closets and no client had unimpeded access to them. During both observation periods staff used a key to open and relock each of the three closets. Clients had to request staff to obtain a pop for the client to drink, soap to wash the clothes in the washer, food to cook for the meals, and a cup to drink coffee from. On 1/13/15 at 4:15pm, the Residential Manager (RM) stated the "extra food, sharps (objects with a sharp edge), emergency food, tools, and chemicals" were "kept locked" and secured by the facility staff. The RM stated "only staff" had a key to the locked items. The RM indicated client #2 had the identified need documented in his BSP (Behavior Support Plan) for locked food. At 4:30pm, GHS (Group Home Staff) #3 was asked by client #2 for chips to eat as a snack. GHS #3 unlocked the closet, selected a single serving bag of chips from the closet, relocked the closet, and gave the bag of chips to client #2. Client #2 then asked for a pop to drink.</p>		<p>for the locked closet to remain locked.</p> <p>The Program Director will be retrained on not locking items without approval to do so, first. The Program Director will be retrained on including these restrictions in the Individualized Support Plans.</p> <p>The Home Manager and Direct Support Staff will be retrained on what items are included in the restrictions.</p> <p>The Home Manager and/or Program Director will complete a check of the house to ensure that all items that should be locked, are actually locked up appropriately.</p> <p>Ongoing, the Program Director will complete a monthly walk thru of the group home to ensure that no inappropriate items are left unlocked.</p> <p>Completion Date: 2-22-2015 Responsible Party: Home Manager and Program Director</p>		

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	<p>GHS #3 repeated the same actions and returned to the table with a can of pop for client #2. GHS #3 indicated the snacks and pop were kept locked so clients in the group home would not eat them at one time. From 3:50pm until 4:45pm, GHS #3 and GHS #4 selected clients #1, #2, #3, #4, and #5's snacks and pop from the locked closet for each client to consume. At 4:45pm, the RM stated "No pop or snacks were accessible by clients (and) all pop and snacks are kept locked." When asked why the food items, chemicals, and sharps were kept secured, the RM stated the items had "always been locked" at the group home. At 4:45pm, the locked food items in the closets included: bags of sugar, chips, pop, bottles of water, canned foods, bread, snack items, crackers, cereal, graham crackers, peanut butter, salad dressing, bag of flour, open container of artificial sweetener, sandwich bags, glass cups, breakable drinking glasses, glass plates, a crock pot, and multiple other food and glass items. On 1/14/15 at 7:20am, client #3 asked the RM to get him his artificial sweetener for his coffee he drank from a plastic glass. At 7:40am, GHS #4 picked up the two containers of open cereal and locked them inside the secured closet.</p> <p>During both observation periods a metal thermometer with a pointed metal tip and</p>			

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	<p>a metal pizza cutter were located inside the silverware drawer of the kitchen and were not kept secured. On 1/13/15 at 4:15pm, GHS #5 locked the pizza cutter and the metal probe thermometer inside the medication closet and indicated these should have been kept locked.</p> <p>On 1/14/15 at 12:50pm, client #1's record was reviewed. Client #1's 8/23/14 ISP (Individual Support Plan) and 2014 CFA (Comprehensive Functional Assessment) did not indicate an identified need to lock sharp objects, snacks, food items, and chemicals. Client #1's record did not indicate consent for locked items.</p> <p>On 1/14/15 at 11:40am, client #2's record was reviewed. Client #2's 8/29/14 ISP and undated CFA did not indicate an identified need to lock sharp objects, snacks, food items, and chemicals. Client #2's record did not indicate consent for locked items. Client #2's 8/30/13 BSP indicated "...5/2012 Due to [client #2's] history of inhaling chemicals such as products in aerosol cans, cleaning products and air fresheners, staff may need to be with [client #2] when he is using any type of aerosol product...it may need to be kept in a locked area...Non restrictive 5/2012 When you see [client #2] making a large portion of food or a food item that was purchased specifically</p>			

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	<p>for the menu / a meal (sic) remind [client #2] of why wasting the food item / eating (sic) the non dietary food item is not appropriate...."</p> <p>On 1/14/15 at 2:00pm, client #3's record was reviewed. Client #3's 4/12/14 ISP and 2014 CFA did not indicate an identified need to lock sharp objects, snacks, food items, and chemicals. Client #3's record did not indicate consent for locked items.</p> <p>On 1/23/15 at 1:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director). The QIDP indicated client #1, #2, #3, #4, and #5's sharps, food items, glasses, and chemicals were kept locked at the group home. The QIDP indicated clients #1, #2, #3, #4, and #5 did not have a key to access the items, did not have goals or a plan to decrease the restrictions of the locked items, and stated "only staff" had keys to the locked closets. The QIDP indicated client #2 needed the sharps and chemicals locked. The QIDP indicated clients #1, #2, #3, #4, and #5 had not given consent for the locked items. The QIDP indicated no assessments were completed for clients #1, #2, #3, #4, and #5. The QIDP indicated the locked items were an issue for two previous clients</p>			

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W000240	<p>who were discharged in 2014 from the group home.</p> <p>9-3-2(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review, and interview, for 1 of 1 sampled client (client #3) who used a seizure helmet, the facility failed to develop a plan for when client #3 should use his seizure helmet.</p> <p>Findings include:</p> <p>On 1/13/15 from 3:50pm until 6:00pm, and on 1/14/15 from 6:00am until 7:50am, observations were conducted and client #3 walked and accessed each room throughout the group home independently. During both observation periods client #3 took off and put on his seizure helmet independently when he was seated in the living room, dining room, and inside his bedroom sitting on his bed.</p> <p>Client #3's record was reviewed on 1/14/15 at 2:00pm. Client #3's 4/12/14 ISP (Individual Support Plan) did not indicate client #3 used a seizure helmet,</p>	W000240	<p>The Program Director/QIDP, in conjunction with the IDT, will add in the use of the seizure helmet in Client #3's Individualized Support Plan.</p> <p>The Program Director will review all other Individualized Support Plans in this house, to ensure that no other use of medical equipment is missing from the plans.</p> <p>Ongoing, the Program Director will review the nursing monthlies to ensure that all medical updates are included in the ISPs.</p> <p>Ongoing, all ISPs will be reviewed by the Area Director and/or Quality Assurance Personnel for accuracy. Completion Date: 2-22-2015 Responsible Party: Program Director and Area Director.</p>	02/22/2015

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W000248	<p>was at risk for falls because of seizures, and did not include guidelines for the use of his prescribed seizure helmet. Client #3's diagnosis included, but was not limited to Seizure Disorder. Client #3's 12/18/14 neurology notes indicated he was to wear a seizure helmet because of seizures and to prevent injuries.</p> <p>On 1/23/15 at 1:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the Area Director (AD). Both staff indicated client #3's ISP did not include guidelines for the use of his prescribed seizure helmet.</p> <p>9-3-4(a)</p> <p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on observation, record review, and interview, for 1 of 2 sampled clients (client #3) who attended outside day service site #1, the facility failed to ensure the outside day services had access to client #3's ISP (Individual Support Plan) and current medical information.</p>	W000248	The Program Director will send all Day Placements the current ISPs, RMAPs, BSPs, and updated protocols for the common clients. The Program Director will be retrained on IDT's. The training will include who to part of the IDT, when to include the IDT, and to remember to ensure that all members of the IDT are kept up to date at all times. Ongoing, the	02/22/2015			

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	<p>Findings include:</p> <p>On 1/15/15 from 8:25am until 10:10am, client #3 was observed at the outside day services. From 8:25am until 10:10am, client #3 wore a seizure helmet, did not wear prescribed eye glasses, and walked independently throughout the workshop areas. At 8:55am, the Workshop Supervisor (WKS) indicated client #3's ISP and medical information received by the workshop from the group home were not current. The WKS stated information was requested and was not "always" provided to the workshop regarding client #3.</p> <p>On 1/15/15 at 8:55am, client #3's outside day service records were reviewed and indicated the following: -For client #3: No ISP from the group home was available. The record included a 12/7/2012 BSP (Behavior Support Plan), and a 11/30/2012 "Risk Management Assessment." No Seizure protocol/plan and Diabetes protocol/plan were available for client #3 at the workshop.</p> <p>On 1/23/15 at 1:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the Area Director (AD). Both staff indicated they were unaware the outside</p>		<p>Area Director will participate in at least one IDT meeting to ensure that the Program Director is including all IDT members when applicable. Ongoing, the Area Director will complete random Day Placement Audits/Observations to ensure that all have current information, including, but not limited to ISPs and BSPs for common clients. Completion Date: 2-22-2015 Responsible Party: Home Manager, Program Director, and Area Director.</p>		

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W000336	<p>day services did not have current copies of client #3's ISP, BSP, and Risk Plans. Both staff indicated client #3 was a diabetic, experienced seizures in which he was required to wear a seizure helmet, and was at risk to fall.</p> <p>9-3-4(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview, for 3 of 3 sampled clients (clients #1, #2, and #3), the facility failed to complete nursing quarterlies for clients #1, #2, and #3.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 1/13/15 at 12:50pm. Client #1's record included nursing quarterly assessments completed on 5/15/14 and 1/28/14. Client #1's record indicated no nursing assessments were available for review before 1/13/15 and after 5/15/14.</p> <p>Client #2's record was reviewed on 1/14/15 at 11:40am. Client #2's record included nursing quarterly assessments</p>	W000336	<p>The Program Nurse will be retrained on the completion of nursing monthlies and quarterlies. The Program Nurse will complete nursing monthlies starting with January 2015. The nursing quarterly will be completed for November 2014, December 2014, and January 2015 by February 20, 2015 for clients 1, 2, 3, 4, 5, and 6. Ongoing, the Program Nurse will give copies of the nursing monthlies and quarterlies by the 5th of the following month for review. Ongoing, the Area Director and/or Quality Assurance will complete random quarterly audits to ensure that all monthlies and quarterlies are completed by the 5th of the following month. Completion Date: 2-22-2015 Responsible Party: Program Nurse,</p>	02/22/2015

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W000436	<p>completed on 8/15/14, 5/15/14, and 10/28/13. Client #2's record indicated no nursing assessments were available for review before 1/14/15 and after 8/15/14 or before 5/15/14 and after 10/28/13.</p> <p>Client #3's record was reviewed on 1/14/15 at 2:00pm. Client #3's record included nursing quarterly assessments completed on 5/15/14 and 1/28/14. Client #3's record indicated no nursing assessments were available for review before 1/13/15 and after 5/15/14.</p> <p>On 1/23/15 at 1:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director). The QIDP indicated the facility's nursing personnel had not completed nursing assessments for clients #1, #2, and #3. The QIDP indicated no additional documentation was available for review.</p> <p>9-3-6(a)</p> <p>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.</p>		Program Director, and Area Director.	

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	<p>Based on observation, record review, and interview, for 2 of 3 sampled clients (clients #2 and #3) with adaptive equipment, the facility failed to teach and encourage clients #2 and #3 to wear their prescribed eye glasses.</p> <p>Findings include:</p> <p>On 1/13/15 from 3:50pm until 6:00pm, and on 1/14/15 from 6:00am until 7:50am, observations were conducted and clients #2 and #3 did not wear their prescribed eye glasses. During both observation periods clients #2 and #3 completed dining, walked throughout the group home, completed medication administration, accessed the computer, and watched television. Clients #2 and #3 were not encouraged to wear their prescribed eyeglasses.</p> <p>Client #2's record was reviewed on 1/14/15 at 11:40am. Client #2's 4/30/14 visual examination indicated client #2 wore prescribed eye glasses to see. Client #2's 8/29/14 ISP (Individual Support Plan) did not indicate an objective to teach and wear his prescribed eye glasses.</p> <p>Client #3's record was reviewed on 1/14/15 at 2:00pm. Client #3's 6/12/14 vision examination indicated client #3</p>	W000436	<p>All Direct Care Staff will be retrained on Indiana MENTOR's policy and procedure for ensuring the individuals are using adaptive equipment as prescribed. This retraining will include using the adaptive equipment, prompting the client's to properly use the equipment, and what to do when they refuse. The Program Director will be retrained on including a formal training objective for those individuals who refuse/need desensitization. The Program Director will complete a training objective for clients 1 and 4 for use of their glasses as prescribed. Ongoing, the Home Manager and/or Program Director will complete random Active Treatment observations three times per week for the first four weeks, and then once a week on going to ensure that all adaptive equipment is used properly. Ongoing the Home Manager and/or Program Director will complete random documentation reviews three times per week for the first four weeks, and then once a week on going to ensure that all adaptive equipment is used properly. Completion Date: 2-22-2015 Responsible Party: Home Manager and Program Director.</p>	02/22/2015

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W000454	<p>wore prescribed eyeglasses. Client #3's 4/12/14 ISP did not indicate an objective to teach and wear his prescribed eye glasses.</p> <p>On 1/23/15 at 1:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director). The QIDP stated client #2 "breaks his eye glasses and throws them away." The QIDP indicated clients #2 and #3 did not have an objective/goal to teach them to wear their prescribed eye glasses. The QIDP indicated the staff should use formal and informal opportunities to teach and encourage clients #2 and #3 to wear their prescribed eye glasses.</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation, interview, and record review, for 3 of 3 sampled clients (clients #1, #2, and #3) and 2 additional clients (clients #4 and #5), the facility failed to teach and encourage sanitary methods by failing to wash the dining room table before consuming food off the table.</p>	W000454	<p>All Direct Support Professionals will be retrained on Indiana MENTOR's policy and Procedure regarding Infection Control. The DSPs will be retrained on ensuring the table is cleaned after and before each use. The clients will be retrained on ensuring the table is cleaned after and before each use.</p>	02/22/2015

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	<p>Findings include:</p> <p>On 1/13/15 from 3:50pm until 6:00pm, and on 1/14/15 from 6:00am until 7:50am, observations were conducted and clients #1, #2, #3, #4, and #5 walked and accessed each room throughout the group home independently. From 3:50pm until 4:30pm, clients #1, #2, #3, #4, and #5 consumed snacks at the dining room table. At 3:50pm, client #2 ate his chips from a bowl with cheese, licked his fingers between bites, dropped bits of cheese and chips onto the table, picked up those items, and consumed the dropped food. No washing of the dining room table was taught or encouraged before client #2 consumed his snack.</p> <p>At 4:00pm, clients #1, #3, #4, and #5 were assisted to obtain their snacks. GHS (Group Home Staff) #3, GHS #5, and the Residential Manager (RM) retrieved clients #1, #3, #4, and #5's snack items and set the snacks on the dining room table in front of each client. No washing of the dining room table was encouraged or taught. At 4:30pm, client #1 emptied his container of chips onto the bare dining room table, consumed the chips and crumbs with his fingers, and no washing of the dining room table was taught or encouraged. From 5:10pm until</p>		<p>The Program Director will complete 2 weekly active treatment observations for 4 weeks, and then 1 per week afterwards to ensure that the infection control policy is being instructed and utilized as expected. Ongoing, the Area Director will complete quarterly pop in visits to ensure that all policies and procedures are being followed. Completion Date: 2-22-2015 Responsible Party: Home Manager, Program Director, and Area Director.</p>	

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W000455	<p>6:00pm, clients #1, #2, #3, #4, and #5 were observed to set the dining room table for supper, handled dishes and utensils by the food contact ends, and no washing of the dining room table before it was set for supper was observed taught or encouraged. From 5:40pm until 6:00pm, clients #1, #2, #3, #4, and #5 sat down at the table to consume their meal and no washing of the dining room table was taught or encouraged.</p> <p>On 1/23/15 at 1:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director). Both the QIDP and AD indicated staff should have assisted clients #1, #2, #3, #4, and #5 to wash the dining room table before and after snacks and meals.</p> <p>On 1/23/15 at 1:00pm, the undated Core A/Core B Medication Administration training manual page 3 indicated "Universal precautions" included washing hands before medication administration, before eating, and after using the restroom.</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL There must be an active program for the</p>						

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	<p>prevention, control, and investigation of infection and communicable diseases. Based on observation, interview, and record review, for 3 of 3 sampled clients (clients #1, #2, and #3) and 2 additional clients (clients #4 and #5), the facility failed to teach and encourage clients #1, #2, #3, #4, and #5 to wash their hands when opportunities existed.</p> <p>Findings include:</p> <p>On 1/13/15 from 3:50pm until 6:00pm, and on 1/14/15 from 6:00am until 7:50am, observations were conducted and clients #1, #2, #3, #4, and #5 walked and accessed each room throughout the group home independently. From 3:50pm until 4:30pm, clients #1, #2, #3, #4, and #5 consumed snacks at the dining room table. At 3:50pm, client #2 ate his chips from a bowl with cheese, licked his fingers between bites, and no handwashing was taught or encouraged before client #2 consumed his snack. At 4:00pm, clients #1, #3, #4, and #5 were assisted to obtain their snacks. GHS (Group Home Staff) #3, GHS #5, and the Residential Manager (RM) retrieved clients #1, #3, #4, and #5's snack items and set the snacks on the dining room table in front of each client. No handwashing was encouraged or taught.</p>	W000455	<p>All Direct Support Professionals will be retrained on Indiana MENTOR's policy and Procedure regarding Infection Control.</p> <p>The DSPs will be retrained on ensuring the clients wash their hands before and after they eat.</p> <p>The clients will be retrained on ensuring they wash their hands before and after they eat.</p> <p>The Program Director will complete 2 weekly active treatment observations for 4 weeks, and then 1 per week afterwards to ensure that the infection control policy is being instructed and utilized as expected.</p> <p>Ongoing, the Area Director will complete quarterly pop in visits to ensure that all policies and procedures are being followed.</p> <p>Completion Date: 2-22-2015 Responsible Party: Home Manager, Program Director, and Area Director.</p>	02/22/2015

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	<p>At 4:30pm, client #4 consumed chocolate pudding from two individual snack packages, did not wash his hands, and scooped the remaining pudding from each container with his finger then licked his fingers. At 4:30pm, client #1 emptied his container of chips onto the bare dining room table, consumed the chips and crumbs with his fingers, and no handwashing was taught or encouraged. From 5:10pm until 6:00pm, clients #1, #2, #3, #4, and #5 were observed to set the dining room table for supper, handled dishes and utensils by the food contact ends, and no handwashing was observed taught or encouraged. From 5:40pm until 6:00pm, clients #1, #2, #3, #4, and #5 sat down at the table to consume their meal and no handwashing was taught or encouraged.</p> <p>On 1/23/15 at 1:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director). Both the QIDP and AD indicated clients #1, #2, #3, #4, and #5 should have assisted staff to wash the dining room table before and after snacks. The QIDP indicated handwashing should have been taught and encouraged.</p> <p>On 1/23/15 at 1:00pm, the undated Core A/Core B Medication Administration</p>			

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W000460	<p>training manual page 3 indicated "Universal precautions" included washing hands before medication administration, before eating, and after using the restroom.</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 3 of 3 sampled clients (#1, #2, and #3) and 2 additional clients (clients #4 and #5), the facility failed to ensure the planned menu was followed and to ensure clients were provided a substitute if requested.</p> <p>Findings include:</p> <p>On 1/13/15 from 3:50pm until 6:00pm, observations were conducted and clients #1, #2, #3, #4, and #5 were not provided the planned menu and substitutions were not available. At 5:20pm, clients #1, #2, #3, #4, and #5 consumed their supper meal of Baked Fish, Salad, Mashed Potatoes, and Grape Koolaid. The 2014-2015 menu posted on the refrigerator in the kitchen indicated a half cup portion of "marinated vegetables</p>	W000460	<p>The Home Manager will be retrained on creating a grocery list based on the menu.</p> <p>The Direct Support Staff will be retrained on assisting the clients to prepare a meal that follows the menu that is prepared by a registered dietician. This retraining will also include the use of the substitution list, and what appropriate substitutions include.</p> <p>The Program Director will complete 2 weekly meal time observations for 4 weeks, and then 1 per week afterwards to ensure that the substitution policy is being instructed and utilized as expected.</p> <p>Ongoing, the Area Director will complete quarterly pop in visits to ensure that all policies and procedures are being followed.</p> <p>Completion Date: 2-22-2015 Responsible Party: Home Manager, Program Director, and Area Director.</p>	02/22/2015

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	<p>with carrots" was to have been served with the meal and no vegetables were provided. From 5:20pm until 6:00pm, clients #1, #2, #3, #4, and #5 sat at the dining room table and consumed the food until all foods were gone. No vegetable substitutions were available.</p> <p>On 1/23/15 at 1:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director). The QIDP indicated clients at the group home do not like that kind of vegetable and that was why the staff did not fix the menued item. Both indicated the staff should have offered a choice of vegetables as a substitution to be served when the clients did not like the menued item.</p> <p>9-3-8(a)</p>			