STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G531	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	3107 HENSEL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for a pre-determined full annual recertification and state licensure survey. This visit included the investigation of complaint #IN00150030. Complaint #IN00150030: SUBSTANTIATED. Federal/State deficiencies related to the allegations are cited at W149 and W153. Dates of Survey: July 22, 23, 24, 25, 28, 29, 30, 31 and August 1, 2014. Facility number: 001045 Provider number: 15G531 AIM number: 10024490 Surveyor: Kathy J. Wanner, QIDP. The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/8/14 by Ruth Shackelford, QIDP.	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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W000102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview, the Condition of Participation: Governing Body and Management was not met as the Governing Body failed to meet the Condition of Health Care Services, and failed to meet the heath care needs of 3 of 4 sampled clients (clients #1, #2 and #4) and for 1 of 1 former client (client #9) to follow physician's orders and best practice to prevent, monitor and treat recurrent aspiration pneumonia. Findings include: Please refer to W104: The governing body failed to exercise operating direction over the facility by failing to meet the health care needs of 3 of 4 sampled clients (clients #1, #2 and #4) and for 1 of 1 former client of the facility	W000102	Please refer to W104 Please refer to W318	08/31/2014

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	(client #9), failed to provide nursing services in accordance with client #9's healthcare needs, administer medication as ordered by his physician and monitor to prevent and treat recurrent aspiration pneumonia according to best practice; The governing body failed to assure the medication administration area was located in an area of the home which did not restrict the rights of 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) access to their bedrooms during medication administration times, failed to maintain the facility odor free, and failed to maintain the flooring in good condition in the bedroom of 2 of 4 sampled clients (clients #2 and #3). Please refer to W318: The Condition of Participation: Health Care Services, was not met as the governing body failed to provide prompt treatment, adequate health care monitoring, and nursing services for 3 of 4 sampled clients (clients #1, #2 and #4) and failed for 1 of 1 former client (client #9) to follow physician's orders and best practice to prevent, monitor and treat recurrent aspiration pneumonia. 9-3-1(a)			

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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, record review and interview, the governing body failed to exercise operating direction over the facility by failing to ensure 3 of 4 sampled clients (clients #1, #2 and #4) received routine and preventative medical care, and for 1 of 1 former client of the facility (client #9), failed to provide nursing services in accordance with client #9's healthcare needs, administer medication as ordered by his physician and monitor to prevent and treat recurrent aspiration pneumonia according to best practice; The governing body failed to assure the medication administration area was located in an area of the home which did not restrict the rights of 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) access to their	W000104	1. Please refer to W149 2. Please refer to W331 3. The Home Manager, Program Nurse and Program Director will evaluate the home to determine if there is a better place for the medication administration to take place so that the clients bedrooms are not blocked during the medication pass. There is a 3rd bathroom in the home that all clients can access if the other direction was temporarily unavailable. The Home Manager, Program Director and Program Nurse will receive retraining to include ensuring that that the medication administration takes place in a location that interferes with the clients daily routine the least amount possible .	08/31/2014

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	bedrooms during medication administration times, failed to maintain the facility odor free, and failed to maintain the flooring in good condition in the bedroom of 2 of 4 sampled clients (clients #2 and #3). Findings include: 1. Please refer to W149: The governing body neglected to follow their policy Quality and Risk Management by failing to ensure 3 of 4 sampled clients (clients #1, #2 and #4) received routine and preventative medical care, and for 1 of 1 former client of the facility (client #9), failed to provide nursing services in accordance with client #9's healthcare needs, administer medication as ordered by his physician and monitor to prevent and treat recurrent aspiration pneumonia according to best practice. 2. Please refer to W331: The governing body failed to exercise operating direction over the nursing services in accordance with client care for 1 of 1 former client (client #9), and for 2 of 4 sampled clients (clients #1 and #4) failed to put risk plans/protocols in place according to best practice for aspiration pneumonia, G-Tube usage, chronic ear infections and toe nail fungus.		Ongoing, the Home Manager, Program Director and Program Nurse will ensure that the medication administration takes place in a location that interferes with the clients daily routine the least amount possible. 4. a. The Home Manager and Program Director will purchase a mattress cover for Client #7's mattress to reduce the chance of the mattress getting wet with urine. The Home Manager will work with staff to ensure that the bed and floor in Client #7 room are cleaned a minimum of daily to ensure the odor of urine is minimized. b. The damaged area rug in client #3 room has been disposed of and replaced. The floor and dresser will be cleaned. The Home Manager and/or Program director will evaluate the need for a new dresser for Client #3 or a tray for her to put her denture care items on to minimize the risk of spillage and build up. Ongoing, the Program Director and/or Home Manager will complete walkthroughs of the home a minimum of weekly to evaluate the cleanliness of the home and address issues with staff as needed to ensure the house is maintained in a clean and odor-free order. Responsible party: Program Director,	

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	3. Medication administration was observed on 7/23/14 from 6:38 A.M. through 6:52 A.M. Medications were administered to clients #5, #7 and #6 from a closet located in the main hallway of the home. Direct Care Staff (DCS) #1 administered the medications from a 1 foot by 2 foot wide shelf attached to the inside of the closet door. During the medication pass time frame clients #1, #2, #3, #4, #5, #6, #7 and #8, were not able to enter the hallway to get to their bedrooms or to two of the bathrooms. A G-Tube (gastrointestinal feeding tube) medication pass and tube feeding for client #1 was observed on 7/23/14 from 4:55 P.M. through 5:10 P.M. The medication administration and tube feeding were conducted by DCS #2 in the main hallway of the group home. During the medication pass and tube feeding time frame clients #2, #3, #4, #5, #6, #7 and #8, were not able to enter the hallway to get to their bedrooms or to two of the bathrooms. DCS #1 was interviewed on 7/23/14 at 6:52 A.M. DCS #1 stated, "Yes, right here is where we pass all meds (medications) and complete tube feedings, but how do we do it on that (pointed to the small shelf)." DCS #1 indicated the other clients were not		Home Manager, Program Nurse	

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	allowed to enter the area during the med pass due to privacy concerns. An observational walk through of the group home with the home manager (HM) was conducted on 7/23/14 at 6:01 P.M. The main hallway and the bedroom of clients #7 and #8 had an odor. The HM stated, "[Client #7] wets the bed. The smell lingers in the air. No the mattress is not wet. The [LPN] told me about some stuff to decrease the odor." The vinyl flooring in client #2 and #3's bedroom had an area 2 foot by 1 foot beside client #3's bed which was sticky, appeared to be damaged with a denture cleanser tablet and powdered substance causing the area rug to become stuck to the floor. The HM stated, "It has been damaged from [client #3's] denture cleanser." Interviews were conducted with the facility LPN and the Area Director (AD) on 7/24/14 at 2:30 P.M. The AD stated, "We will correct the issue with the flooring." The LPN stated, "We are looking at something to clean with. The odor has been a problem for a long time." The LPN stated, "I have been looking into a way to make the medication pass area better." 9-3-1(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, the facility neglected to follow their policy Quality and Risk Management for 1 of 1 allegation of neglect as indicated in 7 of 15 Bureau of Developmental Disabilities Services (BDDS) reports reviewed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 3 of 4 additional clients (clients #5, #6 and #7); and for 1 of 1 former client of the facility	W000149	1. All Direct care staff will be receive retraining on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents. The Home Manager will receive	08/31/2014

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	(client #9), failed to provide nursing services in accordance with client #9's healthcare needs, administer medication ordered by his physician and monitor for recurrent aspiration pneumonia according to clinical best nursing practice. Findings include: 1. Facility records including the BDDS reports dated 1/1/14 through 7/22/14 were reviewed on 7/22/14 at 11:20 A.M. The reports indicated the following: -A BDDS report dated 5/27/14 for an incident on 5/25/14 at 9:00 P.M. indicated "On 5/25/14 at approximately 9:00 P.M. it was reported that staff [name of Direct Care Staff (DCS) #8], at the group home got two residents (clients #2 and #5) out of bed and proceeded to load all eight (facility investigation later revealed client #8 was not in the facility at time of incident) residents of the home into the van. She (DCS #8) then drove them to a house location where she got out of the van and left the engine running, leaving all eight residents inside, while she went inside the house. One resident said she was in the house for about 1/2 hour (30 minutes). There were no other staff with the residents. She (DCS #8) then came back to the house at approximately 9:30 P.M., where another		retraining on documentation review including reviewing all consumer Daily support records, behavior tracking and narrative notes to ensure all incidents that have been documented have been reported to the Program Director so reports can be made to the Bureau of Developmental Disability Services and investigations can be completed as needed. Ongoing, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of twice weekly for 30 days to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines. After the 30 days, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of once per week to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines. Responsible Party: Home Manager, Program Director, Area Director 2. All direct care staff will receive retraining to include notifying the Program Nurse as soon as possible if any consumers have a change in medical condition such as not being	

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	staff was arriving for shift change and questioned staff [DCS #8] about where she had been so late with the residents. Staff (DCS #9) reported the incident to the house manager (HM). All residents were accessed (sic) and appeared to be fine. [DCS #8] was suspended pending a thorough investigation. Staff will monitor all residents for their health and safety." The follow-up BDDS report dated 6/16/14 indicated "After a thorough investigation, evidence supports [DCS #8] took two clients out of their beds and took all of the other clients in the van to complete a personal errand during her shift. Evidence also supports the clients waited alone on the van for up to 30 minutes while [DCS #8] visited with someone inside a house. [DCS #8] was terminated due to neglect of clients in her care." Facility internal investigation documentation was reviewed on 7/22/14 at 11:39 A.M. and indicated "On 5/26/14 during a casual conversation [DCS #9] reported to the [House Manager (HM)] that on 5/25/14 [DCS #8] had all eight clients out of the home. Upon further questioning of the clients it was reported that [DCS #8] left seven clients (clients #1, #2, #3, #4, #5, #6 and #7) in a van that was left running without supervision.		able to complete ADLs as normal, loss of appetite, loss of energy, showing weakness or short of breath. Program Nurse will receive retraining to include ensuring that once a consumer either is diagnosed with pneumonia and/or is showing signs or symptoms of possible pneumonia or general decline in functioning a protocol for daily temperatures and vital signs will be implemented to track if there is any change in consumers medical condition that could lead to a worsening condition. Once certain consumers have been identified as high risk for pneumonia, the Program Nurse will instruct staff to take daily vital signs and temperatures to note any changes. Program Nurse will include in the protocol what baseline range is for the temperature and vitals to fall into. If any vital signs or temperatures are found to be outside the baseline range, the staff will be instructed to notify the Program Nurse immediately so an assessment can be completed on the consumer to determine the further course of action. Ongoing, if a consumer is identified as a high risk for pneumonia, the Program Nurse will implement a protocol for daily temperatures and vital signs to monitor for pneumonia or other medical complications. The Program Nurse will work in	

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	[DCS #8] was suspended by [name of Program Director (PD)] on 5/27/14." The facility's policy Quality and Risk Management dated 4/2011 was reviewed on 7/25/14 at 10:05 A.M. and indicated "Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying evaluating and reducing risk to which individuals are exposed... B.1. Alleged, suspected, or actual abuse, neglect, or exploitation of an individual. An incident in this category shall also be reported...as applicable. The provider shall suspend staff involved in an incident from duty pending investigation by the provider. This may include: ...e. Failure to provide appropriate supervision, care or training; ... 4...q. Inadequate medical support for an individual, including failure to obtain: 1. Necessary medical services; 2. Routine dental or physician services; ... 4. An incident shall be reported by a provider or an employee or agent who: (a) Is providing services to the individual at the time of the incident. (b). Becomes aware of or receives information about an alleged incident. 5. An initial report regarding an incident shall be submitted		conjunction with the Home Manager and Program Director to review the daily temperatures and vital signs a minimum of daily during this period to note any changes in baseline ranges that might require further follow up. The staff working in this home will be retrained on medication administration policy and procedures to include ensuring that all clients are given their medications as directed by the physician and as indicated by the MAR. Staff training will also include ensuring that medications given PRN for medical/dental appointments are only given as directed by the physician prior to appointments as needed. For 4 weeks, the Home Manager and/or Program Director will complete Medication observations a minimum of twice weekly to ensure staff are administering medications as prescribed. After the four weeks and ongoing, the Home Manager and/or the QIDP will complete a weekly medication administration observation to ensure the staff administer medications as prescribed. The HM and/or PD will be responsible for ensuring any necessary follow-up is completed for any errors made in the administration of medications. Responsible Staff: Home Manager,	

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	within twenty-four hours of: (a) the occurrence of the incident; or (b). the reporter becoming aware of or receiving information about an incident. The Program Director, who serves as the QMRP (Qualified Mental Retardation Professional), shall submit a follow-up report concerning the incident on the BDDS's follow-up incident report form at the following times: (a). Within seven days of the date of the initial report; (b). Every seven days thereafter until the incident is resolved; (c). All information required to be submitted to the BDDS shall also be submitted to the provider of case management services to the individual... C. Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. 1. Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident." The Area Director (AD) was interviewed on 7/24/14 at 1:13 P.M. and stated, "Yes, it is our policy for staff to report right away. [DCS #9] should have reported it to the supervisor as soon as possible. [Name of HM] reported to the PD on 5/27/14." The AD indicated the clients		Program Director, Program Nurse	

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	were to have twenty-four hour supervision and should not have been left on the van alone. 2. -A BDDS report dated 1/23/14 for an incident on 1/22/14 at 3:45 P.M. indicated "On 12/27/13 [client #9] was admitted to [Hospital] with symptoms of pneumonia and trouble breathing. [Client #9] was sedated to keep him calm and intibated (sic) because he was having difficulty breathing. Medical staff decided to admit him to ICU (intensive care unit) and began treating him with antibiotics for pneumonia. On 1/5/14 [client #9] was still in the hospital and sedated and intibated (sic). [Client #9] continued to have difficulty breathing. Hospital was questioning that [client #9] may need a tracheotomy. [Client #9's] Health Care Representative (HCR) was contacted and given an update on [client #9's] condition. [Client #9's] HCR/Sister made the decision not to do the tracheotomy and a DNR (Do Not Resuscitate Order) was placed. The hospital exibated (sic) [client #9] and he continued to breath (sic) on his own. On 1/13/14 [client #9] was discharged from Indiana Mentor Services. On 1/20/14 [Client #9] was moved to the [Hospital's Hospice]. On 1/22/14 at approximately 3:45 P.M. [client #9] passed away."			

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	Client #9's record was reviewed on 7/23/14 at 1:17 P.M. Client #9's certificate of death indicated the cause of his death was "Aspiration Pneumonia." Client #9's record indicated he was seen by his physician on 12/4/13. Client #9 was diagnosed with Gastroenteritis and Aspiration Pneumonia. Client #9 was prescribed Zofran (anti-nausea), Augmentin (antibiotic) and Mucinex (anticongestant). Client #9's MAR (medication administration record) dated for 12/2013 indicated he was not administered Mucinex as his physician had ordered. Client #9's MAR indicated he had a PRN (as needed) order for Guaifenesin for cough. The MAR indicated he was not administered his PRN medication during the month of 12/2013. The physician had ordered for to "push fluids to prevent dehydration, see PCP (primary care physician) in 3-5 days for re-check-sooner if not improving." Client #9's MAR indicated there was no documentation of having his temperature, pulse and respiration checked during the month of 12/2013 while he was still at the group home, during the time he was being treated for Aspiration Pneumonia. Client #9 had his blood pressure checked/documented on 12/4/13, 12/11/13, 12/18/13 and 12/25/13. A			

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	Daily Support Record (DSR) dated 12/21/13 for the evening shift indicated "He (client #9) refused to eat dinner due to being sick." A DSR dated 12/27/13 for the A.M. shift indicated "Could not complete his A.M. hygiene. Staff physically dressed him and completed all ADL's (adult daily living skills)." Nursing progress notes for the month of 12/2013 for client #9 indicated "12/4/13 Res. (resident) taken to [urgent care] due to staff reports of malaise, lethargy and dyspnea (shortness of breath/difficulty breathing)....12/10/13 follow-up regarding pneumonia...pneumonia improving as expected. Finish antibiotics...follow-up as needed...12/14/13 Staff alerted author/nurse that res. was having seizure-like activity (i.e. shaking, tremors). Res. does not have a HX (history) of or DX (diagnosis) of seizure D/O (disorder). Staff instructed to take res. to ER (emergency room) immediately for eval. (evaluation) and possible TX (treatment). Home notified author that res. had been admitted overnight for observation. 12/15/13 Res. discharged from hospital back to group home. Staff will continue to monitor and notify nurse of any changes with res... 12/17/13 Res. seen for follow-up re: overnight hospital stay. MD (Medical			

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	Doctor) states 'Back to normal self.'...12/27/13 at 7:30 P.M. Staff notified HM (home manager) that res. was extremely weak and had dyspnea (shortness of breath). Unable to stand to go to [urgent care] or ER. HM instructed staff to call 911 immediately. EMS (ambulance) arrived at group home to transport res. to [Hospital] ER. 12/27/13 at 10:20 P.M. Res. admitted to hospital is in ICU...." The LPN was interviewed on 7/23/14 at 3:12 P.M. When asked about client #9's being "too sick to eat dinner" on 12/21/13 and "too weak to complete his ADLs and dress" on 12/21/13 as indicated in the DSRs, the LPN stated, "Yes, I would have wanted to know he didn't eat his dinner, and to tell me he was weak." The LPN stated, "I should have known on the morning of the 27th that he was to weak to dress and complete his ADLs so I could have assessed him." The LPN indicated she was not sure why staff had not notified her of his change in condition prior to evening. The LPN indicated staff should have been taking client #9's vitals and documenting them on the MAR. The LPN was interviewed on 7/24/14 at 2:37 P.M. and stated, "He (client #9) should have been given his Guaifenesin at least if he wasn't given the Mucinex."			

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	This Federal tag relates to complaint #IN00150030. 9-3-2(a)			
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 record review and interview,	W000153	All Direct care staff will be receive	08/31/2014

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	the facility staff failed to immediately report an allegation of neglect for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 3 of 4 additional clients (clients #5, #6 and #7) to the administrator and to other officials in accordance with State law through established procedures. Findings include: Facility records including the Bureau of Developmental Disabilities Services (BDDS) reports dated 1/1/14 through 7/22/14 were reviewed on 7/22/14 at 11:20 A.M. The reports indicated the following: -A BDDS report dated 5/27/14 for an incident on 5/25/14 at 9:00 P.M. indicated "On 5/25/14 at approximately 9:00 P.M. it was reported that staff [name of Direct Care Staff (DCS) #8], at the group home got two residents (clients #2 and #5) out of bed and proceeded to load all eight (facility investigation later revealed client #8 was not in the facility at time of incident) residents of the home into the van. She (DCS #8) then drove them to a house location where she got out of the van and left the engine running, leaving all eight residents inside, while she went inside the house. One resident said she was in the house for about 1/2 hour (30 minutes). There were		retraining on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents. The Home Manager will receive retraining on documentation review including reviewing all consumer Daily support records, behavior tracking and narrative notes to ensure all incidents that have been documented have been reported to the Program Director so reports can be made to the Bureau of Developmental Disability Services and investigations can be completed as needed. Ongoing, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of twice weekly for 30 days to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines. After the 30 days, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of once per week to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within	

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	no other staff with the residents. She (DCS #8) then came back to the house at approximately 9:30 P.M., where another staff was arriving for shift change and questioned staff [DCS #8] about where she had been so late with the residents. The staff (DCS #9) reported the incident to the house manager (HM). All residents were accessed (sic) and appeared to be fine. [DCS #8] was suspended pending a thorough investigation. Staff will monitor all residents for their health and safety." The follow-up BDDS report dated 6/16/14 indicated "After a thorough investigation, evidence supports [DCS #8] took two clients out of their beds and took all of the other clients in the van to complete a personal errand during her shift. Evidence also support the clients waited alone on the van for up to 30 minutes while [DCS #8] visited with someone inside a house. [DCS #8] was terminated due to neglect of clients in her care." Facility internal investigation documentation was reviewed on 7/22/14 at 11:39 A.M. and indicated "On 5/26/14 during a casual conversation [DCS #9] reported to the [House Manager (HM)] that on 5/25/14 [DCS #8] had all eight clients out of the home. Upon further questioning of the clients it was reported		the designated reporting guidelines. Responsible Party: Home Manager, Program Director, Area Director	

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	that [DCS #8] left seven clients (clients #1, #2, #3, #4, #5, #6 and #7) in a van that was left running without supervision. [DCS #8] was suspended by [name of Program Director (PD)] on 5/27/14." The Area Director (AD) was interviewed on 7/24/14 at 1:13 P.M. and stated, "Yes, it is our policy for staff to report right away. [DCS #9] should have reported it to the supervisor as soon as possible. [Name of HM] reported to the PD on 5/27/14." The AD indicated the clients were to have twenty-four hour supervision and should not have been left on the van alone. This Federal tag relates to complaint #IN00150030. 9-3-2(a)			
W000312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate			

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	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, the facility failed to incorporate the use of a psychotropic medication used for behavior management into the Behavior Support Plan (BSP) for 1 of 3 sampled clients (client #2) who was prescribed psychotropic medications; and for 1 of 3 sampled clients (client #1) to specify a behavior/medication for reduction in his BSP. Findings include: Client #2's record was reviewed on 7/23/14 at 3:04 P.M. Client #2's Physician's Order (PO) dated for 7/2014 indicated she was prescribed Seroquel (antipsychotic) for anxiety. Client #2 did not have a Behavior Support Plan to assist her with decreasing the need for medication for her anxiety/insomnia. There was no plan of reduction for the use of Seroquel. Client #1's record was reviewed on 7/23/14 at 2:43 P.M. Client #1's PO dated for 7/2014 indicated client #1 was prescribed Zyprexa Zydis (anti-psychotic) for psychosis, Klonopin (anti-anxiety) for panic disorder and Oxcarbazepine	W000312	The QIDP will convene the IDT for client #1 and Client #2. The IDT will assess the behaviors for which client #1 is prescribed medication and develop an appropriate titration plan. The IDT will develop a behavior plan for Client #2 to assist with decreasing the need for medication for her anxiety/insomnia. The Behavior plan will include a plan of reduction for the use of the Seroquel. The QIDP will be retrained on the requirement to ensure that all clients that take psychotropic medications have a Behavior Support Plan that includes an appropriate plan to address medication withdrawal based on behaviors. The QIDP will revise the Behavior Plans to include the titration plans developed by the IDT. The QIDP will obtain required approvals as soon as the plan is available. The QIDP will also ensure the staff is trained on the implementation of the plan The QIDP will review each client's files to ensure each client that receives medication to manage behavior has a Behavior Support plan to monitor the use of the	08/31/2014

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	(anti-psychotic) for psychosis. Client #1's record indicated he had a BSP dated 3/29/13. Client #1's BSP did not indicate which of his targeted behaviors (hoarding, manipulative behavior and anger control) was targeted for reduction and which medication was effective for which behavior. Client #1's BSP did not indicate which of his medications his IDT (interdisciplinary team) would look at first for a possible reduction. The Program Director (PD) and the facility LPN were interviewed on 7/24/14 at 2:45 P.M. and indicated Client #2 had a BSP, but it was discontinued on 3/11/14 due to client #2 not having displayed any of her targeted behaviors. The PD stated, "We can write a new plan for her anxiety symptoms." The LPN indicated client #1's plan did not specify a medication for a possible reduction and how his medications effectiveness could be determined. 9-3-5(a)		medications and that includes appropriate titration plans. Responsible Staff: Program Director, Area Director, Behavior Consultant	
W000318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on record review and interview,	W000318		08/31/2014

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	the Condition of Participation: Health Care Services, was not met as the facility failed to provide prompt treatment, adequate health care monitoring, and nursing services for 3 of 4 sampled clients (clients #1, #2 and #4) to ensure they received routine and preventative medical care, and for 1 of 1 former client of the facility (client #9), failed to provide nursing services in accordance with client #9's healthcare needs, administer medication ordered by his physician and monitor for recurrent aspiration pneumonia according to best practice. Findings include: 1. Please refer to W322: The facility health care services failed to obtain annual physical examinations for 3 of 4 sampled clients (clients #1, #2 and #4). 2. Please refer to W323: The facility health care services failed to obtain annual vision and hearing screenings for 3 of 4 sampled clients (clients #1, #2 and #4). 3. Please refer to W331: The facility nurse failed to provide nursing services in accordance with client health status for 1 of 1 former client (client #9), and for 2 of 4 sampled clients (clients #1 and #4)		1. Please refer to W322 2. Please refer to W323 3. Please refer to W331 4. Please refer to W338 5. Please refer to W356 6. Please refer to W 368 7. Please refer to W383 8. Please refer to W386	

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	failed to put risk plans/protocols in place according to best practice for aspiration pneumonia, G-Tube usage, chronic ear infections and toe nail fungus. 4. Please refer to W338: The facility health care services failed to follow-up on a recommended referral for an Occupational Therapy (OT) evaluation for 1 of 4 sampled clients (client #2). 5. Please refer to W356: The facility had failed to ensure 1 of 4 sampled clients (client #2) received comprehensive dental care as recommended by her dentist. 6. Please refer to W368: The facility failed to administer medications according to 2 of 4 additional clients (clients #9 and #6) Physician's Order (PO). 7. Please refer to W383: The facility failed to keep the keys to the medication storage area in a secure place where only authorized persons would have access to the keys for the medications stored in the home where 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) lived. 8. Please refer to W386: The facility failed to establish a system to ensure			

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	sufficient reconciliation of controlled medications for 1 of 2 clients reviewed who were prescribed controlled substance schedule medications (client #6). 9-3-6(a)			
W000322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview, the facility health care services failed to obtain an annual physical examination for 3 of 4 sampled clients (clients #1, #2 and #4). Findings include: Client #1's record was reviewed on 7/23/14 at 2:43 P.M. Client #1's record	W000322	Home Manager, Program Director and Program Nurse will receive retraining to include ensuring that all consumers have physical examinations completed annually. Ongoing, the Area Director will track all consumers' annual physical examination dates and review the list a minimum of monthly. The Area Director will work with the Program Director to monitor which consumers physical examination dates are	08/31/2014

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	indicated his last annual physical was completed on 2/5/13. Client #2's record was reviewed on 7/23/14 at 3:04 P.M. Client #2's record indicated her last annual physical was completed on 3/20/13. Client #4's record was reviewed on 7/23/14 at 3:43 P.M. Client #4's record indicated his last annual physical was completed on 5/8/13. The LPN was interviewed on 7/24/14 at 2:30 P.M. the LPN stated, "They (annual physicals) were scheduled. We missed some because of the winter weather and had to reschedule them. A first shift staff kept calling off, so we were missing appointments. They would all be rescheduled by now." 9-3-6(a)		coming up in the upcoming months so examinations can be scheduled and completed timely. Responsible Party: Home Manager, Program Director, Area Director, Program Nurse	
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, the facility health care services failed to obtain annual vision and hearing	W000323	The Program Nurse will review all consumers' medical appointment records (including Client 1, 2 and 4)	08/31/2014

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	screenings for 3 of 4 sampled clients (clients #1, #2 and #4). Findings include: Client #1's record was reviewed on 7/23/14 at 2:43 P.M. Client #1's record indicated his last annual physical was completed on 2/5/13. His last hearing screening was completed at the annual on 2/5/13 and his vision exam/screening was last completed on 5/16/13. Client #1's record indicated he wore prescription glasses. Client #2's record was reviewed on 7/23/14 at 3:04 P.M. Client #2's record indicated her last annual physical was completed on 3/20/13. Her last hearing screening was completed at the annual on 3/20/13 and her vision exam was completed on 5/11/11 with a recommendation to return in two years. There was no indication client #2 had returned to the eye doctor in 2 years as recommended. Client #2's record indicated she wore prescription glasses. Client #4's record was reviewed on 7/23/14 at 3:43 P.M. Client #4's record indicated his last annual physical was completed on 5/8/13. His last hearing screening was completed at the annual on 5/8/13 with his last audio exam being		and note when their last vision and hearing screening/evaluations were completed. Program Nurse will work with the Home Manager to ensure vision and/or hearing screenings are scheduled for all consumers as needed to ensure they have been reviewed annually. The Program Nurse will ensure that once screenings/evaluations have been completed, documentation is present in the medical charts for review. The Program Nurse will receive retraining to include ensuring that all consumers have annual vision and hearing screenings/evaluations a minimum of annually. Ongoing, the Program Nurse will track all consumers' annual medical appointments and ensure that all consumers have hearing and vision screenings/evaluations a minimum of annually to determine if further follow up is needed. Responsible Party: Home Manager, Program Nurse.	

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	completed on 4/9/10 indicating "Cannot rule out mild/moderate hearing loss in at least the better ear. 1. Cerumen management. 2. Retest hearing once ears are clear." There was no indication client #4 had his hearing retested as recommended. His last vision exam was completed on 3/8/10. The LPN was interviewed on 7/24/14 at 2:30 P.M. the LPN stated, "They (vision and hearing appointments) were scheduled. We missed some because of the winter weather and had to reschedule them. A first shift staff kept calling off, so we were missing appointments. They would all be rescheduled by now." 9-3-6(a)			
W000331	483.460(c) NURSING SERVICES			

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032	

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	The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview, the facility nurse failed to provide nursing services in accordance with client health status for 1 of 1 former client (client #9), and for 2 of 4 sampled clients (clients #1 and #4) failed to put risk plans/protocols in place according to best practice for aspiration pneumonia, G-Tube usage, chronic ear infections and toe nail fungus. Findings include: 1. Facility records including the BDDS reports dated 1/1/14 through 7/22/14 were reviewed on 7/22/14 at 11:20 A.M. The reports indicated the following: A BDDS report dated 1/23/14 for an incident on 1/22/14 at 3:45 P.M. indicated "On 12/27/13 [client #9] was admitted to [Hospital] with symptoms of pneumonia and trouble breathing. [Client #9] was sedated to keep him calm and intibated (sic) because he was having difficulty breathing. Medical staff decided to admit him to ICU (intensive care unit) and began treating him with antibiotics for pneumonia. On 1/5/14 [client #9] was still in the hospital and sedated and intibated (sic). [Client #9] continued to have difficulty breathing.	W000331	1. All direct care staff will receive retraining to include notifying the Program Nurse as soon as possible if any consumers have a change in medical condition such as not being able to complete ADLs as normal, loss of appetite, loss of energy, showing weakness or short of breath. Program Nurse will receive retraining to include ensuring that once a consumer either is diagnosed with pneumonia and/or is showing signs or symptoms of possible pneumonia or general decline in functioning a protocol for daily temperatures and vital signs will be implemented to track if there is any change in consumers medical condition that could lead to a worsening condition. Once certain consumers have been identified as high risk for pneumonia, the Program Nurse will instruct staff to take daily vital signs and temperatures to note any changes. Program Nurse will include in the protocol what baseline range is for the temperature and vitals to fall into. If any vital signs or temperatures are found to be outside the baseline range, the staff will be instructed to notify the Program Nurse immediately so an assessment can be completed on the consumer to determine the further course of action. Ongoing, if a consumer is identified	08/31/2014

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	Hospital was questioning that [client #9] may need a tracheotomy. [Client #9's] Health Care Representative (HCR) was contacted and given an update on [client #9's] condition. [Client #9's] HCR/Sister made the decision not to do the tracheotomy and a DNR (Do Not Resuscitate Order) was placed. The hospital exibated (sic) [client #9] and he continued to breath (sic) on his own. On 1/13/14 [client #9] was discharged from Indiana Mentor Services. On 1/20/14 [Client #9] was moved to the [Hospital's Hospice]. On 1/22/14 at approximately 3:45 P.M. [client #9] passed away." Client #9's record was reviewed on 7/23/14 at 1:17 P.M. Client #9's certificate of death indicated the cause of his death was "Aspiration Pneumonia." Client #9's record indicated he was seen by his physician on 12/4/13. Client #9 was diagnosed with Gastroenteritis and Aspiration Pneumonia. Client #9 was prescribed Zofran (anti-nausea), Augmentin (antibiotic) and Mucinex (anticongestant). Client #9's MAR (medication administration record) dated for 12/2013 indicated he was not administered Mucinex as his physician had ordered. Client #9's MAR indicated he had a PRN (as needed) order for Guaifenesin for cough. The MAR indicated he was not administered his		as a high risk for pneumonia, the Program Nurse will implement a protocol for daily temperatures and vital signs to monitor for pneumonia or other medical complications. The Program Nurse will work in conjunction with the Home Manager and Program Director to review the daily temperatures and vital signs a minimum of daily during this period to note any changes in baseline ranges that might require further follow up. 2. Program Nurse will develop a client specific G-tube protocol for Client #1 that includes checking for g-tube placement prior to med pass and/or feedings; how to check for residual and flushes and how and when they are to be done; how medications are to be given one at a time; what staff are to do with results of placement and residual; and when to notify the nurse. Once the protocol is developed, Program Nurse will ensure that all staff are trained on Client #1 g-tube protocol. Ongoing, the Program Nurse will monitor results of staff completing the protocol and make adjustments to the protocol as needed. Ongoing the Program Nurse will ensure that client specific protocols are developed for each client as needed to address their specific medical needs. 3. Program Nurse will develop client specific protocols for Client #4 to address how to prevent recurring ear infections and recurring toe nail	

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	PRN medication during the month of 12/2013. The physician had ordered for to "push fluids to prevent dehydration, see PCP (primary care physician) in 3-5 days for re-check-sooner if not improving." Client #9's MAR indicated there was no documentation of having his temperature, pulse and respiration checked during the month of 12/2013 while he was still at the group home, during the time he was being treated for Aspiration Pneumonia. Client #9 had his blood pressure checked/documented on 12/4/13, 12/11/13, 12/18/13 and 12/25/13. A Daily Support Record (DSR) dated 12/21/13 for the evening shift indicated "He (client #9) refused to eat dinner due to being sick." A DSR dated 12/27/13 for the A.M. shift indicated "Could not complete his A.M. hygiene. Staff physically dressed him and completed all ADL's (adult daily living skills)." Nursing progress notes for the month of 12/2013 for client #9 indicated "12/4/13 Res. (resident) taken to [urgent care] due to staff reports of malaise, lethargy and dyspnea (shortness of breath/difficulty breathing)....12/10/13 follow-up regarding pneumonia...pneumonia improving as expected. Finish antibiotics...follow-up as		fungus. Program Nurse will follow up with the PCP regarding topical treatment for the nail fungus. Program Nurse will receive retraining to include ensuring that Client Specific Protocols are developed for each client as needed to address recurring issues and/or risk and how to prevent recurrences, such as chronic ear infections and recurring toe nail issues Ongoing, the Program Nurse will review all consumers medical appointment forms within 48 hours of the appointment to determine if any follow up treatment is needed. If any follow up is needed the Program nurse will work with the Home Manager and/or Program Director to ensure that appointments are scheduled, medications are ordered, etc. The Program Nurse will also note if any recurring patterns are present, such as chronic ear infections and work with the Program Director and Home Manager to develop protocols to address to prevent recurrence of the issues. Responsible party: Program Nurse, Home Manager, Program Director	

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	needed...12/14/13 Staff alerted author/nurse that res. was having seizure-like activity (i.e. shaking, tremors). Res. does not have a HX (history) of or DX (diagnosis) of seizure D/O (disorder). Staff instructed to take res. to ER (emergency room) immediately for eval. (evaluation) and possible TX (treatment). Home notified author that res. had been admitted overnight for observation. 12/15/13 Res. discharged from hospital back to group home. Staff will continue to monitor and notify nurse of any changes with res... 12/17/13 Res. seen for follow-up re: overnight hospital stay. MD (Medical Doctor) states 'Back to normal self.'...12/27/13 at 7:30 P.M. Staff notified HM (home manager) that res. was extremely weak and had dyspnea. Unable to stand to go to [urgent care] or ER. HM instructed staff to call 911 immediately. EMS (ambulance) arrived at group home to transport res. to [Hospital] ER. 12/27/13 at 10:20 P.M. Res. admitted to hospital is in ICU...." The LPN was interviewed on 7/23/14 at 3:12 P.M. When asked about client #9's being "too sick to eat dinner" on 12/21/13 and "too weak to complete his ADLs and dress" on 12/21/13 as indicated in the DSRs, the LPN stated, "Yes, I would have wanted to know he didn't eat his			

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	dinner, and to tell me he was weak." The LPN stated, "I should have known on the morning of the 27th that he was to weak to dress and complete his ADLs so I could have assessed him." The LPN indicated she was not sure why staff had not notified her of his change in condition prior to evening. The LPN indicated staff should have been taking client #9's vitals and documenting them on the MAR. The LPN was interviewed on 7/24/14 at 2:37 P.M. and stated, "He (client #9) should have been given his Guaifenesin at least if he wasn't given the Mucinex." 2. A G-Tube (gastrointestinal feeding tube) medication pass and tube feeding for client #1 was observed on 7/23/14 from 4:55 P.M. through 5:10 P.M. The medication administration and tube feeding were conducted by DCS #2 in the main hallway of the group home. Client #1 got a clean towel and placed it on his lap. Client #1 removed the gauze pad from around the tube and looked to see if there was any redness at the site. Client #1 had filled a measuring cup with water and brought it and the syringe to the medication area. DCS #2 did not check for placement of client #1's G-Tube and did not check for residual prior to the medication pass and feeding. There was no documentation for 7/2014 indicating			

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	how much residual client #1 had prior to any of his medication passes/feedings. DCS #2 was interviewed on 7/23/14 at 5:10 P.M. and stated, "No we never check for residual or placement. The syringe is cleaned with a bottle brush and the cup is cleaned by hand, both with soap and warm water." Client #1 was interviewed on 7/23/14 at 5:02 P.M. Client #1 stated, "No, I can't tell if it is in or out of place." Client #1's record was reviewed on 7/23/14 at 2:43 P.M. Client #1's record did not include a client specific g-tube protocol which included checking for placement, residual and flushes that included when and how often they should be done (prior to every feed/medication administration and documented). The record did nor contain how medications are to be given one medication at a time, what the staff are to do with the results of the placement and residual, how to monitor and when to notify the nurse, and when and how a RN was monitoring of client #1's g-tube and RN client specific training for all staff who cared for client #1 at all sites where client #1 attended (home/work) according to clinical best nursing practice.			

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	The LPN was interviewed on 7/24/14 at 1:35 P.M. and stated, "No, we don't check for residual. I don't have them check for placement. I think that is advanced for them. He has been known to pull it out. He is my only G-tube guy." 3. Client #4's record was reviewed on 7/23/14 at 3:43 P.M. Client #4's record indicated he had chronic Otitis (ear infection) and toe nail fungus. Client #4's record indicated he had been seen by his physician for ear infections on 5/8/13, 9/3/13, 12/12/13 and 2/11/14; and for his toe nail fungus on 4/26/13, 5/8/13, 7/18/13, 10/17/13, 2/6/14 and 2/11/14. Client #4's PO indicated he was prescribed Acetic Acid (ear drops) for his left ear each night. Client #4's record did not include a protocol for how staff could assist client #4 with preventing his recurrent ear infections. Client #4's PO did not include any type of treatment for his recurrent toe nail fungus. His 10/17/13 appointment form for his toenail fungus indicated "Still awaiting decision on prescription...was refused due to cost. Nails today are unchanged and stable. Debrided today to reduce fungus." His 2/6/14 appointment form for his toenail fungus indicated "We never did hear back from the group home about nail fungus topical treatment...at this point toe nails appear stable without			

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	hearing further from the group home, there is not much I can do for his nails." Client #4's record did not include any protocol for treating his recurrent toenail fungus. The LPN was interviewed on 7/24/14 at 3:11 P.M. and indicated there were no risk plans or protocols in place to assist client #4 from his recurrent ear infections and toenail fungus. 9-3-6(a)			
W000338	483.460(c)(3)(v) 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 result in any necessary action (including referral to a physician to address client health problems). Based on record review and interview, the facility failed to follow-up on a recommended referral for an Occupational Therapy (OT) evaluation for 1 of 4 sampled clients (client #2).	W000338	Program nurse will obtain a referral and schedule an appointment for Client #2 for an OT evaluation as recommended by her PT evaluation. Program Nurse will receive	08/31/2014

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	Findings include: Client #2's record was reviewed on 7/23/14 at 3:04 P.M. Client #2's record indicated she had a Physical Therapy (PT) evaluation completed on 3/23/13. The PT evaluation indicated "Also recommend OT referral for ADL (adult daily living skills) consult / cognitive re-training." Client #2's record indicated her last OT evaluation was completed on 11/8/11. The LPN was interviewed on 7/24/14 at 2:08 P.M. When asked about client #2's referral to OT, the LPN stated, "I don't think she went to OT. We have to get referrals to go for therapy evaluations now." 9-3-6(a)		retraining to include ensuring that all recommendations for follow up from any medical appointments are reviewed, scheduled and/or completed as needed as soon as possible after the medical appointment. Ongoing, the Program Nurse will review all consumers medical appointment forms within 48 hours of the appointment to determine if any follow up treatment is needed. If any follow up is needed the Program nurse will work with the Home Manager and/or Program Director to ensure that appointments are scheduled, medications are ordered, etc. Responsible Party: Program Nurse, Home manager, Program Director	
W000356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive			

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	dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Based on record review and interview, the facility failed to ensure 1 of 4 sampled clients (client #2) received comprehensive dental care as recommended by her dentist. Findings include: Client #2's record was reviewed on 7/23/14 at 3:04 P.M. Client #2's record indicated she had a dental appointment on 1/23/14. The dental appointment form indicated "Several teeth are mobile due to severe periodontal disease. Pt. (patient) has very heavy plaque and tartar please help with daily brushing and rinses. Completed scale root plane (deep clean). Pt. to return for one month re-evaluation and oral hygiene check." Client #2's record did not indicate the facility had assisted her in returning to the dentist as recommended. The LPN was interviewed on 7/24/14 at 2:08 P.M. When asked about client #2's return appointment to the dentist for a re-evaluation as recommended, the LPN stated, "I don't think I realized that." 9-3-6(a)	W000356	Home Manager or Program Nurse will schedule a follow up dental appointment for Client #2 based on the recommendation from her previous dental appointment. Home Manager, Program Director and Program Nurse will be retrained on the need to follow up to ensure all clients are receiving dental treatment as recommended. Program Nurse will receive retraining to include ensuring that all recommendations for follow up from any medical and/or dental appointments are reviewed, scheduled and/or completed as needed as soon as possible after the medical appointment. Ongoing, the Program Nurse will review all consumers' medical and dental appointment forms within 48 hours of the appointment to determine if any follow up treatment is needed. If any follow up is needed the Program nurse will work with the Home Manager and/or Program Director to ensure that appointments are scheduled, medications are ordered, etc. Responsible Party: Program Nurse, Home manager, Program Director	08/31/2014

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W000368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed to administer medications according to 2 of 4 additional clients (clients #9 and #6) Physician's Order (PO). Findings include: Facility records including the BDDS reports dated 1/1/14 through 7/22/14 were reviewed on 7/22/14 at 11:20 A.M. The reports indicated the following: 1. -A BDDS report dated 1/23/14 for an incident on 1/22/14 at 3:45 P.M. indicated "On 12/27/13 [client #9] was admitted to [Hospital] with symptoms of pneumonia and trouble breathing. [Client #9] was sedated to keep him calm and intibated (sic) because he was having difficulty breathing. Medical staff decided to admit him to ICU (intensive care unit) and began treating him with antibiotics for pneumonia. On 1/5/14	W000368	1,2 The staff working in this home will be retrained on medication administration policy and procedures to include ensuring that all clients are given their medications as directed by the physician and as indicated by the MAR. Staff training will also include ensuring that medications given PRN for medical/dental appointments are only given as directed by the physician prior to appointments as needed. For 4 weeks, the Home Manager and/or Program Director will complete Medication observations a minimum of twice weekly to ensure staff are administering medications as prescribed. After the four weeks and ongoing, the Home Manager and/or the QIDP will complete a weekly medication administration observation to ensure the staff administer medications as prescribed. The HM and/or PD will be responsible for ensuring any necessary follow-up is completed for	08/31/2014

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	[client #9] was still in the hospital and sedated and intibated (sic). [Client #9] continued to have difficulty breathing. Hospital was questioning that [client #9] may need a tracheotomy. [Client #9's] Health Care Representative (HCR) was contacted and given an update on [client #9's] condition. [Client #9's] HCR/Sister made the decision not to do the tracheotomy and a DNR (Do Not Resuscitate Order) was placed. The hospital exibated (sic) [client #9] and he continued to breath (sic) on his own. On 1/13/14 [client #9] was discharged from Indiana Mentor Services. On 1/20/14 [Client #9] was moved to the [Hospital's Hospice]. On 1/22/14 at approximately 3:45 P.M. [client #9] passed away." Client #9's record was reviewed on 7/23/14 at 1:17 P.M. Client #9's certificate of death indicated the cause of his death was "Aspiration Pneumonia." Client #9's record indicated he was seen by his physician on 12/4/13. Client #9 was diagnosed with Gastroenteritis and Aspiration Pneumonia. Client #9 was prescribed Zofran (anti-nausea), Augmentin (antibiotic) and Mucinex (anticongestant). Client #9's MAR (medication administration record) dated for 12/2013 indicated he was not administered Mucinex as his physician had ordered. Client #9's MAR indicated		any errors made in the administration of medications. Responsible Staff: Home Manager, Program Director, Program Nurse	

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	he had a PRN (as needed) order for Guaifenesin for cough. The MAR indicated he was not administered his PRN medication during the month of 12/2013. 2. -A BDDS report dated 6/5/14 for an incident on 5/30/14 at 9:00 P.M. indicated "On 6/5/14, while staff was passing meds. (medication), it was noticed that a specific medication, Valium (Benzodiazepine-controlled substance schedule IV) 5mg (milligrams), for [client #6] was missing from its bubble pack and signed off as given by staff on 5/30/14. This medication was to be given to [client #6] prior to medical appointments. He was not scheduled for a medical appointment for this time." Client #6's record was reviewed on 7/23/14 at 2:09 P.M. Client #6's Physician's Order (PO) dated for 7/2014 indicated he was prescribed Diazepam (generic Valium) 5 mg one tablet by mouth one hour prior to procedure. The Home Manager (HM) was interviewed on 7/23/14 at 5:59 P.M. The HM stated, "It was given in error, it was to have been given on 5/19/14." The LPN was interviewed on 7/24/14 at 2:37 P.M. and stated, "He (client #9)			

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	should have been given his Guaifenesin at least if he wasn't given the Mucinex." "No, he (client #6) should not have been given the Valium on that day. He suffered no ill effects from it and I notified his doctor. We did find out that 5mg of Valium is not sufficient for a pre-med for medical procedures." 9-3-6(a)			
W000383	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview, the facility failed to keep the keys to the medication storage area in a secure place where only authorized persons would have access to the keys for the medications stored in the home where 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8) lived. Findings include:	W000383	The keys to the medication cabinet have been moved so that the clients are not able access them. All staff will receive retraining on the need to ensure that the keys to the medication cabinet are in a location that is not accessible by the consumers. For 4 weeks, the Home Manager and/or Program Director will complete Medication observations a minimum of twice weekly to ensure staff are keeping the keys to the	08/31/2014

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	Observations of the group home were conducted on 7/23/14 from 6:35 A.M. through 7:40 A.M. The keys to the medication storage area were hanging on a hook above the desk in the family room of the group home where clients #1, #2, #3, #4, #5, #6, #7 and #8 lived. The family room was located just inside the front door of the home to the left. Anyone entering the family room or walking through the family room to enter the dining room had access to the keys. On 7/23/14 at 5:40 P.M. client #1 was asked where the medication keys were located. Client #1 stated, "They are up there on the wall." An interview was conducted with the House Manager (HM) on 7/23/14 at 5:38 P.M. When asked if the med keys were secure, the HM stated, "As long as I have worked here they (the clients) have never touched them. They have always been hanging there." The LPN and the Program Director (PD) were interviewed on 7/24/14 at 2:07 P.M. When asked about the keys to the medications hanging on the wall of the family room, the LPN stated, "That is where they have always been kept." The PD stated, "They have been hanging there a long time."		medication cabinet secure and in a spot that consumers cannot readily access them. After the four weeks and ongoing, the Home Manager and/or the QIDP will complete a weekly medication administration observation to ensure the staff are keeping the keys to the medication cabinet secure and in a spot that consumers cannot readily access them Responsible staff: Home Manager, Program Director	

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	9-3-6(a)			
W000386	483.460(l)(4) DRUG STORAGE AND RECORDKEEPING The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq., as implemented by 21 CFR Part 308). Based on record review and interview, the facility failed to establish a system to ensure sufficient reconciliation of controlled medications for 1 of 2 clients reviewed who were prescribed controlled substance schedule medications (client #6). Findings include: Facility records including the BDDS reports dated 1/1/14 through 7/22/14 were reviewed on 7/22/14 at 11:20 A.M. The reports indicated the following: -A BDDS report dated 6/5/14 for an incident on 5/30/14 at 9:00 P.M. indicated "On 6/5/14, while staff was	W000386	All staff will receive retraining to include administering controlled substances as directed and making sure that controlled substance count sheets are filled out at each medication pass. The Home Manager, Program Director and/or Program Nurse will complete medication administration observations twice per week for four weeks to observe if staff are counting and recording controlled substance counts when they are assisting clients with medication administration and reporting any discrepancies to the Program Director and Area Director so that they can be investigated and reconciled as needed. After four weeks the Home Manager, Program Nurse and/or PD will complete	08/31/2014

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	passing meds. (medication), it was noticed that a specific medication, Valium (Benzodiazepine-controlled substance schedule IV) 5mg (milligrams), for [client #6] was missing from its bubble pack and signed off as given by staff on 5/30/14. This medication was to be given to [client #6] prior to medical appointments. He was not scheduled for a medical appointment for this time." Client #6's record was reviewed on 7/23/14 at 2:09 P.M. Client #6's Physician's Order (PO) dated for 7/2014 indicated he was prescribed Diazepam (generic Valium) 5 mg one tablet by mouth one hour prior to procedure, and Amphetamine Salts (generic Adderall-controlled substance schedule II) 30 mg daily at 8:00 A.M. and 30mg at 12:00 P.M. on Saturdays and Sundays. Client #6's record did not include a current count sheet for the controlled medication of Valium and the count sheet for Adderall had blank areas from 64 pills to 61 pills, from 61 pills to 51 pills, from 40 pills to 12 pills, and from 9 pills to 1 pill. There was no Valium count sheet available for review for 5/2014 when the Valium had been given in error on 5/30/14 and not discovered until 6/5/14. There was no Valium count sheet available for review for 6/2014 even though client #6's MAR (medication		medication administration observations once per week to observe if staff are counting and recording controlled substance counts when they are assisting clients with medication administration and reporting any discrepancies to the Program Director and Area Director so that they can be investigated and reconciled as needed. Responsible Staff: Program Nurse, Home Manager, Program Director, Area Director	

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	administration record) indicated he had been administered a Valium on 6/9/14 prior to a procedure. Client #6's Adderall count sheets for 6/2014 were blank except for six days (6/7/14, 6/8/14, 6/14/14, 6/15/14 6/21/14 and 6/22/14). The Home Manager (HM) was interviewed on 7/23/14 at 5:59 P.M. The HM stated, "They didn't have a count sheet for the Valium since it was just the one pill. It was given in error it was to have been given on 5/19/14." The LPN was interviewed on 7/24/14 at 2:37 P.M. and stated, "No, I didn't have a count sheet for the pre-med (Valium) and the count sheet for the Adderall should be filled out each time it is given." 9-3-6(a)			
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			

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	team as needed by the client. Based on observation, record review and interview, the facility failed to maintain in good repair a walking cane for 1 of 1 sampled client (client #3) who was blind and utilized a cane to assist with independent ambulation. Findings include: Observations were conducted at the group home on 7/23/14 from 6:35 A.M. through 7:40 A.M. Client #3 was utilizing a cane while ambulating throughout her home. The cane client #3 was using was missing the tip, was no longer straight and had paint scraped off. Client #3 was interviewed on 7/23/14 at 7:32 A.M. When asked about her cane, client #3 stated, "Yeah, I've had it for awhile. I need a new one." Client #3's record was reviewed on 7/23/14 at 3:28 P.M. Client #3's Physician's Order (PO) dated for 7/2014 indicated she had diagnoses of, but not limited to, Micro Opthalmia (abnormally small eyeballs) both eyes and Blindness. Client #3's Individual Support Plan (ISP) dated 10/30/13 indicated client #3 utilized "cane for blindness." The Program Director (PD) was	W000436	A new cane has been purchased for Client #3. Home Manager, Program Director and Program Nurse will receive retraining to include ensuring that all consumers have necessary adaptive equipment and that it is maintained in good working order. Training will include ensuring that once it is determined that adaptive equipment needs to be fixed or replaced that the Home Manager and/or Program Nurse will communicate with the Program Director to ensure adaptive equipment is repaired and/or replaced as needed in a timely manner. The Home Manager, Program Director will complete active treatment observations twice per week for four weeks to observe if all consumers' adaptive equipment is being maintained in good working order and repaired/replaced as needed. After four weeks and ongoing the Home Manager and/ or Program Director will complete active treatment observations at least once per week to observe if all consumers adaptive equipment is being maintained in good working order and repaired/replaced as needed. Responsible Staff: Program Nurse, Home Manager, Program Director	08/31/2014

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	interviewed on 7/24/14 at 2:19 P.M. The PD stated, "I have been trying to find a new tip for her cane. I haven't been able to find one. Today I tried to purchase a new cane and have not been able to locate one." 9-3-7(a)			