

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G631	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/15/2014
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NAME OF PROVIDER OR SUPPLIER  PARENTS AND FRIENDS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1738 FIFTH ST LA PORTE, IN 46350
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: January 8, 9, 10, 13, and 15, 2014.</p> <p>Facility number: 001204 Provider number: 15G631 AIM number: 100245720</p> <p>Surveyor: Tim Shebel, LSW</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/17/14 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, the facility's governing body failed to exercise general operating direction over the facility by failing to ensure lighting fixtures in the kitchen areas, living room area, and bedroom areas were clean and in good repair for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and 4</p>	W000104	<p>All burned out light bulbs have been replaced and lighting diffuser covers have been cleaned and are free of dirt and dead bugs. To ensure future compliance of this tag, the Interdisciplinary Team will begin conducting on going "Group Home Environmental Observations" on a monthly</p>	02/14/2014

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>additional clients (clients #5, #6, #7, and #8).</p> <p>Findings include:</p> <p>The group home where clients #1, #2, #3, #4, #5, #6, #7, and #8 resided was inspected during the 1/9/14 observation period from 3:02 P.M. until 4:51 P.M. The overhead lighting fixtures in both dining rooms and the living room were noted to have a large amount of dead insects in the diffuser (cover). The dining rooms and the living room were used by all clients of the facility (clients #1, #2, #3, #4, #5, #6, #7, and #8). The overhead light fixture in the bedroom shared by clients #5 and #6 had two of four light bulbs which were working. The overhead light fixture in the bedroom shared by clients #2 and #8 had two of four light bulbs which were working.</p> <p>Residential Director #1 was interviewed on 1/13/14 at 1:47 P.M. Residential Director #1 stated, "It is maintenance (the facility's maintenance department) who is responsible to clean and repair ceiling lights at the group home."</p> <p>9-3-1(a)</p>		<p>basis. Each observation will consist of at least two members of the team monitoring the homes for maintenance, housekeeping and other environmental needs/repairs. The team members will submit a list of needs to the Residential Director who will then review the list with the Maintenance Supervisor. A copy of the form will be given to the Executive Director for any necessary approvals for repairs and to follow-up with the Maintenance Supervisor for completion of all needs identified on the list. Staff will be retrained on the maintenance request forms so they may address needs that arise between the Environmental Observations. A supply of light bulbs will be kept at each group home so that direct support staff may make simple changes when necessary. (Responsible Parties: Stephenie Dreessen, Residential Director; Ron Kuta, Maintenance Supervisor; Debi Hagglund, Residential Program Manager; Jeff Rupe, QDDP; Matthew Cunningham, Behavior Support Specialist; Tina Watts, Team Leader; Victoria Penny, Team Leader)</p>				

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview, the facility failed to obtain hearing and vision evaluations within 30 days of admission for 1 of 4 sampled clients (client #4).</p> <p>Findings include:</p> <p>Client #4's records were reviewed on 1/13/14 at 12:11 P.M. A review of the client's record indicated she was admitted to the facility on 10/4/13. Further review of the client's record failed to indicate client #4 had hearing and vision evaluations completed within 30 days of admission.</p> <p>Nurse #1 was interviewed on 1/13/14 at 1:47 P.M. Nurse #1 indicated client #4 had not yet had hearing and vision evaluations completed.</p> <p>9-3-4(a)</p>	W000210	<p>Nursing staff have made appointments for the individual for eye and audiology evaluations; they are set for February 17, 2014. The RN and a familiar staff will attend the appointment with the individual to ensure compliance. To ensure future compliance of this tag, the nursing staff have created a checklist for new clients that consists of all necessary appointments and the timeframe in which they should be completed. This checklist will be included in the move-in packet. Should the individual refuse to go to set appointments, the IDT will meet to discuss how to gain compliance and/or alternative methods of evaluating the individual. The checklist will be reviewed for completion at the 30 day conference. All individual records will be reviewed to assess the need for audiology evaluations. (Responsible Parties: Stephenie Dreessen, Residential Director; Kerry Sevigny, RN; Marti Pizzinni, RN; Jeff Rupe, QDDP; Elizabeth Collins, Medical Support Staff)</p>	02/14/2014	

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W000220	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development.</p> <p>Based on observation, record review, and interview, the facility failed to obtain speech evaluations for 2 of 4 sampled clients (clients #2 and #4).</p> <p>Findings include:</p> <p>1. Client #2 was observed during the group home observation periods on 1/9/14 from 3:02 P.M. until 4:41 P.M., and on 1/10/14 from 5:44 A.M. until 7:15 A.M. Client #2 did not clearly speak in response to direct care staff's requests. Direct care staff #1, #2, #3, and #5 asked client #2 on 5 occasions during the observation periods to repeat his responses to staff's questions as to be better understood.</p> <p>Client #2's records were reviewed on 1/13/14 at 10:39 A.M. The review indicated the client was admitted to the facility on 9/24/12. A review of a 11/11 Social History indicated client #2 "does not express himself well. His (client #2's) speech is hard to understand and he speaks in single words or short phrases." Further review of client #2's record failed to indicate the client had a speech evaluation completed since his</p>	W000220	<p>The nursing staff have contacted a speech pathologist, Jill Oscars on, MA CCC-SLP, who will evaluate both individuals. Letters have been sent to both the individual's respective primary care physicians, requesting orders for speech evaluation. Upon receipt of the physician orders, we will contact Jill and schedule appointments for the individuals. Jill will also recommend alternative communication methods. To ensure future compliance of this tag, the nursing department has developed a checklist for new clients to be included in the move-in packet. The checklist will instruct staff to request speech evaluations for all individuals who are non-verbal or have other speech deficits. The checklist will be reviewed at the 30 day conference to ensure all required medical appointments/evaluations have been met. All individual records will be reviewed to assess the need for speech evaluations. (Responsible Parties: Stephenie Dreessen, Residential Director; Kerry Sevigny, RN; Marti Pizzinni, RN; JeffRupe, QDDP; Elizabeth Collins, Medical Support Staff)</p>	02/14/2014	

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	<p>admission to the facility.</p> <p>2. Client #4 was observed during the group home observation periods on 1/9/14 from 3:02 P.M. until 4:41 P.M., and on 1/10/14 from 5:44 A.M. until 7:15 A.M. Client #4 did not speak or vocalize.</p> <p>Direct care staff #1 was interviewed on 1/9/14 at 3:37 P.M. Direct care staff #1 stated, "[Client #4] is non-verbal although she understand a lot of what staff says to her."</p> <p>Client #4's records were reviewed on 1/13/14 at 12:11 P.M. The review indicated the client was admitted to the facility on 10/4/13. A review of an 8/25/06 "Initial Case Analysis" indicated client #4 was "non-verbal".</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/13/14 at 1:30 P.M. QIDP #1 indicated client #4's 8/25/06 "Initial Case Analysis" was used as her 10/4/13 admission assessment.</p> <p>Nurse #1 was interviewed on 1/13/14 at 1:47 P.M. Nurse #1 stated, "They (clients #2 and #4) have not received a speech assessment since they were admitted to the group home."</p>						

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W000382	<p>9-3-4(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, the facility failed to ensure medications were locked except when they were being prepared for administration for 1 of 4 sampled clients (client #1).</p> <p>Findings include:</p> <p>Direct care staff #5 was observed passing medications during the 1/10/14 observation period from 5:44 A.M. until 7:15 A.M. At 5:53 A.M., direct care staff #5 prepared medications for client #1 as the client sat in a chair next to the medication cart. Direct care staff #5 stated to the surveyor, "Since you are here, I'm going to set these (client #1's medications) here (on top of medication cart) and go get some water." Direct care staff #5 then exited the medication room to get water for client #1 to take her medications with. Direct care staff #5 was out of the medication area for 33 seconds and had left client #1's medication on the medication cart, unsecured, as client #1 sat in the</p>	W000382	<p>On January 16, 2014, all staff who work at the 5th Street and the Farr and Avenue group homes attended a training in which the QDDP covered the topic of locking all medications. He explained that a Parents and Friends' staff member who has been certified in Med Core A &amp; B are the only acceptable people who may prepare, monitor and dispense medications. If such a person is not available to assist, the medications must be placed in the med cart and locked prior to stepping away. The staff member, who failed to secure the medications when she stepped away from the med cart, was counseled by the group home team leader to ensure her understanding of the training. To ensure future compliance of this tag, the IDT will create a "Mock Survey" that will include on going monitoring of random medication passes at least one time weekly. The team members will communicate their concerns to the Residential Program Manager and determine if the staff member requires additional training, such as a Medication Review Training,</p>	02/14/2014

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W000436	<p>medication office waiting for her morning medications.</p> <p>Residential Director #1 was interviewed on 1/13/14 at 1:47 P.M. Residential Director #1 stated, "Medications are to be locked when they aren't being administered or being prepared to be administered."</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. Based on observation, record review, and interview, the facility failed to implement for 1 of 2 clients who wear prescribed eyeglasses (client #2) an objective to wear his eyeglasses.</p> <p>Findings include:</p> <p>Client #2 was observed during the group home observation periods on 1/9/14 from 3:02 P.M. until 4:41 P.M., and on 1/10/14 from 5:44 A.M. until 7:15 A.M.</p>	W000436	<p>with the nursing staff. The Program Manager will also ensure disciplinary action is followed as stated in the Medication Dispensation Policy/Procedure. The Residential Director will assign a specific month in the year in which all staff will be required to attend the Medication Review Training. (Responsible Parties: Stephenie Dreessen, Residential Director; Jeff Rupe, QDDP; Matthew Cunningham, Behavior Support Specialist; Kerry Sevigny, RN; Marti Pizzinni, RN; Deborah Hagglund, Residential Program Manager)</p> <p>On January 16, 2014, all staff who work at the 5th Street and the Farr and Avenue group homes attended a training in which the QDDP covered the topic of prompting individuals to wear all adaptive equipment. Staff were trained that if an individual should refuse to wear adaptive equipment staff should explain the benefits of compliance, the natural consequences of non-compliance and should continue to periodically prompt</p>	02/14/2014			

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W000488	<p>During the group home observation periods, client #2 did not wear eyeglasses. Direct care staff #1, #2, #3, #4 and #5 were not observed to prompt or assist client #2 to wear his eyeglasses.</p> <p>Client #2's records were reviewed on 1/13/14 at 10:39 A.M. A review of the client's 9/18/13 Individual Program Plan indicated the client had the following objective: "Wear glasses."</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/13/14 at 1:30 P.M. QIDP #1 stated, "[Client #2] has an objective to wear his eyeglasses and staff (direct care staff) should have prompted [client #2] to wear his eyeglasses."</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, record review, and interview, the facility failed to assure 4 of 4 sampled clients (clients #1,</p>	W000488	<p>the individual. To ensure future compliance of this tag, the QDDP will create a desensitization plan for the individual to wear his glasses and ensure all staff are trained on the objective and its implementation. The IDT will create a "Mock Survey" that will include on going monitoring of staff teaching individuals the benefits of wearing and the proper care of adaptive equipment. Mock Surveys will take place at least one time weekly. The team members will communicate their concerns to the Program Manager who will meet with the Team Leader to recommend individualized training and/or disciplinary action for specific staff. The training that was provided to the 5th Street and Farrand Avenue group homes will also be provided to the staff working at the Royal Road and Earl Road group homes. (Responsible Parties: Stephenie Dreessen, Residential Director; Jeff Rupe, QDDP; Matthew Cunningham, Behavior Support Specialist; Deborah Hagglund, Residential Program Manager; Tina Watts, Team Leader)</p> <p>On January 16, 2014, all staff who work at the 5th Street and the Farr and Avenue group homes attended a training in</p>	02/14/2014	

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	<p>#2, #3, and #4) participated in family style dining to the full extent of their assessed capabilities.</p> <p>Findings include:</p> <p>Clients #1, #2, #3, and #4 were observed at the group home during the 1/10/14 observation period from 5:44 A.M. until 7:15 A.M. During the observation, direct care staff #4 prepared individual servings of oatmeal and toast, and poured orange juice and milk and placed these items to each individual clients as clients #1, #2, #3, and #4 sat at the table. Clients #1, #2, #3, and #4 were not to be prompted or assisted by direct care staff #4 in preparing the oatmeal or toast or in pouring their own juice and milk.</p> <p>Client #1's records were reviewed on 1/13/14 at 11:27 A.M. A review of the client's 8/28/13 Ecological Inventory (Comprehensive Functional Assessment) indicated client #1 was developmentally capable, with staff assistance, of assisting with meal preparations and participating in the family style dining.</p> <p>Client #2's records were reviewed on 1/13/14 at 10:29 A.M. A review of the client's 10/13 Ecological Inventory (Comprehensive Functional</p>		<p>which the QDDP covered the topic of family style dining and individuals participating at their developmental level. Staff were reminded to use gestural, verbal or physical prompting and hand over hand assistance when necessary, to keep individuals involved in obtaining their meals and cleaning up when finished. To ensure future compliance of this tag, the IDT will create a "Mock Survey" that will include ongoing monitoring of staff during random meal times and coaching staff to assist each client based on their individual needs. Mock Surveys will take place at least one time weekly. The Team Leader will also monitor staff each time she is present in the home during meal times and will redirect staff to the appropriate procedures. The team members will communicate their concerns to the Program Manager who will meet with the Team Leader to recommend individualized training and/or disciplinary action for specific staff. The training that was provided to the 5th Street and Farrand Avenue group homes will also be provided to the staff working at the Royal Road and Earl Road group homes. (Responsible Parties: Stephenie Dreessen, Residential Director; Jeff Rupe, QDDP; Matthew Cunningham, Behavior Support Specialist; Deborah Hagglund, Residential Program Manager; Tina Watts, Team Leader)</p>				

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	<p>Assessment) indicated client #2 was developmentally capable, with staff assistance, of assisting with meal preparations and participating in the family style dining.</p> <p>Client #3's records were reviewed on 1/13/14 at 9:22 A.M. A review of the client's 7/17/13 Ecological Inventory (Comprehensive Functional Assessment) indicated client #3 was developmentally capable, with staff assistance, of assisting with meal preparations and participating in the family style dining.</p> <p>Client #4's records were reviewed on 1/13/14 at 12:11 P.M. A review of the client's 11/13 Ecological Inventory (Comprehensive Functional Assessment) indicated client #4 was developmentally capable, with staff assistance, of assisting with meal preparations and participating in the family style dining.</p> <p>Residential Director #1 was interviewed on 1/13/14 at 1:47 P.M.. Residential Director #1 indicated clients #1, #2, #3 and #4 were developmentally capable of participating in the preparation of their own meals with verbal prompts or hand over hand assistance from direct care staff.</p>			

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