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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G322 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>12/11/2014 |
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| W000000 | <p>This visit was for a recertification and state licensure survey.</p> <p>Survey Dates: December 5, 8, 9, 10 and 11, 2014</p> <p>Facility Number: 000840<br/>Provider Number: 15G322<br/>AIM Number: 100244010</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/18/14 by Ruth Shackelford, QIDP.</p>   | W000000 |  |            |
| W000104 | <p>483.410(a)(1)<br/>GOVERNING BODY<br/>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the governing body failed to exercise operating direction over the facility by failing to ensure: 1) the walls in the group home were repaired and repainted, 2) client #1 did not use a</p> | W000104 | <p><b>1. What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Maintenance notified regarding repair and painting of walls.</li> <li>· Walls will be repaired and painted.</li> <li>· Plastic ashtray has been disposed of.</li> </ul> | 01/10/2015 |

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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|                    | <p>plastic ashtray for the disposal of her cigarettes on the front porch and 3) staff did not leave the front door open while client #1 smoked on the front porch.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 12/8/14 from 3:26 PM to 6:08 PM and 12/9/14 from 5:53 AM to 7:48 AM. During the observations, the common areas walls and corners (entryway, hallways, dining room and bathrooms) were scuffed, marked, discolored, chipped, cracked, dented, dinged, scratched and missing paint throughout the group home. The walls were damaged from the floor to 18 inches above the floor. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>Client #1 and #2's bedroom had an 18 inch by 18 inch patched but unsanded and unpainted area behind the door. There was a 4 inch round patched, unsanded and unpainted area where the doorknob met the wall behind the door. Throughout client #1 and #2's bedroom, there were numerous unsanded and unpainted patches on the walls.</p> <p>Client #6 and #8's bedroom walls had numerous areas throughout the room where the paint was missing from the</p> |               | <ul style="list-style-type: none"> <li>· Staff trained on proper container that is to be utilized for disposal of cigarettes.</li> <li>· Staff trained on proper protocol for shutting door when clients are outside smoking.</li> </ul> <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All clients have the potential to be affected by this practice and monitoring will be put in place to ensure reporting and correction of issues.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Protocol for smoking developed.</li> <li>· Home Manager trained on reporting and follow-up of maintenance concerns.</li> <li>· Home Manager trained on proper smoking protocols.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Home Manager will document and copy all maintenance requests to Program Director upon submission.</li> <li>· Home Manager will document and copy all follow-up and</li> </ul> |                      |

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|   | <p>walls.</p> <p>On 12/9/14 at 6:08 PM, the Program Director (PD) indicated in an email, "I can not find the email from [name of maintenance staff] regarding the walls, I can have him possibly send me something stating that this is in the works, I am almost positive the board has been bought, he just needs to get down here and install it."</p> <p>On 12/8/14 at 3:28 PM, the Home Manager (HM) indicated maintenance was aware of the issues with the walls at the group home. The HM indicated the walls had been in this manner since at least July 2014 when she started working at the group home. The HM indicated the walls needed to be repaired and repainted. The HM indicated the maintenance staff informed her they were aware of the issue and were planning to repair and repaint the walls.</p> <p>On 12/9/14 at 11:09 AM, the Program Director (PD) indicated there was an email sent to maintenance (surveyor requested a copy of the email but did not receive a copy) about the walls at the group home. The PD indicated the walls needed to be repaired and repainted.</p> <p>2) Observations were conducted at the</p> |   | <p>completion of projects to Program Director.</p> <ul style="list-style-type: none"> <li>· Program Director will review all maintenance requests monthly to ensure that requests are completed.</li> <li>· Health and Safety Assessments completed quarterly to ensure that all maintenance issues are addressed. Assessments forwarded to Quality Assurance for further follow-up.</li> </ul> <p><b>1.What is the date by which the systemic changes will be completed?</b></p> <p>January 10, 2015</p> |   |  |   |  |

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|   | <p>group home on 12/8/14 from 3:26 PM to 6:08 PM and 12/9/14 from 5:53 AM to 7:48 AM. During the observations, there was a discarded cigarette and a flammable, plastic container to the right of the front door to the group home. The cigarette and container were sitting on a window sill. On 12/9/14 at 6:39 AM, client #1 went out the front door to smoke on the front porch. Client #1 discarded her cigarette butt in the plastic container on the window sill. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>On 12/9/14 at 11:09 AM, the Program Director (PD) indicated the designated smoking area at the group home was on the back porch. The PD indicated the plastic container being used for discarded cigarettes was not an approved container. The PD indicated client #1 should not be smoking on the front porch.</p> <p>3) Observations were conducted at the group home on 12/9/14 from 5:53 AM to 7:48 AM. On 12/9/14 at 6:39 AM, client #1 went out the front door to smoke on the front porch. Staff #7 lit client #1's cigarette and returned inside the group home leaving the front door open. At 6:46 AM, clients #2 and #5 complained of the cigarette smell entering the group home from the door being left open. At</p> |   |   |   |  |   |  |

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| W000148   | <p>6:47 AM, client #2 closed the front door and told staff #8 it smelled. This affected clients #2, #3, #4, #5, #6, #7 and #8.</p> <p>On 12/9/14 at 11:09 AM, the Program Director (PD) indicated the door should not be left open when client #1 was smoking. The PD indicated the front porch was not the designated smoking area and client #1 should not be smoking on the front porch.</p> <p>9-3-1(a)</p> <p>483.420(c)(6)<br/>COMMUNICATION WITH CLIENTS, PARENTS &amp;<br/>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview for 1 of 4 clients in the sample with a guardian (#7) and 1 of 4 non-sampled clients with a guardian (#2), the facility failed to ensure the guardians were notified and kept up-to-date regarding a change in services at the day program.</p> <p>Findings include:<br/>On 12/10/14 at 10:31 AM, client #7's</p> | W000148   | <p><b>W 148 Communication with Clients, Parents</b><br/>The facility failed to ensure the guardians were notified and kept up to date regarding a change in services at the day program.</p> <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· All guardians were notified and updated on 12/15 2014 regarding new day service.</li> <li>· IDT with guardians and</li> </ul> | 01/10/2015  |  |   |  |

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|   | <p>guardian indicated he was informed there was a change with client #7's day program at the beginning of 2015. The guardian indicated since the initial contact reporting there was going to be a change, he had not been informed of the status of the change of client #7's day program. Client #7's guardian indicated he was not informed the new day program would not have paid work. Client #7's guardian indicated he wanted to know what options client #7 had for day programming. Client #7's guardian indicated he had not been informed about the options client #7 had for Vocational Rehabilitation Services so client #7 could get or look into community employment. The guardian indicated he wanted to be informed of the changes and wanted to know who to contact at the group home to find out additional information about the pending changes.</p> <p>On 12/10/14 at 11:48 AM, client #2's guardian indicated he was informed there was a change with client #2's day program at the beginning of 2015. The guardian indicated since the initial contact reporting there was going to be a change, he had not been informed of the status of the change of client #2's day program. Client #2's guardian indicated he wanted to be notified of where client #2 would be attending, what services</p> |   | <p>clients regarding new day service.</p> <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>All clients were affected by this practice, and all clients' guardians and involved family have been notified regarding the change on 12/15/2014.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>Training with Home Manager and Program Director regarding notification of guardians and families for major events.</li> <li>Protocol for documentation of communication will be implemented.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>Home Manager and Program Director will document all family and guardian contact utilizing the T-Log module in Therap.</li> <li>Area Director will monitor T-Log module daily.</li> </ul> <p><b>1.What is the date by which the systemic changes will be completed?</b></p> |   |  |   |  |

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|   | <p>were offered and when the change would take place.</p> <p>On 12/9/14 at 9:08 AM, a review of client #7's record was conducted. There was no documentation in the record indicating the guardian was notified of the pending changes with the day program services.</p> <p>On 12/9/14 at 9:09 AM, a review of client #2's record was conducted. There was no documentation in the record indicating the guardian was notified of the pending changes with the day program services.</p> <p>On 12/11/14 at 10:55 AM, the Program Director (PD) indicated the guardians should be notified of the upcoming changes at the day program. The PD indicated she could only provide the information she had regarding the changes. The PD indicated she needed to make phone calls to the guardians and family members to let them know of the upcoming changes. The PD stated, "I don't want any concerns." The PD indicated she wanted the guardians to have the information she had regarding the changes at the day program. The PD stated, "I didn't even think about it" when asked if she contacted the clients' guardians about the upcoming changes.</p> |   | January 10, 2015  |   |  |   |  |

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| W000149   | <p>The PD indicated the guardians were notified there would be a change but there had been no updates provided to the guardians.</p> <p>9-3-2(a)</p> <p>483.420(d)(1)<br/>STAFF TREATMENT OF CLIENTS<br/>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 4 of 24 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6, #7 and #8, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients, conduct a thorough investigation and take appropriate corrective actions to address staff not implementing a program plan appropriately and staff failing to immediately report an allegation of neglect to the administrator.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/5/14 at 11:55 AM and indicated the following:</p> | W000149   | <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Training with group home direct support professionals regarding reporting abuse in a timely manner.</li> <li>· Training with group home direct support professionals regarding abuse/neglect policy.</li> <li>· Training with group home direct support professional regarding what constitutes abuse.</li> <li>· Training with day service staff on behavior plan for client who hit client 2 with a phone charger.</li> <li>· Training with Program Director and Area Director on thorough investigations.</li> <li>· Training with Home Manager on utilizing corrective action with staff exhibiting inappropriate behavior (i.e. lying on couch).</li> </ul> | 01/10/2015  |  |   |  |

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|   | <p>1) On 10/31/14 at 6:00 AM, staff #7 reported staff #10 was asleep when she arrived for her shift. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. The investigation, dated 11/6/14, indicated, "Evidence supports that [staff #10] was sleeping on 10.31.14." A Termination Notice, dated 11/7/14, indicated, "An allegation was made that [staff #10] was sleeping during an awake shift on October 31, 2014. During the investigation [staff #10] admitted that she did fall asleep. At this time we are ending [staff #10's] employment due to her admitting to falling asleep during an awake shift which is a direct violation of the Employee Information Guide which states that 'Sleeping during working hours, unless sleeping is explicitly permitted on an overnight shift' is a type of behavior that will not be permitted. [Staff #10] acknowledged the Employee Information Guide on July 20, 2014."</p> <p>On 12/8/14 at 3:03 PM, the Program Director (PD) indicated the facility had a policy and procedure prohibiting abuse and neglect of the clients. The PD indicated the facility should prevent abuse and neglect of the clients.</p> <p>On 12/9/14 at 8:30 AM, the Home Manager (HM) indicated staff #7 arrived</p> |   | <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>All residents were affected by this practice.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>Checklist developed to ensure investigations are timely, thorough and that all follow-up is completed.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>Quality Assurance will monitor investigations for thoroughness and timely reporting.</li> </ul> <p><b>1.What is the date by which the systemic changes will be completed?</b></p> <p>January 10, 2015</p> |   |  |   |  |

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|                    | <p>to work on 10/31/14 and observed staff #10 sleeping. Staff #7 reported it to the HM and the HM reported it to the PD. The HM indicated staff #10 was terminated. The HM indicated she periodically completed checks during the overnight shifts. The HM indicated prior to this incident, during one of her unannounced overnight visits, she observed staff #10 lying on the couch covered up with a blanket but she was not asleep. The HM indicated she told staff #10 she could not lie down during her shift.</p> <p>2) On 10/20/14 at 9:00 AM, staff #7 reported to the Home Manager that client #7 told her that former staff #10 had been sleeping while on shift the night before. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>The investigation, dated 10/23/14, indicated staff #7 was aware of the allegation on 10/17/14. The investigation indicated, "Reported that [client #7] had informed her on 10.20.14 that the overnight staff [staff #10] was sleeping on shift. Reported that she asked [client #7] if [staff #10] was sitting up or laying down, and [client #7] reported that she was laying down with a blanket. Reported that [client #7] had told her this on Friday (10.17.14) as well. Reported</p> |               |   |                      |

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|   | <p>that she did not report it on Friday because [client #7] kept changing her story. Reported that [client #7] told her on Friday that [staff #10] was laying down, and then [client #7] told her that [staff #10] was sitting up and that her eyes were awake. Reported that [client #7] finally told her that [staff #10] was not asleep on Friday. Reported that she had never personally witnessed [staff #10] sleeping." The Conclusion of the investigation indicated, "Evidence does not support that [staff #10] was sleeping on 10.20.14." The investigation did not address in the findings or conclusion staff #7 failing to immediately report the allegation of staff #10 sleeping on 10/17/14.</p> <p>There was no documentation of corrective action being taken with staff #7 for failing to immediately report client #7's allegation of staff #10 sleeping on 10/17/14.</p> <p>On 12/9/14 at 8:30 AM, the Home Manager (HM) indicated client #7 reported to her on 10/20/14 staff #10 was sleeping during her shift. The HM indicated she reported the allegation to the Program Director and staff #10 was suspended and an investigation was completed. Staff #10 returned to work after the investigation was</p> |   |   |   |  |   |  |

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|   | <p>unsubstantiated. The HM indicated she was not informed of the allegation by any of the staff. The HM indicated client #7 reported the allegation to staff #7 on 10/17/14. The HM indicated staff #7 should have immediately reported the allegation to the HM on 10/17/14. The HM indicated a Record of Discussion was completed with staff #7 for failing to immediately report the allegation.</p> <p>On 12/9/14 at 10:06 AM, the Program Director (PD) indicated she did not complete a Record of Discussion with staff #7 for failing to immediately report the allegation.</p> <p>On 12/9/14 at 10:06 AM, the Area Director (AD) indicated the investigation determined staff #7 was aware of the allegation on 10/17/14 but it was not reported until 10/20/14. The AD indicated there was no Record of Discussion completed with staff #7 due to client #7 changing her story when she was reporting it to staff #7. The AD indicated there was no recommendation in the investigation for a Record of Discussion so there was no need for the corrective action.</p> <p>3) On 9/17/14 at 11:02 AM at an outside services workshop, client #2 was hit by a peer with a phone charger. The Bureau</p> |   |   |                      |   |

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|                    | <p>of Developmental Disabilities Services (BDDS) report, dated 9/18/14, indicated, "He took a phone charger from a peers (sic) table and used it as a whip to hit [client #2]... [Client #2] had a red mark across her wrist." The investigation, dated 9/19/14, indicated in the Conclusion section, "Evidence supports staff did not implement BSP (Behavior Support Plan) appropriately." The Recommendations/Corrective Measures to Prevent the Likelihood of Future Occurrences section indicated, "Monitor for pattern of incidents between two clients." The investigation did not address staff not implementing the BSP appropriately.</p> <p>On 12/8/14 at 12:23 PM, the Area Director (AD) indicated in an email, "It should've been marked that they did implement the behavior plan correctly. That was mismarked."</p> <p>On 12/8/14 at 2:59 PM, the Program Director (PD) indicated she did not mark the investigation correctly. The PD indicated client #2's peer at the workshop was redirected per his plan. The PD indicated she should have marked the investigation appropriately. The PD indicated it was not a thorough investigation.</p> |               |   |                      |

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|   | <p>4) On 8/10/14 at 11:15 AM, client #8 reported former staff #9 had yelled at her and called her a derogatory name. No staff heard this take place but staff did report that staff #9 came out from attempting to assist client #8 and said client #8 was being a "b----."</p> <p>The BDDS follow-up report, dated 9/3/14, indicated, "An investigation was completed per protocol. Results were that the alleged staff was terminated."</p> <p>The investigation, dated 8/12/14, indicated in the Conclusion section, "Evidence supports that [staff #9] was verbally aggressive toward [client #8] on 8/10/2014. Evidence supports that [staff #9] was inappropriate in conversation about [client #8] in front of another resident." Staff #9's Termination Notice, dated 8/15/14, indicated, "On August 10, 2014 an allegation of verbal abuse was made against [staff #9]. During the investigation evidence supported the fact that [staff #9] used inappropriate language and called a client a derogatory name. At this time we are ending [staff #9's] employment for violating the Employee Information Guide which states that 'any acts of disrespect, abuse, and/or neglect toward the individuals we support' as an activity that are not permitted by Indiana MENTOR. [Staff</p> |   |   |   |  |   |  |

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|   | <p>#9] acknowledged this policy on February 15, 2014."</p> <p>On 12/8/14 at 3:03 PM, the Program Director (PD) indicated the facility had a policy and procedure prohibiting abuse and neglect of the clients. The PD indicated the facility should prevent abuse and neglect of the clients.</p> <p>On 12/5/14 at 4:51 PM, a review of the facility's Quality and Risk Management policy, dated April 2011, was conducted. The policy indicated, in part, "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." The policy indicated, "Any allegation of abuse or human rights violation is thoroughly investigated by the Area Director in consultation with Human Resources Department and/or Quality Assurance/Risk Management Department." The policy indicated, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing</p> |   |   |                      |   |

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| W000153   | <p>agencies. This list of rights should include, but is not limited to: e. Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment... o. The following actions are prohibited by employees of Indiana MENTOR: 1) abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds. 2) violation of an individual's rights."</p> <p>9-3-2(a)</p> <p>483.420(d)(2)<br/>STAFF TREATMENT OF CLIENTS<br/>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.<br/>Based on record review and interview for 1 of 24 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6, #7 and #8, the facility failed to ensure staff immediately reported an allegation of neglect to the administrator.</p> <p>Findings include:<br/><br/>A review of the facility's incident/investigative reports was conducted on 12/5/14 at 11:55 AM and</p> | W000153   | <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Training with group home direct support professionals regarding reporting abuse in a timely manner.</li> <li>· Training with group home direct support professionals regarding abuse/neglect policy.</li> <li>· Training with group home direct support professional regarding what constitutes abuse.</li> </ul> | 01/10/2015  |  |   |  |

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|                    | <p>indicated the following: On 10/20/14 at 9:00 AM, staff #7 reported to the Home Manager that client #7 told her that former staff #10 had been sleeping while on shift the night before. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>The investigation, dated 10/23/14, indicated staff #7 was aware of the allegation on 10/17/14. The investigation indicated, "Reported that [client #7] had informed her on 10.20.14 that the overnight staff [staff #10] was sleeping on shift. Reported that she asked [client #7] if [staff #10] was sitting up or laying down, and [client #7] reported that she was laying down with a blanket. Reported that [client #7] had told her this on Friday (10.17.14) as well. Reported that she did not report it on Friday because [client #7] kept changing her story. Reported that [client #7] told her on Friday that [staff #10] was laying down, and then [client #7] told her that [staff #10] was sitting up and that her eyes were awake. Reported that [client #7] finally told her that [staff #10] was not asleep on Friday. Reported that she had never personally witnessed [staff #10] sleeping." The Conclusion of the investigation indicated, "Evidence does not support that [staff #10] was sleeping on 10.20.14."</p> |               | <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>All residents were affected by this practice.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>Checklist developed to ensure investigations are timely, thorough and that all follow-up is completed.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>Quality Assurance will monitor investigations for thoroughness and timely reporting.</li> </ul> <p><b>1.What is the date by which the systemic changes will be completed?</b></p> <p>January 10, 2015</p> |                      |

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| W000154   | <p>On 12/9/14 at 8:30 AM, the Home Manager (HM) indicated client #7 reported to her on 10/20/14 staff #10 was sleeping during her shift. The HM indicated she reported the allegation to the Program Director and staff #10 was suspended and an investigation was completed. Staff #10 returned to work after the investigation was unsubstantiated. The HM indicated she was not informed of the allegation by any of the staff. The HM indicated client #7 reported the allegation to staff #7 on 10/17/14. The HM indicated staff #7 should have immediately reported the allegation to the HM on 10/17/14.</p> <p>On 12/9/14 at 10:06 AM, the Area Director (AD) indicated staff #7 did not immediately report the allegation to the administrator on 10/17/14 due to client #7 changing her reporting of the incident.</p> <p>9-3-2(a)</p> <p>483.420(d)(3)<br/>STAFF TREATMENT OF CLIENTS<br/>The facility must have evidence that all alleged violations are thoroughly investigated.<br/>Based on record review and interview for</p> | W000154   | 1.What corrective action will be accomplished?  | 01/10/2015  |  |   |  |

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|   | <p>2 of 24 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6, #7 and #8, the facility to conduct thorough investigations of allegations of abuse and neglect of the clients.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/5/14 at 11:55 AM and indicated the following:</p> <p>1) On 10/20/14 at 9:00 AM, staff #7 reported to the Home Manager that client #7 told her that former staff #10 had been sleeping while on shift the night before. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>The investigation, dated 10/23/14, indicated staff #7 was aware of the allegation on 10/17/14. The investigation indicated, "Reported that [client #7] had informed her on 10.20.14 that the overnight staff [staff #10] was sleeping on shift. Reported that she asked [client #7] if [staff #10] was sitting up or laying down, and [client #7] reported that she was laying down with a blanket. Reported that [client #7] had told her this on Friday (10.17.14) as well. Reported that she did not report it on Friday because [client #7] kept changing her</p> |   | <ul style="list-style-type: none"> <li>· Training with Program Director and Area Director on thorough investigations.</li> <li>· Training with Home Manager on utilizing corrective action with staff exhibiting inappropriate behavior (i.e. lying on couch).</li> </ul> <p><b>2 How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents were affected by this practice.</li> </ul> <p><b>3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Checklist developed to ensure investigations are timely, thorough and that all follow-up is completed.</li> </ul> <p><b>4 How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Quality Assurance will monitor investigations for thoroughness and timely reporting.</li> </ul> <p><b>5 What is the date by which the systemic changes will be completed?</b></p> <p>January 10, 2015</p> |                      |   |

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|  | <p>story. Reported that [client #7] told her on Friday that [staff #10] was laying down, and then [client #7] told her that [staff #10] was sitting up and that her eyes were awake. Reported that [client #7] finally told her that [staff #10] was not asleep on Friday. Reported that she had never personally witnessed [staff #10] sleeping." The Conclusion of the investigation indicated, "Evidence does not support that [staff #10] was sleeping on 10.20.14." The investigation did not address in the findings or conclusion staff #7 failing to immediately report the allegation of staff #10 sleeping on 10/17/14.</p> <p>On 12/9/14 at 8:30 AM, the Home Manager (HM) indicated client #7 reported to her on 10/20/14 staff #10 was sleeping during her shift. The HM indicated she reported the allegation to the Program Director and staff #10 was suspended and an investigation was completed. Staff #10 returned to work after the investigation was unsubstantiated. The HM indicated she was not informed of the allegation by any of the staff. The HM indicated client #7 reported the allegation to staff #7 on 10/17/14. The HM indicated staff #7 should have immediately reported the allegation to the HM on 10/17/14.</p> |  |  |  |
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|                    | <p>On 12/9/14 at 10:06 AM, the Area Director (AD) indicated the investigation determined staff #7 was aware of the allegation on 10/17/14 but it was not reported until 10/20/14. The AD indicated there was no Record of Discussion completed with staff #7 due to client #7 changing her story when she was reporting it to staff #7.</p> <p>2) On 9/17/14 at 11:02 AM at an outside services workshop, client #2 was hit by a peer with a phone charger. The Bureau of Developmental Disabilities Services (BDDS) report, dated 9/18/14, indicated, "He took a phone charger from a peers (sic) table and used it as a whip to hit [client #2]... [Client #2] had a red mark across her wrist." The investigation, dated 9/19/14, indicated in the Conclusion section, "Evidence supports staff did not implement BSP (Behavior Support Plan) appropriately." The Recommendations/Corrective Measures to Prevent the Likelihood of Future Occurrences section indicated, "Monitor for pattern of incidents between two clients." The investigation did not address staff not implementing the BSP appropriately.</p> <p>On 12/8/14 at 12:23 PM, the Area Director (AD) indicated in an email, "It should've been marked that they did</p> |               |   |                      |

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| W000157            | <p>implement the behavior plan correctly. That was mismarked."</p> <p>On 12/8/14 at 2:59 PM, the Program Director (PD) indicated she did not mark the investigation correctly. The PD indicated client #2's peer at the workshop was redirected per his plan. The PD indicated she should have marked the investigation appropriately. The PD indicated it was not a thorough investigation.</p> <p>9-3-2(a)</p> <p>483.420(d)(4)<br/>STAFF TREATMENT OF CLIENTS<br/>If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 24 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6, #7 and #8, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients, conduct a thorough investigation and take appropriate corrective actions to address staff not implementing a program plan appropriately and staff failing to immediately report an allegation of neglect to the administrator.</p> | W000157       | <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Training with group home direct support professionals regarding reporting abuse in a timely manner.</li> <li>· Training with group home direct support professionals regarding abuse/neglect policy.</li> <li>· Training with group home direct support professional regarding what constitutes abuse.</li> <li>· Training with day service staff on behavior plan for client who hit</li> </ul> | 01/10/2015           |

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| NAME OF PROVIDER OR SUPPLIER<br><br>REM OCCAZIO LLC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>568 YORKTOWN RD<br>GREENWOOD, IN 46142 |  |   |  |
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|   | <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/5/14 at 11:55 AM and indicated the following: On 10/20/14 at 9:00 AM, staff #7 reported to the Home Manager that client #7 told her that former staff #10 had been sleeping while on shift the night before. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>The investigation, dated 10/23/14, indicated staff #7 was aware of the allegation on 10/17/14. The investigation indicated, "Reported that [client #7] had informed her on 10.20.14 that the overnight staff [staff #10] was sleeping on shift. Reported that she asked [client #7] if [staff #10] was sitting up or laying down, and [client #7] reported that she was laying down with a blanket. Reported that [client #7] had told her this on Friday (10.17.14) as well. Reported that she did not report it on Friday because [client #7] kept changing her story. Reported that [client #7] told her on Friday that [staff #10] was laying down, and then [client #7] told her that [staff #10] was sitting up and that her eyes were awake. Reported that [client #7] finally told her that [staff #10] was not asleep on Friday. Reported that she</p> |   | <p>client 2 with a phone charger.</p> <ul style="list-style-type: none"> <li>· Training with Program Director and Area Director on thorough investigations.</li> <li>· Training with Home Manager on utilizing corrective action with staff exhibiting inappropriate behavior (i.e. lying on couch).</li> </ul> <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents were affected by this practice.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Checklist developed to ensure investigations are timely, thorough and that all follow-up is completed.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Quality Assurance will monitor investigations for thoroughness and timely reporting.</li> </ul> <p><b>1.What is the date by which the systemic changes will be completed?</b></p> <p>January 10, 2015</p> |   |  |   |  |

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|                    | <p>had never personally witnessed [staff #10] sleeping." The Conclusion of the investigation indicated, "Evidence does not support that [staff #10] was sleeping on 10.20.14." The investigation did not address in the findings or conclusion staff #7 failing to immediately report the allegation of staff #10 sleeping on 10/17/14.</p> <p>There was no documentation of corrective action being taken with staff #7 for failing to immediately report client #7's allegation of staff #10 sleeping on 10/17/14.</p> <p>On 12/9/14 at 8:30 AM, the Home Manager (HM) indicated client #7 reported to her on 10/20/14 staff #10 was sleeping during her shift. The HM indicated she reported the allegation to the Program Director and staff #10 was suspended and an investigation was completed. Staff #10 returned to work after the investigation was unsubstantiated. The HM indicated she was not informed of the allegation by any of the staff. The HM indicated client #7 reported the allegation to staff #7 on 10/17/14. The HM indicated staff #7 should have immediately reported the allegation to the HM on 10/17/14. The HM indicated a Record of Discussion was completed with staff #7 for failing to</p> |               |   |                      |

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| W000240            | <p>immediately report the allegation.</p> <p>On 12/9/14 at 10:06 AM, the Program Director (PD) indicated she did not complete a Record of Discussion with staff #7 for failing to immediately report the allegation.</p> <p>On 12/9/14 at 10:06 AM, the Area Director (AD) indicated the investigation determined staff #7 was aware of the allegation on 10/17/14 but it was not reported until 10/20/14. The AD indicated there was no Record of Discussion completed with staff #7 due to client #7 changing her story when she was reporting it to staff #7. The AD indicated there was no recommendation in the investigation for a Record of Discussion so there was no need for the corrective action.</p> <p>9-3-2(a)</p> <p>483.440(c)(6)(i)<br/>INDIVIDUAL PROGRAM PLAN<br/>The individual program plan must describe relevant interventions to support the individual toward independence.<br/>Based on observation, interview and record review for 1 of 4 clients in the sample (#1), the facility failed to ensure client #1's Dining Plan included relevant</p> | W000240       | <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Client 1's dining plan updated to include positioning during meals.</li> <li>· Formal programming for</li> </ul> | 01/10/2015           |

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|                    | <p>interventions on the position client #1 was supposed to be in during meals.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/8/14 from 3:26 PM to 6:08 PM and 12/9/14 from 5:53 AM to 7:48 AM. On 12/8/14 at 5:40 PM, client #1 started to eat her dinner. Client #1 was sitting in a wheelchair, her body tilted forward, with her chin at plate level. Client #1 ate her meal in this position without being prompted to sit up or change her position in her wheelchair. At 6:01 PM, client #1 finished her meal in the same position. On 12/9/14 at 5:53 AM, client #1 was eating breakfast. Client #1 was sitting in a wheelchair with her body tilted forward and her head at the level of the table. Client #1 continued to eat her breakfast in this position until she was finished eating at 6:15 AM. Client #1 was not prompted to sit up or change her position during breakfast.</p> <p>On 12/9/14 at 8:38 AM, a review of client #1's record was conducted. Client #1's August 2014 Dining Plan indicated, in part, "Prompt for good positioning with eating." The Dining Plan did not specify or instruct the staff on what "good positioning" was for client #1 during</p> |               | <p>Client 1 to ensure proper positioning during meals.</p> <ul style="list-style-type: none"> <li>· Training with direct support professionals regarding updated dining plan and formal program for Client 1.</li> </ul> <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All dining plans will be reviewed to ensure that they are updated and include most recent recommendations from dietician.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Daily documentation of formal programming for Client 1 in regard to positioning during meal by direct support staff.</li> <li>· Daily observation and documentation of client 1's positioning during meal time.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Home Manager will scan all observation documentation to Program Director and Area Director daily.</li> </ul> <p><b>1.What is the date by which the</b></p> |                      |

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| W000249   | <p>meals. Client #1's Risk Plan, dated 8/11/14, indicated, in part, for Choking, "During Mealtime: 1. Make sure person has proper positioning during mealtime (sit upright, bottom at back of chair)...". Client #1's Quarterly Nutrition Review, dated 8/6/14, indicated, in part, "Prompt [client #1] for good positioning at the table to ensure safety with eating and for good digestion... Follow dining plan."</p> <p>On 12/9/14 at 11:23 AM, the nurse indicated client #1 should be sitting in her wheelchair as far back as possible with her body and legs at 90 degrees. The nurse indicated client #1's plan needed to be revised to include the position she should be in during meals. The nurse indicated client #1 would change her position if the staff prompted her to change her position.</p> <p>9-3-4(a)</p> <p>483.440(d)(1)<br/>PROGRAM IMPLEMENTATION<br/>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> |   | <p><b>systemic changes will be completed?</b></p> <p>January 10, 2015</p>                                       |   |  |   |  |

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|   | <p>Based on observation, record review and interview for 8 of 8 clients, the facility failed to ensure staff implemented, as written, the following: 1) client #1, #3 and #8's medication administration training objectives, 2) client #4's dining plan to use toddler utensils, 3) client #1's dining plan for positioning, 4) client #1's plan to access her cigarettes, 5) client #1, #2, #3, #4, #5, #6 and #8's risk plans to encourage fluid between bites and 6) client #3's Dining Plan for when to notify the nursing staff.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/8/14 from 3:26 PM to 6:08 PM and 12/9/14 from 5:53 AM to 7:48 AM.</p> <p>1) On 12/9/14 at 6:07 AM, client #8 received a medication from staff #7. Client #8 was not prompted to select the correct medication card for the medication pass, identify the correct medication for the medication pass, check to ensure the correct pills were in the medication packaging for the medication pass and open the correct medication package for the medication pass. Staff #7 asked client #8 to identify the purpose of her medication.</p> | W000249   | <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Staff training regarding formal programming during med administration.</li> <li>· Staff training regarding Client 4's dining plan to utilize toddler spoons.</li> <li>· Formal programming for Client 4 to utilize correct adaptive equipment during meal.</li> <li>· Staff training regarding Client 1's formal programming to access her cigarettes.</li> <li>· Review of Client 1, 2, 3, 4, 5, 6 and 8's risk plans to ensure they are consistent with dietary recommendations in regard to alternating fluid between bites.</li> <li>· Update of Risk Plans for clients who are not at risk for choking or fast-pace eating to not include alternating fluid between bites.</li> <li>· Staff training regarding all dining plan updates.</li> <li>· Staff training regarding Client 3's dining plan and protocol to notify nursing staff.</li> </ul> <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All dining plans, risk plans and formal programming reviewed to ensure recommendations from dietician are followed.</li> </ul> | 01/10/2015  |  |   |  |

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|   | <p>On 12/9/14 at 7:26 AM, staff #7 indicated client #8's medication training objective was to pick the correct medication cabinet where her medication was stored.</p> <p>On 12/9/14 at 9:15 AM, a review of client #8's Individual Support Plan (ISP), dated 4/22/14, indicated she had a medication training objective to independently select the correct medications for the medication pass. The tasks indicated, "Did she select (sic) the correct medication card for that med pass? Did she identify the correct meds for that med pass by reading the time/date on the package? Did she check to make sure the correct pulls were in the med bubble for that med pass? Did she open the correct med bubble for that med pass?"</p> <p>On 12/9/14 at 6:18 AM, client #3 received her medications from staff #7. Client #3 was not prompted to state the purpose of two of her medications.</p> <p>On 12/9/14 at 7:26 AM, staff #7 indicated client #3's medication training objective was to sanitize her hands and take her medications with applesauce.</p> <p>On 12/9/14 at 9:18 AM, a review of client #3's ISP, dated 8/9/14, indicated</p> |   | <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Daily documentation of Client 4's program to utilize toddler spoons during meal.</li> <li>· Daily documentation of Client 1's program regarding accessing cigarettes.</li> <li>· Daily observation and documentation to ensure clients dining plans are followed and clients are utilizing all adaptive equipment during meals.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Home Manager will scan all observation documentation to Program Director and Area Director daily.</li> </ul> <p><b>1.What is the date by which the systemic changes will be completed?</b></p> <p>January 10, 2015</p> |                      |   |

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|                    | <p>she had a medication training objective to independently state the purpose of two of her medications. The task indicated, "When given 3 choices, did she state the correct purpose for taking this medication?"</p> <p>On 12/9/14 at 6:32 AM, client #1 received her medications from staff #7. Staff #7 did not prompt client #1 to pull the medication packages from the medication cart during the medication pass.</p> <p>On 12/9/14 at 8:38 AM, client #1's ISP, dated 4/4/14, indicated she had a medication training objective to pull her medication packages from the medication cart during the medication pass.</p> <p>On 12/9/14 at 7:25 AM, staff #7 indicated client #1's medication training objective was to name the purpose of her medications. Staff #7 indicated she did not implement the medication training objective during client #1's medication pass.</p> <p>On 12/9/14 at 11:19 AM, the Program Director (PD) indicated the clients' medication training objectives should be implemented at every medication pass.</p> <p>2) On 12/8/14 at 5:42 PM, client #4</p> |               |   |                      |

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|                    | <p>started eating her dinner. Client #4 did not have toddler utensils for her use during dinner. On 12/9/14 at 6:40 AM while client #4 was eating breakfast, client #4 did not have toddler utensils. During both meals, client #4 ate her meals using regularly sized utensils.</p> <p>On 12/9/14 at 8:49 AM, a review of client #4's ISP, dated 8/8/14, indicated her adaptive equipment included the use of toddler utensils.</p> <p>On 12/9/14 at 11:09 AM, the Program Director (PD) indicated client #4's plan for the use of toddler utensils should be implemented as written.</p> <p>On 12/9/14 at 11:09 AM, the nurse indicated client #4's plan for the use of toddler utensils should be implemented as written.</p> <p>3) On 12/8/14 at 5:40 PM, client #1 started to eat her dinner. Client #1 was sitting in a wheelchair, her body tilted forward, with her chin at plate level. Client #1 ate her meal in this position without being prompted to sit up or change her position in her wheelchair. At 6:01 PM, client #1 finished her meal in the same position. On 12/9/14 at 5:53 AM, client #1 was eating breakfast. Client #1 was sitting in a wheelchair with</p> |               |   |                      |

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|   | <p>her body tilted forward and her head at the level of the table. Client #1 continued to eat her breakfast in this position until she was finished eating at 6:15 AM. Client #1 was not prompted to sit up or change her position during breakfast.</p> <p>On 12/9/14 at 8:38 AM, a review of client #1's record was conducted. Client #1's August 2014 Dining Plan indicated, in part, "Prompt for good positioning with eating." Client #1's Risk Plan, dated 8/11/14, indicated, in part, for Choking, "During Mealtime: 1. Make sure person has proper positioning during mealtime (sit upright, bottom at back of chair)...". Client #1's Quarterly Nutrition Review, dated 8/6/14, indicated, in part, "Prompt [client #1] for good positioning at the table to ensure safety with eating and for good digestion... Follow dining plan."</p> <p>On 12/9/14 at 11:23 AM, the nurse indicated client #1's dining plan should be implemented as written. The nurse indicated the staff should have prompted client #1 to have proper positioning (sitting in her wheelchair as far back as possible with her body and legs at 90 degrees) during the meal.</p> <p>On 12/9/14 at 11:23 AM, the PD indicated client #1's dining plan should</p> |   |   |   |  |   |  |

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|   | <p>have been implemented as written. The PD indicated the staff should have prompted her to sit up during the meals.</p> <p>4) On 12/9/14 at 6:38 AM, staff #7 used a key accessible to the staff to unlock a locked box to access client #1's cigarettes. Staff #7 took out a bag from the box and gave client #1 one cigarette. Staff #7 did not prompt client #1 to locate where her cigarettes were stored. Staff #7 did not prompt client #1 to access her cigarettes. Staff #7 did not give client #1 a choice to have more than one cigarette.</p> <p>On 12/9/14 at 8:38 AM, a review of client #1's ISP, dated 4/4/14, indicated she had a training objective to independently locate and access her cigarettes. The plan indicated, "With staff monitoring did [client #1] locate where her cigarettes are kept? Did [client #1] count out 3 cigarettes? Did [client #1] take her cigarettes out and place them in her case or a baggie?"</p> <p>On 12/9/14 at 11:34 AM, the PD indicated the staff should implement client #1's plan to access her cigarettes as written.</p> <p>5) On 12/8/14 at 5:40 PM, clients #1, #2, #3, #4, #5, #6 and #8 started to eat their</p> |   |   |   |  |   |  |

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|                    | <p>dinner. Clients #1, #2, #3, #4, #5, #6 and #8 were not encouraged to take drinks between bites during dinner. On 12/9/14 at 5:53 AM, clients #1 and #3 were eating breakfast. Clients #1 and #3 were not encouraged to take drinks between bites. At 5:55 AM, client #6 ate her breakfast. Client #6 was not encouraged to take drinks between bites. At 6:40 AM while clients #4 and #8 were eating breakfast, they were not prompted to take drinks between bites.</p> <p>On 12/9/14 at 8:38 AM, client #1's Risk Plan for choking, dated 8/11/14, was reviewed. The plan indicated, in part, "Encourage fluid between bites/bites no larger than 1 teaspoon."</p> <p>On 12/9/14 at 9:09 AM, client #2's Risk Plan for choking, dated 8/25/14, was reviewed. The plan indicated, in part, "Encourage fluid between bites/bites no larger than 1 teaspoon."</p> <p>On 12/9/14 at 9:18 AM, client #3's Risk Plan for choking, dated 8/25/14, was reviewed. The plan indicated, in part, "Encourage fluid between bites/bites no larger than 1 teaspoon."</p> <p>On 12/9/14 at 8:49 AM, client #4's Risk Plan for choking, dated 8/25/14, was reviewed. The plan indicated, in part,</p> |               |   |                      |

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|                    | <p>"Encourage fluid between bites/bites no larger than 1 teaspoon."</p> <p>On 12/9/14 at 9:01 AM, client #5's Risk Plan for choking, dated 8/25/14, was reviewed. The plan indicated, in part, "Encourage fluid between bites/bites no larger than 1 teaspoon."</p> <p>On 12/9/14 at 10:03 AM, client #6's Risk Plan for choking, dated 8/25/14, was reviewed. The plan indicated, in part, "Encourage fluid between bites/bites no larger than 1 teaspoon."</p> <p>On 12/9/14 at 9:15 AM, client #8's Risk Plan for choking, dated 8/25/14, was reviewed. The plan indicated, in part, "Encourage fluid between bites/bites no larger than 1 teaspoon."</p> <p>On 12/11/14 at 10:55 AM, the Program Director (PD) indicated the clients' plans should be implemented as written. The PD indicated the staff should prompt the clients to take drinks after each bite per the plan.</p> <p>6) On 12/8/14 at 5:51 PM during dinner, client #3 coughed after taking a drink. Staff #7 got client #3 a straw to drink out of. At 5:54 PM, client #3 coughed again after taking a bite of spaghetti. On 12/9/14 at 6:51 AM, client #3 took a</p> |               |   |                      |

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|                    | <p>drink of coffee and then coughed several times. Client #3 stated, "I'm fine, just take a spell."</p> <p>On 12/9/14 at 9:18 AM, a review of client #3's Dining Plan, dated 6/10/14, indicated, in part, "Triggers to notify nursing staff: coughing with signs of struggle (watery eyes, drooling, facial redness)." There was no documentation in client #3's record indicating the nursing staff was notified.</p> <p>On 12/10/14 at 2:50 PM, the nurse indicated she was not notified on 12/9/14 or 12/10/14 of client #3 coughing during meals. The nurse indicated she should have been notified. The nurse indicated client #3's dining plan indicated if client #3 coughs, the nurse should be notified.</p> <p>On 12/11/14 at 10:55 AM, the PD indicated she was not informed of client #3 coughing during meals. The PD indicated client #3's plan for nursing notification should be implemented as written.</p> <p>9-3-4(a)</p> |               |   |                      |

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| W000331   | <p>483.460(c)<br/>NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 4 clients in the sample (#1), the facility's nursing services failed to ensure client #1 had a follow-up neurologist appointment, as recommended.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 12/9/14 at 8:38 AM. Client #1's most recent neurologist appointment, dated 3/14/14, indicated a return to clinic recommendation in 6 months. Client #1's record did not include documentation of a follow-up appointment.</p> <p>On 12/9/14 at 11:03 AM, the nurse indicated client #1 should have had a follow-up neurologist appointment as indicated on the documentation from the 3/14/14 appointment.</p> <p>9-3-6(a)</p> | W000331   | <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>Client 1's appointment with neurologist scheduled for 12/30/2014.</li> </ul> <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>Review all recommendations from client appointments to ensure follow-up appointments are made.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>Develop Protocol for reporting of outcomes of appointments to nursing staff.</li> <li>Training with Home Manager regarding protocol for reporting outcomes of appointments to nursing staff.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>Home Manager will scan appointment notes to RN, Program Director and Area Director immediately following appointment.</li> </ul> | 01/10/2015           |   |

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| W000436   | <p>483.470(g)(2)<br/>SPACE AND EQUIPMENT<br/>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation and interview for 1 of 4 clients in the sample with adaptive equipment (#5) and 2 of 2 non-sampled clients with adaptive equipment (#3 and #8), the facility failed to ensure: 1) client #3's portable oxygen tank's gauge worked properly, 2) client #5's glasses were replaced when they were lost and 3) client #8's wheelchair was in good repair.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 12/9/14 from 5:53 AM to</p> | W000436   | <ul style="list-style-type: none"> <li>· Home Manager will include enter follow-up appointment information into Therap appointment module.</li> <li>· RN, Program Director and Area Director will review notes and ensure follow-up instructions have been followed.</li> </ul> <p><b>1.What is the date by which the systemic changes will be completed?</b></p> <p>January 10, 2015</p> <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Client 3's portable oxygen tank replaced.</li> <li>· Client 5's glasses replaced.</li> <li>· Client 8's wheelchair replaced.</li> </ul> <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All client's adaptive equipment will be checked to ensure that it is in working order.</li> </ul> | 01/10/2015           |   |

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|   | <p>7:48 AM. On 12/9/14 at 6:16 AM, client #3's portable oxygen tank's gauge indicating the amount of oxygen in the tank read zero.</p> <p>On 12/9/14 at 6:16 AM, staff #7 indicated the gauge had been broken for over a year. Staff #7 indicated the staff could tell by picking up the tank whether or not the tank had oxygen or not (by the weight of the tank). Staff #7 indicated the gauge did not move and did not indicate the amount of oxygen in the tank.</p> <p>On 12/9/14 at 6:17 AM, client #3 stated, "I need a new one. I've had this one for a very long time."</p> <p>On 12/10/14 at 2:50 PM, the nurse indicated client #3's oxygen tank's gauge should function properly. The nurse indicated she was not aware the gauge was not working. The nurse indicated the tank needed to be replaced to ensure client #3 had a tank with a functioning gauge.</p> <p>On 12/11/14 at 10:55 AM, the Program Director (PD) indicated she was not aware of client #3's oxygen tank gauge not functioning. The PD indicated the gauge should function properly.</p> |   | <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Staff training regarding monitoring of adaptive equipment.</li> <li>· Implement protocol for staff to report defective or damaged adaptive equipment.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Home Manager will document and log progress with getting adaptive equipment replaced or repaired.</li> </ul> <p><b>1.What is the date by which the systemic changes will be completed?</b></p> <p>January 10, 2015</p> |   |  |   |  |

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|   | <p>2) Observations were conducted at the group home on 12/8/14 from 3:26 PM to 6:08 PM and 12/9/14 from 5:53 AM to 7:48 AM. During the observations, client #5 was not observed to wear glasses.</p> <p>On 12/8/14 at 4:58 PM, client #5 stated, "I can't find my glasses. Been missing awhile."</p> <p>On 12/11/14 at 10:55 AM, the PD indicated client #5 should have her glasses and the staff should prompt her to wear her glasses. The PD indicated she was not aware of client #5's glasses being lost.</p> <p>3) On 12/9/14 at 6:10 AM, client #8's right wheelchair armrest had a 1.5 inch area where the cover was ripped and the padding was exposed. Below the rip, there was a 2 inch plastic piece with sharp edges broken off her armrest. Client #8's seatbelt buckle and hanging over the side of the wheelchair. The buckle was tied on with a knot in the seatbelt. The seatbelt was not in use and was not used during the observations on 12/8/14 from 3:26 PM to 6:08 PM and 12/9/14 from 5:53 AM to 7:48 AM.</p> <p>On 12/11/14 at 10:55 AM, the PD indicated staff were supposed to assist her with cleaning and assessing her</p> |   |   |   |  |   |  |

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| W000455   | <p>wheelchair a couple times a week. The PD indicated client #8's wheelchair should be in good working order and maintained. The PD indicated she was not aware of the ripped armrest and the broken plastic piece on the wheelchair. The PD indicated the seatbelt should be in working order. The PD indicated the wheelchair needed to be evaluated for repairs.</p> <p>9-3-7(a)</p> <p>483.470(l)(1)<br/>INFECTION CONTROL<br/>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 1 of 4 clients in the sample (#1), the facility failed to ensure client #1 did not eat off the dining room floor.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 12/8/14 from 3:26 PM to 6:08 PM. At 6:01 PM after client #1 finished the food on her plate, client #1 picked up spaghetti she dropped on the floor and ate it. Client #1 picked up several bites off the floor and ate it. The staff were not positioned at the table</p> | W000455   | <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Staff training regarding supervision during meals.</li> <li>· Staff training regarding prompting during meals.</li> </ul> <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All clients have the potential to be affected by this practice.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the</b></p> | 01/10/2015  |  |   |  |

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| W000488            | <p>where they could she client #1 eating off the floor.</p> <p>On 12/10/14 at 2:50 PM, the nurse indicated it was a sanitary issue since the clients walk in the area where client #1 was eating off the floor. The nurse indicated she was not aware of this issue occurring in the past. The nurse indicated this was the first time she had heard of client #1 eating off the floor.</p> <p>On 12/11/14 at 10:55 AM, the Program Director (PD) indicated it was a sanitary issue. The PD stated, "I wouldn't eat off the floor." The PD indicated this was not a known behavior and she had not been notified previously of this being an issue for client #1.</p> <p>9-3-7(a)</p> <p>483.480(d)(4)<br/>DINING AREAS AND SERVICE<br/>The facility must assure that each client eats in a manner consistent with his or her developmental level.<br/>Based on observation and interview for 4 of 8 clients living in the group home (#1, #3, #4 and #8), the facility failed to ensure the clients were involved with meal preparation and serving themselves.</p> <p>Findings include:</p> | W000488       | <p><b>deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>Daily observation and documentation during meal time regarding clients eating practices.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>Home Manager will scan all observation documentation to Program Director and Area Director daily.</li> </ul> <p><b>1.What is the date by which the systemic changes will be completed?</b></p> <p>January 10, 2015</p> <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>Formal Programming for Clients 1, 3, 4 and 8 regarding involvement in meal preparation.</li> <li>Training with staff regarding active treatment.</li> </ul> <p><b>1.How will we identify other</b></p> | 01/10/2015           |

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|   | <p>An observation was conducted at the group home on 12/8/14 from 3:26 PM to 6:08 PM. At 4:11 PM, client #7 cleaned out client #1, #4 and #8's lunchboxes. Client #7 continued cleaning out client #1, #4 and #8's lunchboxes until 4:28 PM. Client #5 assisted client #7 with cleaning out client #1, #4 and #8's lunchboxes at 4:24 PM. At 4:28 PM, client #1 asked client #5 to get her a cup of coffee. Client #5 got client #1 a cup of coffee after asking staff #4 if it was okay. At 5:40 PM, client #2 gave a plate to client #1. Client #7 gave client #1 a piece of garlic bread. Client #2 served client #1 fruit. At 5:42 PM, staff #4 served client #3's spaghetti. At 5:42 PM, client #4 was given a divided plate with pureed food already prepared. Client #4 was not involved with preparing her food. At 5:42 PM, staff #4 served client #3 a piece of garlic bread. Staff #4 cut up client #3's garlic bread without teaching client #3 how to do it. At 5:46 PM, client #2 served client #3's fruit. Staff #4 poured liquid on client #3's garlic bread to moisten it. At 5:51 PM, client #3 was given a straw by staff #7. At 6:00 PM, client #6 poured client #4's juice.</p> <p>An observation was conducted at the group home on 12/9/14 from 5:53 AM to 7:48 AM. At 5:53 AM, client #2 gave</p> |   | <p><b>residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>All clients have the potential to be affected by this deficient practice.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>Daily documentation of formal meal preparation programming for Clients 1, 3, 4 and 8.</li> <li>Daily meal observation and documentation to ensure that all clients are involved in meal preparation.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>Home Manager will scan all observation documentation to Program Director and Area Director daily.</li> </ul> <p><b>1.What is the date by which the systemic changes will be completed?</b></p> <p>January 10, 2015</p> |                      |   |

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|                    | <p>client #1 a cup of coffee. Client #2 gave client #1 a bowl. At 5:51 AM, client #2 poured client #1's cereal. Client #2 put ice cubes into client #3's cup. At 6:10 AM, client #2 made client #4's cereal. Client #2 gave client #8 a bowl and poured cereal into it. Client #8 went to the refrigerator. Client #8 got out a container of almond milk. Client #2 removed the container of almond milk from client #8's hands and poured the milk into client #8's bowl. Client #2 poured client #8 a cup of milk. At 6:44 AM, client #4 started to open a bottle of Ensure however client #2 took the bottle from her hand and opened it. Client #2 stated, "Hold on, hold on, let me help you." At 7:11 AM, client #5 removed client #8's dishes from the table and rinsed them off. Client #6 packed client #1's lunch. Client #6 indicated to a new staff working in the home that she (the new staff) needed to pack client #1, client #4 and client #3's lunches for them. Client #6 stated, "Just helping the new staff out packing lunches." Client #6 told the new staff client #8 was supposed to pack her own lunch.</p> <p>On 12/9/14 at 11:23 AM, the Program Director (PD) indicated the clients should be involved with meal preparation, serving themselves and packing their own lunches. The PD indicated the</p> |               |   |                      |

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| W009999   | <p>clients were capable of participating in meal preparation, serving themselves and packing their own lunches. The PD indicated the staff should prompt the clients to do as much for themselves as possible.</p> <p>9-3-8(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p> <p>460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to</p> | W009999   | <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· TB test done for Staff 4.</li> </ul> <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· Review of all staff's personnel files to ensure that TB tests are current.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· Record all TB tests dates in electronic system.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> | 01/10/2015  |  |   |  |

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|   | <p>complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 employee files reviewed (staff #4), the facility failed to ensure an annual Mantoux (5TU, PPD) tuberculosis (TB) screening was conducted.</p> <p>Findings include:</p> <p>A review of the facility's employee files was conducted on 12/8/14 at 3:01 PM. Direct Care Staff #4 had a negative TB test on 10/25/13. There was no documentation in staff #4's personnel file staff #4 had an annual screening or TB test conducted since 10/25/13.</p> <p>On 12/8/14 at 3:06 PM, the Program Director (PD) indicated the staff should have an annual TB test</p> <p>On 12/9/14 at 11:08 AM, the nurse indicated the staff should have an annual TB test.</p> <p>9-3-3(e)</p> |   | <p>Area Director to monitor for upcoming expired TB tests monthly.</p> <p><b>1. What is the date by which the systemic changes will be completed?</b></p> <p>January 10, 2015</p> |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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