

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G045	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2015
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NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 829 EARL RD MICHIGAN CITY, IN 46360
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W 000 Bldg. 00	<p>This visit was for a post-certification revisit to a fundamental recertification and state licensure survey completed on December 8, 2014.</p> <p>Dates of Survey: February 23 and 24, 2015.</p> <p>Facility number: 000601 Provider number: 15G045 AIM number: 100233480</p> <p>Surveyor: Tim Shebel, LSW</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 2, 2015 by Dotty Walton, QIDP.</p>	W 000		
W 104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the facility's governing body failed to exercise general operating direction over the facility by failing to assure the facility</p>	W 104	To correct this citation immediately the front and back doors at this home have been repaired. The rust was removed, rust preventative paint has been applied and a spray vinyl coating	03/14/2015

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>exit doors were well maintained for 3 of 3 sampled clients (clients #1, #2, and #3), and 3 of 3 additional clients (clients #4, #5, and #6).</p> <p>Findings include:</p> <p>The group home where clients #1, #2, #3, #4, #5, and #6 resided was inspected during the 2/23/15 observation period from 5:34 A.M. until 7:00 A.M. The entrance doorway frames at the front and the back of the group home were rusted from floor level to one foot above the floor.</p> <p>Residential Director #1 was interviewed on 2/24/15 at 8:15 A.M. Residential Director #1 stated, "We (the facility) are in the process of having the doors repaired."</p> <p>This deficiency was cited on 12/8/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>		<p>was applied on top of the paint. This home is the only home that houses individuals 24 hours a day. The doors are used so frequently that they do not have time to dry during wet/snowy weather. For future compliance the vinyl coating will prevent the rust from recurring. One other home has been identified as having the potential for the same citation, as it has steel doors. Currently the doors at the other home are in good repair. To correct this citation systemically the maintenance man will monitor the doors each month at all homes to ensure they are not in need of repairs, painting, sanding, replacement, etc. etc., regardless of the type of door (steel or wood).</p>	

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W 130 Bldg. 00	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview, the facility failed to assure privacy when toileting for 1 of 3 sampled clients (client #2) who required privacy.</p> <p>Findings include:</p> <p>Client #2 was observed at the group home on 2/23/15 from 5:34 A.M. until 7:00 A.M. At 6:14 A.M., client #2 was verbally prompted by direct care staff #1 to use the bathroom. Client #2 sat on the toilet voiding with the bathroom door open. At 6:20 A.M., direct care staff #1 walked back to the bathroom and stood in the bathroom doorway directing client #2 to pull up his pants and wash his hands. Direct care staff #1 did not prompt or assist client #2 in closing the bathroom door for privacy while the client toileted himself.</p> <p>Residential Director #1 was interviewed on 2/24/15 at 8:15 P.M.. Residential Director #1 stated, "[Direct care staff #1] should have directed or assisted client #2 in closing the bathroom door for privacy.</p>	W 130	To correct this citation immediately the staff working with this client has been retrained on client rights, specific to the right to privacy. All clients have been identified as having the potential to be affected. All staff will be retrained by the QIDP and the Program Manager on client rights, paying special attention to the right to privacy. To correct this citation systemically each IDT member will monitor that staff are supporting client privacy through verbal prompting or physical assistance. The monitor will take place at least two times weekly at each group home for a period of 6 weeks, then will be reduced to one time weekly on an ongoing basis. If a staff member fails to ensure client privacy during personal care and treatment, the team member monitoring will provide immediate corrective instructions and report findings to the Program Manager for further training and/or disciplinary action.	03/26/2015

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W 249 Bldg. 00	<p>9-3-2(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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>Based on observation, record review, and interview, the facility failed to ensure staff implemented gait belt usage for 1 of 3 sampled clients (client #1).</p> <p>Findings include:</p> <p>Client #1 was observed at the group home during the 2/23/15 observation period from 5:34 A.M. until 7:00 A.M.. From 5:34 A.M. until 6:36 A.M., client #1 walked around the group home without wearing a gait belt. During this time, direct care staff #1 and #2 did not prompt or assist client #1 in wearing a gait belt.</p> <p>The facility records were reviewed on 2/23/15 at 7:03 A.M. A review of</p>	W 249	To correct this citation immediately the staff members working with this client have been retrained on implementing this client's fall risk plan, which includes prompting him to use a gait belt when he is up and moving around his home. Staff were trained that despite the fact the client may refuse to wear the gait belt they must actively prompt him based on the instructions in the fall risk plan. They must document all refusals on the refusal tracking sheet provided, so the IDT can make necessary adjustments to obtain compliance. All other clients have the potential to be affected by this citation. To ensure compliance of this citation systemically, all staff will be retrained on program implementation by the QIDP and the RN, paying special attention	03/26/2015

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	<p>incident reports from 1/7/15 to 2/23/15 indicated client #1 fell on 2/22/15 while getting out of bed in the morning.</p> <p>Client #1's record was reviewed on 2/23/15 at 10:07 A.M. A review of the client's 96/20/14 physical therapy evaluation indicated the following: "Patient (client #1) is unsafe with ambulation and requires contact guard assist with gait belt to prevent falls."</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 2/23/15 at 10:45 A.M. QIDP #1 stated client #1 should wear a gait belt "whenever he (client #1) is up and walking around."</p> <p>Residential Director #1 was interviewed on 2/24/15 at 8:15 A.M. Residential Director #1 stated, "Staff (direct care staff) should have assisted or prompted [client #1] to wear his gait belt."</p> <p>9-3-4(a)</p>		<p>to how to prompt clients to participate in their plans. All members of the IDT will monitor that staff are following client programs as they are written. The monitor will initially take place twice a week for 6 weeks and then be reduced to one time per week on an ongoing basis. Team members who discover staff failing to implement programs will provide immediate corrective instructions and report their interaction with the Program Manager to determine further training needs or disciplinary action.</p>		