

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G407	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/26/2014
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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2113 E KESSLER BLVD INDIANAPOLIS, IN 46220
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 2/20/14, 2/21/14, 2/25/14 and 2/26/14.</p> <p>Facility Number: 000921 Provider Number: 15G407 AIMS Number: 100249310</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/5/14 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.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#2 and #3), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients #2 and #3's personal finances were not in excess of the predetermined</p>	W000104	The Program Director and Home Manager will be retrained on Client Finances, including ensuring that the client is not over resources at any time. The Program Director and Home Manager will work with the teams to complete a spend down for	03/28/2014

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>maximum amount allowed by Medicaid.</p> <p>Finding include:</p> <p>1. Client #2's financial record was reviewed on 2/26/14 at 2:57 PM. Client #2's facility based cluster account ledger report dated 11/1/13 through 2/25/14 indicated the following:</p> <p>-11/1/13, Beginning balance was \$3,206.29.</p> <p>-11/1/13, Deposit of \$974.00 with an ending balance of \$4,180.29.</p> <p>-12/3/13, Deposit of \$974.00 with an ending balance of \$5,154.29.</p> <p>-12/19/13, Withdrawal of \$4,610.00 with an ending balance of \$544.29.</p> <p>-1/3/14, Deposit of \$989.00 with an ending balance of \$1,533.29.</p> <p>Client #2's average balance for the period of 11/1/13 through 2/25/14 was \$2,923.69.</p> <p>2. Client #3's financial record was reviewed on 2/26/14 at 3:15 PM. Client #3's facility based cluster account ledger report dated 11/1/13 through 2/25/14 indicated the following:</p>		<p>each client who is over the Medicaid \$1500 allowable. All financial transactions are monitored by the Home Manager, reconciled on a monthly basis by the Program Director, and then reviewed by the Client Finance Specialist at the completion of each month. Once a month the Client Finance Specialist will notify the Area Director of all clients, if any, that are over resources, so that the Area Director can follow up on the plan of correction. Ongoing, the Area Director will complete quarterly reviews of a random sample of client finances to ensure that all is completely accurately and correctly. Responsible Party: Home Manager, Program Director, Client Finance Specialist, and Area Director.</p>		

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	<p>-11/1/13, Beginning balance of \$2,097.41.</p> <p>-11/1/13, Deposit of \$300.00 with an ending balance of \$2,397.41.</p> <p>-11/10/13, Withdrawal of \$383.00 with an ending balance of \$2,014.41.</p> <p>-12/1/13, Withdrawal of \$332.00 with an ending balance of \$1,682.41.</p> <p>-12/5/13, Deposit of \$498.00 with an ending balance of \$2,180.41.</p> <p>-1/1/14, Withdrawal of \$337.00 with an ending balance of \$1,843.41.</p> <p>-1/8/14, Deposit of \$323.00 with an ending balance of \$2,166.41.</p> <p>Client #3's average balance for the period of 11/1/13 through 2/25/14 was \$2,054.55.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 2/25/14 at 12:30 PM. QIDP #1 indicated the predetermined maximum amount allowed by Medicaid for clients receiving services was \$1,500.00. QIDP #1 indicated clients #2 and #3's finances were in excess of the</p>			

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W000137	<p>\$1,500.00 limit.</p> <p>9-3-1(a)</p> <p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to ensure clients #1, #2, #3 and #4 had access to their personal hygiene items.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/25/14 from 6:40 AM through 8:00 AM. Clients #1, #2, #3 and #4's personal hygiene items were located in a closet in the group home's hallway directly across from the medication administration room. The closet door was open with a padlock attached to the top portion of the door. Clients #1, #2, #3 and #4 each retrieved their personal hygiene items from the closet and completed their individual morning hygiene tasks before returning the hygiene items to the closet.</p> <p>Staff #1 was interviewed on 2/25/14 at</p>	W000137	<p>The Home Manager and Program Director will be retrained on not restricting clients on any areas when it is not needed. The Home Manager will get in contact with maintenance and ensure that the broken hinge is repaired and/or replaced. The Home Manager will ensure that the lock is removed so no clients will be restricted in the future. Ongoing, the Home Manager will complete a weekly walk through of the house to ensure that all maintenance issues are addressed in a timely matter. When any issues arise, the Home Manager will inform maintenance of the issue via Indiana MENTOR's maintenance procedure. The Home Manager will then document this for future reference. Ongoing, the Program Director will complete a monthly walk through of the group home to ensure that all maintenance issues are addressed and followed up on in a timely manner. Responsible Party: Home Manager and Program</p>	03/28/2014

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	<p>7:15 AM. Staff #1 indicated the facility kept the clients' hygiene items in the closet. Staff #1 indicated the closet had a padlock.</p> <p>HM (Home Manager) #1 was interviewed on 2/25/14 at 7:45 AM. HM #1 indicated the clients' hygiene items were kept in the hallway closet. HM #1 indicated the closet door had a padlock attached to the door. HM #1 stated, "We don't always keep the door locked. Just when somebody is trying to get in it to take the other clients' things."</p> <p>1. Client #1's record was reviewed on 2/25/14 at 8:39 AM. Client #1's ISP (Individual Support Plan) dated 6/24/13 and BSP (Behavior Support Plan) dated 6/24/13 did not indicate client #1's personal hygiene items should be locked/restricted.</p> <p>2. Client #2's record was reviewed on 2/25/14 at 9:42 AM. Client #2's ISP dated 6/25/13 and BSP dated 2/29/13 did not indicate client #2's personal hygiene items should be locked/restricted.</p> <p>3. Client #3's record was reviewed on 2/25/14 at 10:38 AM. Client #3's ISP dated 1/22/14 and BSP dated 3/1/13 did not indicate client #3's personal hygiene</p>		Director				

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W000149	<p>items should be locked/restricted.</p> <p>4. Client #4's record was reviewed on 2/25/14 at 11:10 AM. Client #4's ISP dated 4/24/13 and BSP dated 4/24/13 did not indicate client #4's personal hygiene items should be locked/restricted.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 2/25/14 at 12:30 PM. QIDP #1 stated, "[HM #1] said that he put that (lock) on the door because one of the hinges on the door was broken. He was using it (lock) to keep the door in place. I asked him why... he didn't just fill out a maintenance request to get the door fixed?" QIDP #1 indicated clients #1, #2, #3 and #4's personal hygiene items should not be locked. QIDP #1 indicated clients #1, #2, #3 and #4 did not have active treatment goals/training to teach them how to access their hygiene items or have keys to the closet.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 8 allegations of abuse, neglect,</p>	W000149	The Program Director will be retrained on completing a thorough	03/28/2014			

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	<p>mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to implement its policy and procedures to ensure the facility conducted an investigation regarding an injury of unknown origin for client #1 and to ensure the facility reported the results of an investigation regarding a separate injury of unknown origin for client #1 to the facility administrator within 5 business days of the incident.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/20/14 at 2:26 PM. The review indicated the following:</p> <p>1. BDDS report dated 1/21/14 indicated on 1/20/14 client #1 was picked up from his day service provider with a cut on his right arm. Client #1 was taken to the ER (Emergency Room) and received stitches to cover the wound. Client #1's injury was not observed by staff and client #1 was unable to describe the circumstances of his injury.</p> <p>-The review indicated client #1's 1/20/14 injury of unknown origin was investigated by the facility. The facility provided an investigation of client #1's</p>		<p>investigation, specifically on ensuring that all parties involved are questioned regarding the related incident. This retraining will also cover factual findings and what to compare them to for accuracy in an investigation.</p> <p>The Program Director will also be retrained on concerns that are brought up during an interview/investigation and ensuring that they are addressed appropriately. Any concerns should and will be brought to the entire team to discuss if any changes are needed or need to be addressed.</p> <p>To ensure that all investigations are completed accurately and thoroughly, Indiana MENTOR's Quality Assurance Specialist will assist this PD with the next three investigations.</p> <p>Ongoing, all investigations will be reviewed by both the Area Director and the Quality Assurance Specialist to ensure that all issues are addressed and that the investigation is completed thoroughly.</p> <p>Responsible Party: Program Director and Area Director and Quality Assurance Specialist.</p>				

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	<p>injury of unknown origin dated 1/30/14 with administrative review dated 2/6/14.</p> <p>2. BDDS report dated 2/4/14 indicated on 2/4/14 client #1's right elbow was swollen and had a skin infection on his right ear. Client #1 was sent to the ER for assessment.</p> <p>-Follow up BDDS report dated 2/10/14 indicated, "The (ER) doctor confirmed that [client #1's] elbow was an (sic) separate incident. Even though (sic) the swollen elbow was near the area of the incident where [client #1] received stitches, it was still enough distance away to determine this was a separate incident." The 2/10/14 follow up BDDS report indicated, "Continue to monitor the health and safety of [client #1] at all times, plus it seems to me that a pattern could be occurring if two separate incidents are occurring in the same area at two different times. We will track [client #1's] daily habits to see if (sic) locations are occurring where possibly he's hitting his elbow and causing injury."</p> <p>The review did not indicate documentation of an investigation regarding client #1's 2/4/14 injury of unknown origin.</p>						

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	<p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 2/25/14 at 12:30 PM. QIDP #1 indicated client #1's 1/20/14 injury of unknown origin investigation was completed on 1/30/14 with administrative review on 2/6/14. QIDP #1 indicated client #1's second incident of injury of unknown origin dated 2/4/14 was not investigated. QIDP #1 indicated allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be investigated. QIDP #1 indicated the results of investigations of allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be reported to the administrator within 5 business days of the incident. QIDP #1 indicated the facility's abuse and neglect policy should be implemented.</p> <p>The facility's policy and procedures were reviewed on 2/26/14 at 2:02 PM. The facility's April 2011 policy and procedure entitled Quality Risk Management indicated "Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. (1.) Investigation findings will be submitted to the Area</p>						

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W000154	<p>Director for review and development of further recommendations as needed within 5 days of the incident."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 8 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to conduct an investigation regarding an injury of unknown origin for client #1.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/20/14 at 2:26 PM. The review indicated the following:</p> <p>BDDS report dated 2/4/14 indicated on 2/4/14 client #1's right elbow was swollen and had a skin infection on his right ear. Client #1 was sent to the ER for assessment.</p> <p>-Follow up BDDS report dated 2/10/14 indicated, "The (ER) doctor confirmed</p>	W000154	<p>The Program Director will be retrained on completing a thorough investigation, specifically on ensuring that all parties involved are questioned regarding the related incident. This retraining will also cover factual findings and what to compare them to for accuracy in an investigation.</p> <p>The Program Director will also be retrained on concerns that are brought up during an interview/investigation and ensuring that they are addressed appropriately. Any concerns should and will be brought to the entire team to discuss if any changes are needed or need to be addressed. To ensure that all investigations are completed accurately and thoroughly, Indiana MENTOR's Quality Assurance Specialist will assist this PD with the next three investigations.</p> <p>Ongoing, all investigations will be reviewed by both the Area Director and the Quality Assurance Specialist to ensure that all issues are</p>	03/28/2014

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	<p>that [client #1's] elbow was an (sic) separate incident. Even though (sic) the swollen elbow was near the area of the incident where [client #1] received stitches, it was still enough distance away to determine this was a separate incident." The 2/10/14 follow up BDDS report indicated, "Continue to monitor the health and safety of [client #1] at all times, plus it seems to me that a pattern could be occurring if two separate incidents are occurring in the same area at two different times. We will track [client #1's] daily habits to see if (sic) locations are occurring where possibly he's hitting his elbow and causing injury."</p> <p>The review did not indicate documentation of an investigation regarding client #1's 2/4/14 injury of unknown origin.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 2/25/14 at 12:30 PM. QIDP #1 indicated client #1's second incident of injury of unknown origin dated 2/4/14 was not investigated. QIDP #1 indicated allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be investigated.</p>		<p>addressed and that the investigation is completed thoroughly. Responsible Party: Program Director and Area Director and Quality Assurance Specialist.</p>				

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W000156	<p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 8 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to report the results of an investigation regarding an injury of unknown origin for client #1 to the facility administrator within 5 business days of the incident.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/20/14 at 2:26 PM. The review indicated the following:</p> <p>BDDS report dated 1/21/14 indicated on 1/20/14 client #1 was picked up from his day service provider with a cut on his right arm. Client #1 was taken to the ER (Emergency Room) and received stitches to cover the wound. Client #1's injury was not observed by staff and client #1 was unable to describe the</p>	W000156	<p>The Program Director will be retrained on ensuring that all investigations are reported and reviewed by an administrator within 5 business days. The investigation for the incident dated 1/28/2013 was completed within the 5 day period; however, it was not given to the administrator for final approval. Ongoing, the Program Director will complete all investigations within the 5 day period. Ongoing, the Administrator will review all investigations within the 5 day period.</p>	03/28/2014
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W000159	<p>circumstances of his injury.</p> <p>-The review indicated client #1's 1/20/14 injury of unknown origin was investigated by the facility. The facility provided an investigation of client #1's injury of unknown origin dated 1/30/14 with administrative review dated 2/6/14.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 2/25/14 at 12:30 PM. QIDP #1 indicated client #1's 1/20/14 injury of unknown origin investigation was completed on 1/30/14 with administrative review on 2/6/14. QIDP #1 indicated the results of investigations of allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be reported to the administrator within 5 business days of the incident.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 2 of 4 sampled clients (#1 and #2), the QIDP (Qualified Intellectual Disabilities Professional) failed to</p>	W000159	1. Please see W218 The Program Director will be retrained on monitoring each client's active treatment plan. The Program Director will work together with	03/28/2014	

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	<p>integrate, coordinate and monitor each client's active treatment program by failing to ensure a current/or accurate SA (Sensorimotor Assessment) had been completed to meet client #1's needs, to provide a current active treatment schedule for staff to follow when the clients #1 and #2 did not attend the day services, to ensure the facility's HRC (Human Rights Committee) reviewed, monitored and approved the use of psychotropic medication for the management of client #1's behavior and to ensure the facility's HRC obtained the written informed consent of client #1's HCR (Health Care Representative) before the use of psychotropic medication for the management of client #1's behavior.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The QIDP failed to integrate, coordinate and monitor each client's active treatment program by failing to ensure a current/or accurate SA (Sensorimotor Assessment) had been completed to meet client #1's needs. Please see W218.</li> <li>2. The QIDP failed to integrate, coordinate and monitor each client's active treatment program by failing to provide a current active treatment</li> </ol>		<p>the nurse, to ensure that a sensorimotor assessment is scheduled and completed on client #1. The Program Director will ensure that the results of the assessment are followed up on, and ensure that client #1 has access to any adaptive equipment that is needed. Ongoing, the Program Director and Nurse will complete bimonthly active treatment observations to ensure that all client's needs are met. Should any concerns arise from these observations then the Program Director and nurse will follow up and ensure that they are addressed in a timely manner. 2. Please see W250 The Program Director will be retrained on completing active treatment schedules. The Program Director will complete an updated active treatment schedule for clients #1 and 2. The Program Director will review active treatment schedules for clients 3, 4, 5, 6, 7, and 8 to ensure that they accurately address each client's needs and properly show the client's daily activities. Ongoing, the Program Director will ensure that each client's active treatment schedule is reviewed no less than quarterly by the team, and will make all changes necessary when needed. 3. Please see W262 The Program Director will be retrained on Indiana MENTOR's Human Rights Committee policy and procedures. Ongoing, the</p>		

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W000218	<p>schedule for staff to follow when the clients #1 and #2 did not attend the day services. Please see W250.</p> <p>3. The QIDP failed to integrate, coordinate and monitor each client's active treatment program by failing to ensure the facility's HRC reviewed, monitored and approved the use of psychotropic medication for the management of client #1's behavior. Please see W262.</p> <p>4. The QIDP failed to integrate, coordinate and monitor each client's active treatment program by failing to ensure the facility's HRC obtained the written informed consent of client #1's HCR before the use of psychotropic medication for the management of client #1's behavior. Please see W263.</p> <p>9-3-3(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure a current/or accurate SA (Sensorimotor Assessment) had been completed to meet client #1's needs.</p>	W000218	<p>Program Director will seek guardian approval, then HRC approval, before implementing any behavior controlling measures, for all clients, including client #1. 4. Please see W263 The Program Director will be retrained on Indiana MENTOR's Human Rights Committee policy and procedures. Ongoing, the Program Director will seek guardian approval, then HRC approval, before implementing any behavior controlling measures, for all clients, including client #1. Responsible Party: Program Director</p> <p>The Program Director will be retrained on monitoring each client's active treatment plan. The Program Director will work together with the nurse, to ensure that a sensorimotor assessment is scheduled and completed on client #1. The Program Director and/or Nurse will complete active</p>	03/28/2014			

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	<p>Findings include:</p> <p>Observations were conducted at the group home on 2/20/14 from 4:30 PM through 5:30 PM. Client #1 was observed in the home throughout the observation period. Client #1 was visually impaired in that he had no vision in either his left or right eyes. At 5:00 PM client #1 was participating in the group home's family style dining for the evening meal. Client #1 had lasagna, tossed salad, garlic toast and peas. Client #1 utilized a standard dining plate with a fork. Client #1 consumed his meal by placing his left hand fingers on his plate while he pushed/scooped bites of his food onto his fork with his right hand.</p> <p>HM #1 (Home Manager) was interviewed on 2/20/14 at 5:10 PM. HM #1 indicated client #1 used his fingers to push his food onto his fork. HM #1 indicated client #1 did not have adaptive meal time equipment. HM #1 indicated client #1 was blind.</p> <p>Client #1's record was reviewed on 2/25/14 at 8:39 AM. Client #1's ISP (Individual Support Plan) dated 6/24/13 indicated, "Dining equipment utilized: N/A (Not Applicable). Assessment of dining skills: [client #1] can use a fork,</p>		<p>treatment observations on the other 7 clients in the home to see if any other sensorimotor assessments are needed. If it is found that it is needed, the Program Nurse will get the referrals and get them scheduled. The Program Director will ensure that the results of the assessment are followed up on, and ensure that client #1 has access to any adaptive equipment that is needed. Ongoing, the Home Manager, Program Director and/or Program Nurse will complete active treatment observations once a week for the first four weeks to ensure that all client's needs are met. After the initial four weeks, the Home Manager will continue with bi-weekly active treatment observations ongoing. Should any concerns arise from these observations then the Program Director and nurse will follow up and ensure that they are addressed in a timely manner with the entire team.</p>				

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	<p>spoon and a knife but he will need hand over hand assistance when cutting up his food. [Client #1] will remain upright 30 minutes after meals." Client #1's ISP indicated, "Assessment of food and liquid intake: [client #1] will need to take a drink between bits (sic) of food during meal time; [client #1] will have 1 to 1 observations during meals." Client #1's ISP did not indicate assessment of client #1's use of his fingers to scoop or push food onto his fork or spoon when eating. Client #1's record did not indicate SA assessment of client #1's dining skills/behaviors. Client #1's ISP indicated client #1 was blind in both eyes.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 2/25/14 at 12:30 PM. QIDP #1 indicated client #1 had a visual impairment. QIDP #1 indicated client #1 used his fingers to push his food onto his fork during meals. When asked if the IDT (Interdisciplinary Team) had made recommendations regarding client #1's meal time needs or been assessed for dining equipment needs, QIDP #1 stated, "No, we really haven't. It seems like maybe we need to have him assessed. Just to see where he is. That's something I can do."</p>						

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W000250	<p>9-3-4(a)</p> <p>483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on observation, record review and interview for 2 of 4 sampled clients (#1 and #2), the facility failed to provide a current active treatment schedule for staff to follow when the clients did not attend the day services.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/25/14 from 6:40 AM through 8:00 AM. Client #1 did not participate in the group home's preparation for day services. Client #1 did not attend day services and remained at the group home.</p> <p>HM (Home Manager) #1 was interviewed on 2/25/14 at 7:45 AM. HM #1 indicated client #1 did not go to day services on Tuesdays and Thursdays. HM #1 indicated client #2 did not attend day services on Mondays, Wednesdays and Fridays.</p> <p>1. Client #1's record was reviewed on 2/25/14 at 8:39 AM. Client #1's ISP</p>	W000250	<p>The Program Director will be retrained on completing active treatment schedules. The Program Director will complete an updated active treatment schedule for clients #1 and 2. The Program Director will review active treatment schedules for clients 3, 4, 5, 6, 7, and 8 to ensure that they accurately address each client's needs and properly show the client's daily activities. Ongoing, the Program Director will ensure that each client's active treatment schedule is reviewed no less than quarterly by the team, and will make all changes necessary when needed.</p>	03/28/2014
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	<p>(Individual Support Plan) dated 6/24/13 indicated client #1 attended day services three times a week. Client #1's 12/23/13 Active Treatment Schedule indicated client #1 attended day services Monday through Friday five days a week from 9:00 AM through 3:00 PM. Client #1's record did not indicate an active treatment schedule for the Tuesdays and Thursdays that client #1 remained at the group home during the 9:00 AM through 3:00 PM hours.</p> <p>2. Client #2's record was reviewed on 2/25/14 at 9:42 AM. Client #2's ISP dated 6/25/13 indicated client #2 attended day services twice a week on Monday and Wednesday. Client #2's Active Treatment Schedule dated 12/23/13 indicated client #2 attended day services Monday through Friday five days a week from 9:00 AM through 3:00 PM. Client #2's record did not indicate an active treatment schedule for Tuesdays, Thursdays and Fridays when client #2 remained at the group home during the 9:00 AM through 3:00 PM hours.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 2/25/14 at 12:30 PM. QIDP #1 indicated client #1 and #2's active treatment schedules should be</p>			

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W000262	<p>updated to address their altered day services attendance.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview for 1 of 4 sampled clients (#1), the facility's HRC (Human Rights Committee) failed to review, monitor and approve the use of psychotropic medication for the management of client #1's behavior.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 2/25/14 at 8:39 AM. Client #1's BSP (Behavior Support Plan) dated 6/24/13 indicated a PRN (As Needed) order for Halcion 0.25 milligrams (sedative) prior to dental procedures. Client #1's HRC forms dated 11/13/13 and 2/3/13 did not indicate review or approval of client #1's use of Halcion 0.25 milligrams for dental resistance behaviors. Client #1's record did not indicate documentation of HRC review or approval of client #1's use of Halcion 0.25 milligrams for</p>			W000262	<p>The Program Director will be retrained on Indiana MENTOR's Human Rights Committee policy and procedures. The Program Director will ensure that guardian approval and HRC approval is obtained for the use of the PRN medication for client 1. All other client's medical records were reviewed and no other psychotropic medications had been given without guardian and HRC approval first. The Program Nurse and Home Manager will monitor appointments a month in advance and inform the Program Director of any appointments that require sedation so that the Program Director can seek the appropriate approvals as needed. Ongoing, the Program Director will seek guardian approval, then HRC approval, before implementing any behavior controlling measures, for all clients, including client #1.</p>		03/28/2014

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W000263	<p>dental resistance behaviors.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 2/25/14 at 12:30 PM. QIDP #1 indicated client #1's use of psychotropic medication should be reviewed and approved by the facility's HRC prior to use.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 1 of 4 sampled clients (#1), the facility's HRC (Human Rights Committee) failed to obtain the written informed consent of client #1's HCR (Health Care Representative) before the use of psychotropic medication for the management of client #1's behavior.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 2/25/14 at 8:39 AM. Client #1's ISP (Individual Support Plan) dated 6/24/13 indicated client #1 had a HCR. Client #1's BSP (Behavior Support Plan) dated</p>			W000263	<p>The Program Director will be retrained on Indiana MENTOR's Human Rights Committee policy and procedures. The Program Director will ensure that guardian approval and HRC approval is obtained for the use of the PRN medication for client 1. All other client's medical records were reviewed and no other psychotropic medications had been given without guardian and HRC approval first. The Program Nurse and Home Manager will monitor appointments a month in advance and inform the Program Director of any appointments that require sedation so that the Program Director can seek the appropriate approvals as needed.</p>		03/28/2014

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W000371	<p>6/24/13 indicated a PRN (As Needed) order for Halcion 0.25 milligrams (sedative) prior to dental procedures. Client #1's BSP dated 6/24/13 and/or record did not indicate documentation of client #1's HCR's written informed consent for the use of Halcion 0.25 milligrams for dental resistance behaviors.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 2/25/14 at 12:30 PM. QIDP #1 indicated written informed consent should be obtained from client #1's HCR prior to the use of psychotropic medication.</p> <p>9-3-4(a)</p> <p>483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1 had medication administration training.</p> <p>Findings include:  Client #1's record was reviewed on</p>	W000371	<p>Ongoing, the Program Director will seek guardian approval, then HRC approval, before implementing any behavior controlling measures, for all clients, including client #1.</p> <p>The Program Director will be retrained on assessing each client and their needs. The Program Director will reassess client #1's ability to self-administer medications. The Program Director will work with client #1's Interdisciplinary team to discuss the results of the assessment to self-administer his</p>	03/28/2014			

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	<p>2/25/14 at 8:39 AM. Client #1's ISP (Individual Support Plan) dated 6/24/13 indicated, "[Client #1] cannot self medicate and he will rely on the staff to administer his medications to him." Client #1's ISP dated 6/24/13 indicated, "Increase medication administration skills through a formal goal." Client #1's record did not indicate documentation of a formal medication administration goal or training for client #1.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 2/25/14 at 12:30 PM. QIDP #1 indicated client #1 did not have a formal medication administration goal. QIDP #1 indicated client #1 should have a medication administration goal to increase his medication administration skills.</p> <p>9-3-6(a)</p>		<p>medication. Based on the results, the IDT will work together to put a medication goal in place to assist client #1 with becoming independent in medication administration. For the first four weeks, the Program Director and/or Home Manager, will complete active treatment observations to ensure that staff are completing the medication administration goal for client #1 as written. After the initial four weeks, the Program Director and/or Home Manager will complete 1 active treatment observation per week, ongoing.</p>		