

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G799	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2016
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940
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W 0000 Bldg. 00	<p>This visit was for the pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: 3/14, 3/15, 3/16, 3/17, 3/18, 3/21, 3/22, 3/23, and 3/24/2016.</p> <p>Provider Number: 15G799 Facility Number: 0012562 AIM Number: 201017540</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed 3/31/16 by #09182.</p>	W 0000		
W 0129 Bldg. 00	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy.</p> <p>Based on observation, record review, and interview, for 2 of 2 sampled clients (clients #1 and #2) and 2 additional clients (clients #3 and #4), the facility failed to keep client #1, #2, #3, and #4's personal information confidential by posting each client's names, medications, and active treatment schedules taped on the wall in the laundry room.</p>	W 0129	All personal information has been removed from the laundry room wall. All staff will receive retraining on the Confidentiality Policy to ensure that all client information remains private. The staff will be monitored by the QIDP and by the Residential Manager and their observations will be documented on the CQA which will be submitted to the director so compliance can be	04/23/2016

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>Findings include:</p> <p>On 3/14/16 from 4:20pm until 6:20pm and on 3/15/16 from 5:30am until 8:05am, clients #1, #2, #3, and #4 were observed at the facility with the following client information on sheets of paper posted on the laundry room wall:</p> <p>-Four sheets of individual paper which documented clients #1, #2, #3, and #4's Monday through Sunday active treatment schedules which included the following training goals/objectives: oral hygiene, hair/grooming, shaving, tooth brushing, medication administration, money, community, add up receipts, day services 10am-2pm, exercise, laundry, cooking, "respect roommates," and snacks.</p> <p>-Three sheets of four by four inch papers which indicated client #3's full name, "Byetta (diabetes medication) B4 (be for meal, breakfast/dinner. 5 units Humalog (insulin) right after meals. 2 (sic) hours after check BS (Blood Sugar). Over 100 = 10 units. 40 mins. (minutes) later check BS over 100 call nurse. Under 60 give Glutose 15 gel tablet. Byetta - 5 units 6pm, Humalog- 5 units after meal, Lantus (insulin)- 30 units 8pm."</p> <p>On 3/17/16 at 1:30pm, an interview with the Residential Manager (RM), the</p>		<p>monitored. The monitoring will occur on a monthly basis. The CQA's will be submitted to the director on a monthly basis to monitor ongoing compliance.</p>		

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W 0130 Bldg. 00	<p>Behavior Consultant (BC), and the Agency Licensed Practical Nurse (LPN) was conducted. The RM, the BC, and the LPN indicated visitors, other clients, family members, and staff had access to where clients #1, #2, #3, and #4's personal information was posted on the wall. The BC and LPN indicated clients #1, #2, #3, and #4's personal information should not have been posted on the wall.</p> <p>On 3/24/16 at 1:15pm, an interview with the Site Director (SD) was conducted. The SD indicated clients #1, #2, #3, and #4's personal information should not have been posted on the wall in the laundry room. The SD indicated the group home staff failed to keep client #1, #2, #3, and #4's personal information confidential.</p> <p>9-3-2(a)</p> <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, record review and interview for 1 additional client (client #3), the facility failed to protect the client #3's personal privacy when walking through the group home nude.</p>	W 0130	A goal for dressing and privacy will be added to the ISP for client #3. All staff will receive retraining on the ISP for client #3. The staff will be monitored by the QIDP and by the Residential Manager and their observations will be documented on the Meaningful	04/23/2016

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	<p>Findings include:</p> <p>During observations on 3/15/16 from 6:15am until 6:45am, client #3 was nude with bowel movement on this buttocks, both legs, and feet and walked out of his bedroom into the living room, dining room, kitchen, and medication/laundry rooms. From 6:15am until 6:45am, client #3 changed the channel on the television in the living room and turned up the volume; retrieved a glass from the cabinet and independently got a drink of water in the kitchen, and stopped in each room to talk with the two female facility staff on duty. At 6:17am, GHS (Group Home Staff) #8 asked client #3 to put on a robe, client #3 stood in the dining room, touched his privates, and did not acknowledge GHS #8's request. From 6:17am until 6:45am, no robe and no personal privacy was encouraged. At 6:45am, client #3 walked with GHS #8 and #11 to enter the bathroom for a shower.</p> <p>Client #3's record was reviewed on 3/17/16 at 1:15pm. Client #3's 4/9/15 ISP (Individual Support Plan) indicated client #3 had an objective to maintain privacy for himself and to wear a robe.</p> <p>Interview with RM (Residential Manager), the BC (Behavior Consultant),</p>		<p>DayTracking Form which will be submitted to the director so compliance can be monitored. The initial monitoring will occur three times weekly for three months with weekly review by the director. Monitoring after the 3 months will revert to the ongoing monitoring in place which includes monthly goal tracking by the QIDP.</p>				

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W 0193 Bldg. 00	<p>and the Agency LPN (Licensed Practical Nurse) was conducted on 3/17/16 at 1:30pm. The three professional staff indicated client #3 should be prompted to go to the bathroom when incontinent of bowel and should wear a robe for personal privacy. The RM indicated client #3 should have been redirected back into his bedroom and assisted by the facility staff.</p> <p>9-3-2(a)</p> <p>483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. Based on observation, record review, and interview, for 1 of 2 sampled clients (client #1) who had known behaviors of elopement and Suicide attempts, the facility failed to ensure staff were able to demonstrate skills and consistently implement supervision techniques to prevent client #1's elopement behavior.</p> <p>Findings include:</p> <p>On 3/17/16 at 2:00pm, the Behavior Consultant (BC) provided an additional BDDS (Bureau of Developmental Disabilities Services) Report for client</p>	W 0193	The support team including the Residential Director, Residential Manager, QIDP, Behavior Analyst, Regional Director, and the guardian for client #1 met and made changes to improve the likelihood of success for the Behavior Support Plan of client #1. All staff were trained on the changes to the plan and the guardian and Human Rights Committee approved the changes. The previous plan indicated that staff should follow client #1 if he left the home and redirect him back. The staff followed the plan which was in place at the time of the incident. The new plan includes strategies	04/23/2016	

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	<p>#1's elopement behavior.</p> <p>-A 3/16/16 BDDS report for an incident on 3/15/16 at 11:30pm indicated client #1 eloped from the facility. The report indicated client #1 "was lying on the couch watching TV (sic) and suddenly ran out of the front door. Staff followed [client #1] out the door and lost sight of him in the dark. The manager called the police immediately as [client #1] has a history of elopement. Police, supervisors, and staff looked for [client #1] in the fields and roads surrounding the home. At around 1:45am, a supervisor found [client #1] walking in the direction of the house approximately a half mile from the home. [Client #1] got into the supervisor's vehicle and rode home...[Client #1] had superficial scratches on the lower part of both legs and feet due to the brush. All were treated with first aid. The IDT (Interdisciplinary Team) met on 3/16/16 to review the incident. The BSP is being revised to include staff positioning themselves in between [client #1] and the front door during time of agitation...."</p> <p>Client #1's record was reviewed on 3/17/16 at 11:25pm. Client #1's record indicated a 8/19/15 BDDS report for an incident on 8/18/15 at 10:40pm which indicated client #1 "became upset based</p>		to prevent client #1 from leaving the premises. The incidents are being monitored by the Behavior Analyst to ensure that the training has been effective and that staff are implementing the plan. All staff have been retrained on the plans for all of the clients in the home and are being monitored through review of internal behavior data sheets, staff meetings and debriefings as needed.		

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	<p>on an incident that happened the day before. [Client #1] ran for the door and two staff ran behind him. Staff lost sight of [client #1] when he ran into the field and wooded area at 10:40pm. Staff called police immediately as [client #1] has a history of elopement. Staff got into a vehicle and began to look for [client #1] with headlights and flashlights. Police and staff set a perimeter around the field in which [client #1] was believed to be in and staff and officers walked the field several times looking for [client #1] and calling his name. At 5:05am, [client #1] walked out of the field/wooded (sic) area and walked to the Residential Director's vehicle. He was easily redirected into the vehicle and agreed to return to the group home." The report indicated client #1 had a "1" (inch) superficial scratch on his left shoulder, two 2" superficial scratches and two 4" deeper scratches on the left lower leg, a 1/4" scratch on the left side of his foot, and a 1/2" scratch on the left side of his face." The report indicated "The IDT (Interdisciplinary Team) debriefed and reviewed the incident. [Client #1's] supervision level is being increased to eyesight during times of agitation to reduce the risk of [client #1] running outside and providing additional guidance to staff related to Mandt (interventions to prevent elopement and physical aggression) blocking if needed</p>			

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	<p>in the future."</p> <p>Client #1's 1/29/16 ISP (Individual Support Plan) and 1/28/16 BSP (Behavior Support Plan) indicated client #1 should be supervised by the facility staff. Client #1's record indicated he was not safe alone in the community. Client #1's BSP indicated targeted behaviors of Physical Aggression, Verbal Aggression, Elopement, Property Destruction, SIB (Self Injurious Behavior), Inappropriate Social Behaviors, and "Suicidal Gestures: Wrapping things around his neck in an attempt to choke himself, swallowing inedible items, making cuts on his body or any other self-inflicted act that threatens his own physical safety. If any actual attempts to harm himself are made, staff must try to intervene to block the attempt while verbally redirecting him."</p> <p>Client #1's record and 1/28/16 BSP indicated "VII. Elopement/AWOL: includes any acts or attempts to leave a designated area without staff supervision and/or permission. 1. Verbally tell [client #1] to stop...2. Physically block his attempts to leave the designated area, if it appears that he is agitated and intent on fleeing from the area. This is especially the case with the front door, as it has been the main route of egress from the home when [client #1] has escalated to</p>			
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	<p>assaultive/destructive behaviors. 3. If blocking [client #1] attempts to leave the home through the front door do not work and [client #1] decides to elope out the front door of the home; then it is considered that [client #1] is putting himself in imminent danger of hurting himself. Once [client #1] reaches the driveway, [client #1] should be placed in the least restriction and acceptable Mandt restraint. Once [client #1] reaches the road many dangerous things could happen to [client #1] and therefore, the Mandt restraint would be used to keep [client #1] safe. 4. If [client #1] does leave the property, staff are to follow [client #1] and maintain eye sight at all times. 5. Stay as close to [client #1] as possible, ideal situation is that one staff follow on foot and one staff follow with the vehicle. Never leave [client #1] to go get the vehicle. If there is only one staff, follow him on foot...." Client #1's BSP was revised to include "Restrictive support Reminder...15 minute checks when [client #1] is asleep. Increase to eyesight during times of agitation or demonstration of unsafe behaviors..." Client #1 "requires a supervision level of 24 hours, seven days per week, with a staff to client ratio of 1:1 (one staff on one client) during normally awake hours. Overnight ratio is minimally 2 staff to 4 clients. During instances where 1:1 staff</p>			

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	<p>is required, the staff member responsible to supervise [client #1] will not also be responsible for supervising anyone else. [Client #1] will be assigned his own staff member to monitor him at a 1:1 ratio. Proximity to [client #1] is not determined by factors such as arm's length or line of sight because these measures fail on a routine basis even when the situation is not unsafe...when someone turns a corner or walks into another room. Instead, [client #1's] assigned staff members are directed to be in close enough proximity to provide safety. The staff members must be aware of [client #1's] location at all times. This wording is specifically designed to provide adequate supervision without getting tied up in semantics such as how long is the staff person's arm. Staff are trained and understand that closer supervision is needed when a person is upset or escalated. This wording allows for that, which also relaxes the restriction of very close supervision when it is not required for safety."</p> <p>Client #1's 3/10/16 revised BSP indicated "Supervision should increase to eyesight supervision when [client #1] is escalated, making threats to harm himself..."</p> <p>Client #1's 3/10/16 revised BSP indicated client #1 was to have eyesight supervision defined "as having [client #1]</p>			

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	<p>in eyesight at all times during waking hours except when using the restroom, showering, or changing his clothes...."</p> <p>Client #1's revised BSP indicated additional interventions for staff to "block the doorways" should client #1 attempt to leave the group home during elopement behaviors.</p> <p>On 3/17/16 at 10:05am, an interview with the Behavior Consultant (BC) was conducted. The BC indicated client #1 had a history of AWOL behaviors and suicide threats with attempts. The BC indicated client #1's last elopement before 3/16/16 was on 8/18/15 at 10:40pm. The BC indicated client #1's last suicidal attempt was when client #1 left the facility AWOL on 11/26/14 when staff failed to implement his plans correctly, client #1's behaviors had escalated, client #1 walked down the road during an elopement from the group home, and "jumped off" a bridge. The BC indicated client #1 suffered a "fractured back" and leg injuries from his previous suicide attempt. The BC indicated during client #1's elopement on 3/16/16 staff did not block the front door and client #1's behaviors had escalated during the day. The BC indicated staff did not implement client #1's plan to prevent his escalating behaviors and resulted in his elopement. The BC</p>			

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W 0327 Bldg. 00	<p>indicated client #1's plan was implemented but interventions had been added in an attempt to make it clear what staff should do if client #1's behaviors escalated. The BC stated after client #1's elopement behavior client #1's plan was revised to ensure staff "prevented" client #1 from leaving (elopement) from the group home during his escalating behaviors. The BC stated client #1 was gone from the group home on 3/16/16 "about two hours" and on 8/18/15 for "approximately six (6) hours" during client #1's elopement behaviors. The BC indicated client #1's plans were revised to also include learning programs to teach client #1 coping skills.</p> <p>9-3-3(a)</p> <p>483.460(a)(3)(iv) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Based on interview and record review, for 1 of 2 sampled clients (client #2), the facility failed to read client #2's Mantoux (tuberculin skin test) and/or screening in millimeters (mm).</p>	W 0327	The management staff will review annual appointments monthly and ensure that upcoming appointments are scheduled. Managers complete monthly quality assurance checks at the	04/23/2016			

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W 0352 Bldg. 00	<p>Findings include:</p> <p>On 3/17/16 at 10:21am, client #2's record was reviewed. Client #2 was admitted to the facility on 4/11/11. Client #2's 3/18/15 physician's visit included a Mantoux skin test which was read as "nag (sic) (negative)" and not in millimeters.</p> <p>On 3/17/16 at 1:30pm, an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated clients living in the group home should receive a yearly Mantoux/Tuberculin skin test and/or a tuberculosis screening read in millimeters. The LPN indicated client #2's Mantoux skin test was not read in mm and no further information was available for review.</p> <p>9-3-6(a)</p> <p>483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. Based on record review and interview, for 1 of 2 sampled clients (client #1), the facility failed to obtain a dental assessment and dental examination</p>	W 0352	<p>home which include appointments being completed. These are documented on a CQA and reviewed by the director for compliance. Action plans completed if applicable and are monitored by the compliance specialist.</p> <p>The management staff will review annual appointments monthly and ensure that upcoming appointments are scheduled. Managers complete monthly</p>	04/23/2016

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W 0382 Bldg. 00	<p>annually for client #1.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 3/17/16 at 11:25am. Client #1's record indicated a dental assessment on 1/28/15. Client #1's record did not indicate a current dental assessment.</p> <p>On 3/17/16 at 1:30pm, an interview with the LPN (Licensed Practical Nurse). The LPN indicated client #1 should have been seen by the dentist "at least" annually or directed by the dentist. The LPN stated clients #1 had no current dental examinations completed since 1/28/15.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on observation, record review, and interview, for 4 of 4 clients (clients #1, #2, #3, and #4), the facility failed to ensure client #1, #2, #3, and #4's medications were kept secured when not being administered.</p> <p>Findings include:</p>	W 0382	<p>quality assurance checks at the home which include appointments being completed. These are documented on a CQA and reviewed by the director for compliance. Action plans completed if applicable and are monitored by the compliance specialist.</p> <p>All staff will receive retraining on the Medication Storage Policy to ensure that all medications are stored properly. The staff will be monitored by the QIDP and by the Residential Manager and their observations will be documented on the Medication Administration Tracking Form which will be submitted to the director so compliance can be monitored.</p>	04/23/2016			

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	<p>On 3/14/16 from 5:40pm until 5:45pm, GHS (Group Home Staff) #12 left the medication cabinet unsecured. At 5:40pm, GHS #12 had checked client #3's unlabeled Byetta 5mg (milligrams) Insulin Pen (for diabetes) against client #3's 3/2016 MAR (Medication Administration Record). GHS #12 pushed the drawer to shut the drawer, the drawer did not secure to the unit to close tightly, GHS #12 pushed the medication cart lock inward to lock the cart, and then left the medication room. From 5:40pm until 5:45pm, clients #1 and #2 entered and exited the medication/laundry room where the unsecured drawer was located. At 5:45pm, GHS #12 returned with client #3 for his insulin injection. At 5:45pm, GHS #12 indicated the top medication drawer was not secured when the drawer did not close tightly to lock the medications for clients #1, #2, #3, and #4. GHS #12 indicated the medication should have been kept secured.</p> <p>On 3/17/16 at 1:30pm, an interview with the Agency Licensed Practical Nurse (LPN) was conducted. The LPN indicated medications at the group home should be kept secured when not being administered. The LPN indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p>		The initial monitoring will occur three times weekly for three months with weekly review by the director. Monitoring after the 3 months will revert to the ongoing monitoring in place which includes weekly monitoring by the management which will be submitted to the director on a monthly basis to monitor ongoing compliance.		

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W 0391 Bldg. 00	<p>On 3/17/16 at 1:30pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be kept secured when not being administered.</p> <p>On 3/17/16 at 1:30pm, the facility's undated "Medication Pass Instructions" policy indicated staff were to follow the instructions and "...13. Return the medication to the cabinet and lock it...19. Medication cabinet must remain locked at all times...."</p> <p>9-3-6(a)</p> <p>483.460(m)(2)(ii) DRUG LABELING</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, record review, and interview, for 2 of 4 clients (clients #2 and #3), the facility failed to remove from use clients #2 and #3's unlabeled medications.</p> <p>Findings include:</p> <p>1. On 3/14/16 from 5:40pm until</p>	W 0391	All staff will receive retraining on the Medication Labeling Policy and the Medication Administration Policy to ensure that all medications are labeled properly. The staff will be monitored by the QIDP and by the Residential Manager and their observations will be documented on the Medication Administration Tracking Form which will be	04/23/2016

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	<p>5:45pm, GHS (Group Home Staff) #12 checked client #3's unlabeled Lantus and Humalog insulin pens which were stored loose inside the drawer and indicated client #3's Byetta 5mcg (micrograms) Insulin Pen was not stored in the top medication drawer in the same compartment with paper clips, rubber bands, ink pens, and compared the insulin pen to client #3's 3/2016 MAR (Medication Administration Record). GHS #12 located client #3's Byetta insulin pen in the refrigerator and the Byetta 5mg did not have a pharmacy label. GHS #12 located pharmacy bags in a wad which were wedged in the back of the drawer and indicated the bags had the labels for each of client #3's insulin pen medications on them.</p> <p>On 3/17/16 at 1:30pm, client #3's 12/2015 "Physician's Order" indicated "Byetta 5mcg (micrograms) sub Q (injectable) 2 times a day before meals" for Diabetes.</p> <p>2. On 3/15/16 at 7:17am, GHS #8 selected client #2's unlabeled Artificial Tears medication for dry eyes, prompted client #2 to place one drop of the medication into each eye, and no pharmacy label was present on the medication. Client #2's Artificial Tears did not have client #2's name, or the</p>		<p>submitted to the director so compliance can be monitored. The initial monitoring will occur three times weekly for three months with weekly review by the director. Monitoring after the 3 months will revert to the ongoing monitoring in place which includes weekly monitoring by the management which will be submitted to the director on a monthly basis to monitor ongoing compliance.</p>	

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	<p>physician prescribing client #2's medication on the box. The Artificial Tear box had directions for one drop into each eye twice daily. Client #2's 3/2016 MAR indicated "Artificial Tears, 1 drop into each eye twice daily."</p> <p>On 3/17/16 at 10:21am, client #2's 12/29/15 "Physician's Order" indicated "Artificial Tears, instill 1 drop into each eye 2 times a day for dry eyes."</p> <p>On 3/17/16 at 1:30pm, an interview with the Agency Licensed Practical Nurse (LPN) was conducted. The LPN indicated medications at the group home should have a pharmacy label on the medication and/or kept inside the pharmacy container with the label on it. The LPN indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration. The LPN indicated medications should be removed from use when there was not a pharmacy label on the medication which identified the client name, medication, dosage, and directions for its use.</p> <p>On 3/17/16 at 1:30pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of</p>			

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W 0436 Bldg. 00	<p>"Administering Medication" medications should have a pharmacy label on each medication.</p> <p>On 3/17/16 at 1:30pm, the facility's undated "Medication Pass Instructions" policy indicated staff were to follow the instructions on the pharmacy label.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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, record review, and interview, for 1 of 2 sampled clients (client #1) and 1 additional client (client #3) with adaptive equipment, the facility failed to teach and encourage clients #1 and #3 to wear their prescribed eye glasses at the group home.</p> <p>Findings include:</p> <p>On 3/14/16 from 4:20pm until 6:20pm and on 3/15/16 from 5:30am until 8:05am, clients #1 and #3 were observed at the group home. During the observation periods clients #1 and #3</p>	W 0436	All staff will receive retraining on the requirement of wearing adaptive equipment. The staff will be monitored by the QIDP and by the Residential Manager and their observations will be documented on the Medication Administration Tracking Form which will be submitted to the director so compliance can be monitored. The initial monitoring will occur three times weekly for three months with weekly review by the director. Monitoring after the 3 months will revert to the ongoing monitoring in place which includes weekly monitoring by the management which will be submitted to the director on a	04/23/2016			

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	<p>watched television, client #1 cooked fried fish on the stove in hot grease, wrote on paper, walked throughout the group home, consumed meals, completed medication administration, shaved, played video games on their gaming stations, and did not wear their prescribed eye glasses. During both observation periods clients #1 and #3 were not encouraged to wear their prescribed eye glasses.</p> <p>Client #1's record was reviewed on 3/17/16 at 11:25am. Client #1's 1/19/15 vision assessment indicated he wore prescribed eye glasses. Client #1's 1/29/16 ISP (Individual Support Plan) indicated he wore prescribed eye glasses to see. Client #1's ISP did not indicate a goal/objective to teach him to wear his prescribed eye glasses and staff "should record" client #1 wearing his eye glasses on the MAR (Medication Administration Record).</p> <p>Client #3's record was reviewed on 3/17/16 at 1:15pm. Client #3's 1/29/14 vision assessment indicated he wore prescribed eye glasses. Client #3's 4/9/15 ISP did not indicate a goal/objective for client #3 to be taught and encouraged to wear his eye glasses. Client #3's ISP indicated "Vision Difficulties: Has glasses, refuses to wear most of the time.</p>		<p>monthly basis to monitor ongoing compliance. A goal for using adaptive equipment will be added to the ISP's for client #1 and #3. All staff will receive retraining on the ISP for client #1 and #3. The staff will be monitored by the QIDP and by the Residential Manager and their observations will be documented on the Medication Administration Tracking Form which will be submitted to the director so compliance can be monitored. The initial monitoring will occur three times weekly for three months with weekly review by the director. Monitoring after the 3 months will revert to the ongoing monitoring in place which includes monthly goal tracking by the QIDP.</p>	

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W 0440 Bldg. 00	<p>Staff encourage [client #3] to wear his glasses daily and also clean the glasses daily. This is tracked on the MAR.</p> <p>On 3/17/16 at 1:30pm, an interview was conducted with the Residential Manager (RM), the Behavior Consultant (BC), and the Agency LPN (Licensed Practical Nurse). The three professional staff indicated clients #1 and #3 wore prescribed eye glasses to see. The BC and the LPN both indicated clients #1 and #3 should have been taught and encouraged to wear their prescribed eye glasses during formal and informal opportunities. The BC indicated each client should be taught and encouraged to wear their glasses throughout the day. The RM indicated eye glasses were usually kept in each clients' bedroom and stated she had "no idea" if clients #1 and #3's eye glasses were in good repair.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, for 4 of 4 clients (clients #1, #2, #3, and #4) living in the group home, the facility failed to conduct quarterly evacuation drills for the 7:00am until 3:00pm and the</p>	W 0440	Evacuation drills will be completed across shifts as required. A drill schedule will be placed in the home. In addition, all drills will be placed on the home calendar. Finally, DSP	04/23/2016

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	<p>11:00pm until 7:00am shifts of personnel.</p> <p>Findings include:</p> <p>On 3/16/16 at 2:30pm, a review of the facility's evacuation drills from 3/2015 through 3/2016 was conducted. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, and #4 between 4/24/15 at 8:21am and 2/17/16 at 11:45am for the 7:00am until 3:00pm shift of personnel, and between 5/28/15 at 3:28am and 3/2/16 at 4:30am for the 11:00pm until 7:00am shift of personnel.</p> <p>On 3/17/16 at 11:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated the day shift of personnel was daily from 7:00am until 3:00pm and the night shift of personnel was daily from 11:00pm until 7:00am. The RM indicated no additional evacuation drills were available for review.</p> <p>On 3/24/16 at 1:15pm, an interview with the Site Director (SD) was conducted. The SD indicated no further evacuation drills were available for review.</p> <p>9-3-7(a)</p>		<p>staff members will receive training on how to follow schedule. The management is responsible for ensuring that drills take place. This includes placing the schedule in the home and transferring the dates and times to the home calendar. In addition, the management will follow-up after a drill is scheduled to ensure that it took place as scheduled. The management will submit the drills to the director on a monthly basis so that compliance can be monitored.</p>	

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W 9999 Bldg. 00	<p>State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-2(c)(3) Resident protections Authority: IC12-28-5-19 Affected: IC 4-21.5;IC 5-2-55; IC 12-28-5-12; IC 22-12</p> <p>(c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5, and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>The State rule is not met as evidenced by:</p> <p>Based on record review and interview, for 1 of 3 personnel files reviewed</p>	W 9999	A new Human Resource Recruiter has been assigned to the area. A BMV record screening and Indiana criminal history was completed for GHS #10 on the day of survey. All new hire folders will be reviewed by the Human Resource Coordinator prior to extending an offer for employment.	04/23/2016

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	<p>(Group Home Staff (GHS) #10), the facility failed to complete a bureau of motor vehicles (BMV) record screening and a criminal history.</p> <p>Findings include:</p> <p>On 3/17/16 at 9:50am, the facility staff personnel records were reviewed for GHS #10 with the Human Resource Coordinator (HRC) and indicated the following:</p> <p>-GHS #10 was hired on 9/16/15. GHS #10's record did not indicate a completed BMV screening and a state wide criminal history. GHS #10's record indicated she had a "Juvenile" county search completed and GHS #10's Juvenile county record indicated a 2009 misdemeanor conviction and did not indicate the crime. No investigation was available for review to determine if GHS #10's 2009 conviction record was against a dependent population. At 10:00am, HRC indicated GHS #10's personnel file "did not have" a completed state wide criminal history from the State of Indiana, an investigation into GHS #10's Juvenile conviction record to ensure the conviction was not against a dependent population, and did not have a completed BMV screening.</p> <p>On 3/17/16 at 11:30am, the HRC stated</p>			

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	<p>GHS #10's Juvenile conviction was for a "girl fight in school" and indicated no BMV and no State of Indiana criminal history were available for review. The HRC indicated the facility's policy and procedure was to have a completed BMV and criminal history completed before the employee starts their employment to screen employees for a history of abuse, neglect, and to protect the clients the agency serves.</p> <p>On 3/18/16 at 9:35am, GHS #10's 3/17/16 State of Indiana criminal history and 3/17/16 BMV screening were provided for review.</p> <p>On 3/18/16 at 9:35am, an interview with the BC (Behavior Consultant) and the Residential Manager (RM). The BC and RM both indicated the facility's policy and procedure was to have a BMV and a criminal history completed before the third day of employment. Both staff indicated GHS #10 did not have a BMV screening and criminal history completed until 3/17/16.</p> <p>9-3-2(c)(3)</p>			