

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N LOGANSPORT, IN 46947
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W000000	<p>This visit was for full annual recertification and state licensure survey.</p> <p>Dates of Survey: June 4, 5, 6, 7, 10, 11, 12, 13, 14, and 17, 2013.</p> <p>Provider Number: 15G538 Facility Number: 001052 AIM Number: 100239830</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/24/13 by Ruth Shackelford, QIDP.</p>	W000000		

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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W000102	<p><b>483.410 GOVERNING BODY AND MANAGEMENT</b> The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 2 of 2 sampled clients (clients #1 and #2) and for 1 additional client (client #5). The governing body failed to provide oversight and management to ensure the Conditions of Participation: Client Protections and Healthcare Services were met. The Governing Body failed to ensure the facility implemented the facility's policy and procedures to accurately report the events of client #5's death, to ensure neglect was prohibited, to report the results of the death investigation, and to ensure monitoring and implementation of medical services.</p> <p>Findings include:</p> <p>Please refer to W122. The governing body failed to exercise operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections as the facility failed to implement their policy and procedures during client #5's medical emergency at the group home, failed to accurately report to BDDS (Bureau of Developmental Disabilities Services) in</p>	W000102	<p><b>w102:</b> Please refer to W122, W318 and W104</p>	07/05/2013			

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	<p>accordance with state law, failed to report the results of client #5's death investigation, and failed to ensure implementation of medical services.</p> <p>Please refer to W318. The governing body failed to exercise operating direction over the facility to ensure the facility met the Condition of Participation: Health Care Services, as the facility failed to provide health care services, monitoring, and oversight of nursing services for 2 of 2 sampled clients (clients #1 and #2) and 1 additional client (client #5).</p> <p>Please refer to W104. The governing body failed to exercise operating direction over the facility to ensure the facility's policy and procedure to prevent abuse, neglect, and/or mistreatment was implemented, failed to ensure accurate reporting of significant events, failed to report the results of a death investigation, failed to ensure the facility staff immediately initiated CPR (Cardiac Pulmonary Resuscitation) in an emergency, and failed to provide administrative oversight of the group home to ensure services were provided for 1 additional client (client #5).</p> <p>9-3-1(a)</p>						

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W000104	<p><b>483.410(a)(1) GOVERNING BODY</b> The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 1 additional client (client #5), the governing body failed to exercise operating direction over the facility to ensure the facility's policy and procedure to prevent abuse, neglect, and/or mistreatment was implemented, failed to ensure accurate reporting of significant events, failed to report the results of a death investigation, failed to ensure the facility staff immediately initiated CPR (Cardiac Pulmonary Resuscitation) in an emergency, and failed to provide administrative oversight of the group home to ensure services were provided.</p> <p>Findings include:</p> <p>Please refer to W149. The governing body failed to exercise operating direction over the facility to ensure the facility implemented the policy and procedure for 1 additional client (client #5). The governing body failed to ensure implementation of their policy and procedure to prevent abuse, neglect, and/or mistreatment, to accurately report significant events, to report the results of client #5's death investigation, to immediately initiate CPR (Cardiac</p>	W000104	<p><b>W104:</b> Please refer to W149 and W331</p>	07/05/2013			

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	<p>Pulmonary Resuscitation), and to provide oversight to ensure services in the group home were provided.</p> <p>Please refer to W331. The governing body failed to exercise operating direction over the facility's nursing services to develop an assessment of client #2's pain and failed to ensure the facility staff initiated emergency measures, initiated CPR (Cardiac Pulmonary Resuscitation), and medical monitoring during the overnight hours for client #5.</p> <p>9-3-1(a)</p>			

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 1 additional client (client #5), the facility failed to meet the Condition of Participation: Client Protections as the facility failed to implement their policy and procedures during client #5's medical emergency at the group home, failed to accurately report to BDDS (Bureau of Developmental Disabilities Services) in accordance with state law, failed to report the results of client #5's death investigation, failed to initiate CPR (Cardiac Pulmonary Resuscitation)/emergency measures, and failed to ensure medical services were provided.</p> <p>Findings include:</p> <p>Please refer to W149. The facility neglected to implement the policy and procedure to prevent abuse, neglect, and/or mistreatment, neglected to accurately report significant events, neglected to report the results of investigations, neglected to ensure staff immediately initiated CPR/emergency measures and neglected to ensure medical services in the group home were provided for 1 additional client (client #5).</p>	W000122	<p><b>W122:</b> Please refer to W149, W153 and W156</p>	07/05/2013			

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	<p>Please refer to W153. The facility failed to accurately report client #5's death and events for 1 additional client (client #5).</p> <p>Please refer to W156. The facility failed to report the results of client #5's death investigation for 1 additional client (client #5).</p> <p>9-3-2(a)</p>			

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W000149	<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 1 additional client (client #5), the facility neglected to implement their policy and procedure to prevent abuse, neglect, and/or mistreatment, neglected to accurately report significant events, neglected to report the results of investigations, neglected to immediately initiate CPR (Cardiac Pulmonary Resuscitation)/emergency measures, and neglected to ensure services in the group home were provided.</p> <p>Findings include:</p> <p>On 6/4/13 at 9:30am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 06/2012 through 06/4/13.</p> <p>-A 5/11/13 BDDS report for an incident on 5/11/13 at 5:53am, indicated during client #5's 5:53am bed check at the group home, client #5 was not moving or responding, and her tongue was sticking out of her mouth which "could not be moved." The report indicated "staff then started emergency procedures. EMTs (Emergency Medical Team) on the scene notified staff of death and coroner was</p>	W000149	<p><b>W149:</b> The facility currently has policy and procedures in place regarding the mistreatment, neglect or abuse of a client and the reporting there of. All new employees are trained upon hire and annually thereafter on the policy and the procedure for reporting injury of the clients to the proper authorities within and outside the agency. The facility has written policies on emergency policies and procedures as well. All new employees are trained on these procedures and on how to report emergencies. Emergency phone list are located in the houses for the staff. In addition all staff is trained in CPR/First aid for emergencies and must maintain current status on each during course of employment. The QMRP's are trained on BDDS reporting procedures upon hire and annually thereafter. The QMRP are trained to file reports per the BDDS guidelines and are to ensure accuracy in these reports. Follow up reports are to be submitted per guidelines until closure notice is given, and additional reports if more reportable information is obtained after incident.</p> <p>All staff has been re-trained in the specific needs for each client regarding supervision level.</p>	07/05/2013	

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	<p>notified. Coroner placed time of death at 5:00am."</p> <p>On 6/4/13 at 9:30am, the 5/17/13 investigation into client #5's death was reviewed. The 5/17/13 investigation indicated the following:</p> <p>-On 5/11/13 - Client #5's Death occurred at the group home.</p> <p>-On 5/14/13 Coroner: [Name of County], "Death Certificate" indicated "Time of death 5/11/13 at 05:00AM," and the "Cause of death: Myocardial Infarction, Aortic Stenosis."</p> <p>-On 5/11/13 at 5:53am, QIDP (Qualified Intellectual Disabilities Professional) was called by the Group Home staff person on duty from the group home. The QIDP did not answer her phone because she was not on call. The investigation indicated a message was left on the QIDP's answering machine to state Client #5 "was dead."</p> <p>-On 5/11/13 at 5:54am, QIDP called back the one staff person (Group Home Staff #22) on duty at the group home. The Staff "[Group Home Staff #22] answered hysterically crying that [Client #5] was dead." QIDP asked Group Home Staff #22 if she called 9-1-1 and the "staff had not." Group Home Staff #22 told QIDP that Client #5's "tongue that protruded</p>		<p>All staff has been re-trained on emergency procedures specifically including when 911 should be called, initiating CPR when a client is found unresponsive, abuse, neglect, exploitation, incident reporting procedures and documentation standards prohibiting falsification of documentation.</p> <p>In addition the QMRP has been trained on incident reporting for BDDS, and follow up reports for additional information.</p> <p>Weekly a member of management will do an observation on varied shifts for the next 3 months to ensure implementation of policies and procedures is being followed. In addition at the next 3 monthly staff meetings the abuse and neglect policy and emergency procedures will be reviewed and retrained on the contents. The Area Director will review the BDDS reports to ensure they are accurate and no additional follow up is needed after the incident has been reviewed.</p> <p>Responsible Party: Area Director Completion Date: 7/5/2013</p>				

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	<p>was stiff and couldn't be moved." QIDP instructed Group Home Staff #22 to call 9-1-1 and the QIDP was on her way to the group home.</p> <p>-On 5/11/13 at 6:15am, the QIDP arrived at the group home. EMTs were present and the EMTs tried CPR, but "ruled that [Client #5] had been dead for awhile and the coroner had been contacted."</p> <p>-On 5/11/13 8:20am, Group Home Staff #22 was interviewed. On 5/10/13 at 11pm she began her shift as the only staff at the group home for the overnight period. Group Home Staff #22 indicated:</p> <p>-At 11:15pm checked on clients. Client #5 was facing the wall with her right arm above her head, laying on her right side, and was repositioned.</p> <p>-At 1:15am, "Next check" was completed. Client #5 was sleeping towards the wall on her right side with left thumb in her mouth. Repositioned.</p> <p>-At 5:00am, "Next check" was completed. Client #5 was facing the opposite wall towards her roommate. She was laying on her left side with her left thumb in her mouth. Group Home Staff #22 stated Client #5 "still felt warm, took [Client #5's] thumb out of her mouth, and blew a puff of air in [Client #5's] face trying to wake her. No response." Group Home Staff #22 stated "she cradled</p>						

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	<p>[Client #5] in her arms trying to wake her and realized that [Client #5] was dead." The interview indicated Group Home Staff #22 called "on call immediately." Group Home Staff #22 stated "[Client #5's] tongue was hard, she had tried to put it back into her mouth and could not." Group Home Staff #22 indicated she "cradled [Client #5] until EMT personnel had shown up" just before 6:14am.</p> <p>-Group Home Staff #22 was interviewed again on 5/13/13, no time documented. Group Home Staff #22 indicated "Re verified bed checks were completed at 11:15pm, 1:15am, and 5am." Group Home Staff #22 was asked by REM agency investigators "if she knew the time frame for checks when clients were asleep or out of sight." Group Home Staff #22 stated "yes ma'am, 15 minute checks, 2 hour brief checks." Group Home Staff #22 was asked why the intervals on 5/11/13 did not show 15 minute checks; Group Home Staff #22 stated "she had forgotten." Group Home Staff #22 stated "About the DSR (Daily Service Record/staff charting notes) that had been completed on [Client #5] by [Group Home Staff #22] for 5/11/13 from 12am until 9am," indicated "[Client #5] slept well thru (through) the night, she woke up this staff done (sic) her am care, she took her am meds. Relaxed at her table, ran</p>						

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	<p>her AM goals, she ate her breakfast, went back to her table, flipped thru her books (sic)."</p> <p>During the 5/13/13 interview Group Home Staff #22 was asked "if she had written this up before the end of her shift, she replied yes." Group Home Staff #22 "also agreed that none of these events in the summary occurred." Group Home Staff #22 was asked "if she should have pre filled her documentation," and she replied "no." Group Home Staff #22 told the REM investigator "she routinely pre documents so she can help the morning staff get the other clients ready."</p> <p>During the 5/13/13 interview Group Home Staff #22 stated she "did not initiate life saving measures or CPR because she could not get [Client #5's] tongue back in her mouth." Group Home Staff #22 stated that she "was sorry she did not and she was sorry for pre filling out her DSR."</p> <p>On 6/4/13 at 9:30am, Client #5's record and the 5/11/13 investigation both were reviewed and indicated the following: Client #5's "Medical File: Profound Mental Retardation, Labs WNL (Within Normal Limits), 1/7/13 Echocardiogram tracking history of Aortic valve shows severe aortic regurgitation and heavy</p>			

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	<p>calcification with restricted motion. Significant change since the original diagnosis back in 1999." Client #5's Physical Exam 1/30/13 indicated stable with no changes, and client #5's "Nursing quarterly" 3/26/13, was unchanged from previous exams. Client #5's record indicated she was a full Code and should have had CPR initiated. Client #5's record indicated she had a problem with her Aortic valve of her heart, blindness, and an enlarged tongue. Client #5's record indicated she was to be assisted by the facility staff to the bathroom every two hours during the night and was to have been checked on by the facility staff every fifteen minutes.</p> <p>On 6/4/13 at 12:30pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the facility neglected to implement the policy and procedure to prevent the neglect of client #5 by not initiating CPR when client #5 was a full code and should have had CPR immediately. The QIDP indicated the facility neglected to accurately report client #5's death on the BDDS report to include the events that Group Home Staff #22 did not initiate CPR or call 9-1-1 immediately and had falsified her 15 minute client wellness and bed checks, had falsified documents for data</p>						

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	<p>recording, and had not completed the every two (2) hour toileting and repositioning schedule. The QIDP indicated the facility neglected to report the results of client #5's death investigation.</p> <p>On 6/4/13 at 12:30pm, the facility's undated policy "Operating Practices: XVI. Safety" indicated "Disaster and Emergency Plans...(page 3) Severe Illness and Injury, In the event of severe Illness or injury, time is an essential factor. Within a matter of a few minutes, an individual can die from severe bleeding and/or coronary and respiratory arrest. In the event of a severe illness or injury, the procedures listed below will be followed: The employee will get the person immediate medical attention...In an extreme emergency or if unable to transport the person to the hospital, employees can call 9-1-1 or the local emergency numbers. Until the ambulance arrives, all appropriate first aid measures shall be taken. Some of the first aid points to remember in the event of illness or injury are: Keep the victim's airway open. If the person is not breathing, call 9-1-1 immediately and begin CPR. You must administer CPR until help arrives...."</p> <p>On 6/4/13 at 12:30pm, a review of the</p>			

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	<p>4/2003 BDDS "Reportable incidents to the Bureau of Developmental Disabilities Services" indicated "Reportable incidents are any events characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual...."</p> <p>9-3-2(a)</p>			

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W000153	<p><b>483.420(d)(2)</b> <b>STAFF TREATMENT OF CLIENTS</b> 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.</p> <p>Based on record review and interview for 1 additional client (client #5), the facility failed to accurately report the events of client #5's death to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>On 6/4/13 at 9:30am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 06/2012 through 06/4/13.</p> <p>-A 5/11/13 BDDS report for an incident on 5/11/13 at 5:53am, indicated during client #5's 5:53am bed check at the group home, client #5 was not moving or responding, and her tongue was sticking out of her mouth which "could not be moved." The report indicated "staff then started emergency procedures. EMTs (Emergency Medical Team) on the scene notified staff of death and coroner was notified. Coroner placed time of death at 5:00am."</p>	W000153	<p><b>W153:</b> The facility currently has policy and procedures in place regarding the mistreatment, neglect or abuse of a client and the reporting there of. All new employees are trained upon hire and annually thereafter on the policy and the procedure for reporting injury of the clients to the proper authorities within and outside the agency. Indiana Mentor follows the BDDS incident reporting policy as outlined in the provider standards to ensure accurate and timely reports are completed. All staff has been trained on abuse, neglect, and exploitation and incident reporting procedures. (Attachment #1)</p> <p>In addition the QMRP has been trained on incident reporting for BDDS, and follow up reports for additional information. (Attachment #2)</p> <p>The Area Director will review the BDDS reports to ensure they are accurate and no additional follow up is needed after the incident has been reviewed.</p> <p>Responsible Party: Program Director/Area Director Completion Date: 7/5/2013</p>	07/05/2013			

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	<p>On 6/4/13 at 9:30am, the 5/17/13 investigation into client #5's death was reviewed. The 5/17/13 investigation indicated the following:</p> <p>-On 5/11/13 - Client #5's Death occurred at the group home.</p> <p>-On 5/14/13 Coroner: [Name of County], "Death Certificate" indicated "Time of death 5/11/13 at 05:00AM," and the "Cause of death: Myocardial Infarction, Aortic Stenosis."</p> <p>-On 5/11/13 at 5:53am, the QIDP (Qualified Intellectual Disabilities Professional) was called by the Group Home staff person on duty from the group home. The QIDP did not answer her phone because she was not on call. The investigation indicated a message was left on the QIDP's answering machine to state Client #5 "was dead."</p> <p>-On 5/11/13 at 5:54am, the QIDP called back the one staff person (Group Home Staff #22) on duty at the group home. The Staff "[Group Home Staff #22] answered hysterically crying that [Client #5] was dead." The QIDP asked Group Home Staff #22 if she called 9-1-1 and the "staff had not." Group Home Staff #22 told QIDP that Client #5's "tongue that protruded was stiff and couldn't be moved." QIDP instructed Group Home</p>			

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	<p>Staff #22 to call 9-1-1 and the QIDP was on her way to the group home.</p> <p>-On 5/11/13 at 6:15am, the QIDP arrived at the group home. EMTs were present and the EMTs tried CPR, but "ruled that [Client #5] had been dead for a while and the coroner had been contacted."</p> <p>-On 5/11/13 8:20am, Group Home Staff #22 was interviewed. On 5/10/13 at 11pm she began her shift as the only staff at the group home for the overnight period. Group Home Staff #22 indicated: -At 5:00am, Client #5 was facing the opposite wall towards her roommate. Client #5 was laying on her left side with her left thumb in her mouth. Group Home Staff #22 stated Client #5 "still felt warm, took [Client #5's] thumb out of her mouth, and blew a puff of air in [Client #5's] face trying to wake her. No response." Group Home Staff #22 "stated she cradled [Client #5] in her arms trying to wake her and realized that [Client #5] was dead." The interview indicated Group Home Staff #22 called "on call immediately." Group Home Staff #22 stated "[Client #5's] tongue was hard, she had tried to put it back into her mouth and could not." Group Home Staff #22 indicated she "cradled [Client #5] until EMT personnel had shown up."</p>						

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	<p>During the 5/13/13 no time documented, Group Home Staff #22 was interviewed again and stated "she did not initiate life saving measures or CPR because she could not get [Client #5's] tongue back in her mouth." Group Home Staff #22 stated that she "was sorry she did not."</p> <p>On 6/4/13 at 12:30pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the facility failed to accurately report client #5's death to include the events that Group Home Staff #22 did not initiate CPR or call 9-1-1 immediately and had falsified her 15 minute client wellness and bed checks, had falsified documents for data recording, and had not completed the every two (2) hour toileting and repositioning schedule.</p> <p>9-3-2(a)</p>				

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W000156	<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 additional client (client #5), the facility failed to report the results of client #5's death investigation.</p> <p>Findings include:</p> <p>On 6/4/13 at 9:30am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 06/2012 through 06/4/13.</p> <p>-A 5/11/13 BDDS report for an incident on 5/11/13 at 5:53am, indicated during client #5's 5:53am bed check at the group home, client #5 was not moving or responding, and her tongue was sticking out of her mouth and "could not be moved." The report indicated "staff then started emergency procedures. EMTs (Emergency Medical Team) on the scene notified staff of death and coroner was notified. Coroner placed time of death at 5:00am."</p> <p>On 6/4/13 at 9:30am, the 5/17/13 investigation into client #5's death was reviewed. The 5/17/13 investigation</p>	W000156	<p><b>W156:</b>Indiana Mentor follows the BDDS incident reporting policy as outlined in the provider standards to ensure accurate and timely reports are completed. Indiana Mentor completes thorough investigations per state guidelines and reports these results within agency guidelines. Indiana Mentor completes the mortality review for all instances of death and sends the reviews along with thorough investigations to the state for review. The QMRP has been trained on incident reporting for BDDS, and follow up reports for additional information. This includes doing follow up reports as information is learned through the course of investigations and upon completion of investigations to report findings (attachment #2)On going, the Area director will review the BDDS reports to ensure proper follow up and findings are reported within the time perimeters.Responsible Party: Program Director/Area Director Completion Date: 7/5/2013</p>	07/05/2013

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	<p>indicated the following:</p> <p>-On 5/11/13 - Client #5's Death occurred at the group home.</p> <p>-On 5/14/13 Coroner: [Name of County], "Death Certificate" indicated "Time of death 5/11/13 at 05:00AM," and the "Cause of death: Myocardial Infarction, Aortic Stenosis."</p> <p>-On 5/11/13 at 5:53am, the QIDP (Qualified Intellectual Disabilities Professional) was called by the Group Home staff person on duty from the group home. The QIDP did not answer her phone because she was not on call. The investigation indicated a message was left on the QIDP answer machine to state Client #5 "was dead."</p> <p>-On 5/11/13 at 5:54am, the QIDP called back the one staff person (Group Home Staff #22) on duty at the group home. The Staff "[Group Home Staff #22] answered hysterically crying that [Client #5] was dead." The QIDP asked Group Home Staff #22 if she called 9-1-1 and the "staff had not." Group Home Staff #22 told QIDP that Client #5's "tongue that protruded was stiff and couldn't be moved." The QIDP instructed Group Home Staff #22 to call 9-1-1 and the QIDP was on her way to the group home.</p>			
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	<p>-On 5/11/13 at 6:15am, the QIDP arrived at group home. EMTs were present and the EMTs tried CPR, but "ruled that [Client #5] had been dead for awhile and the coroner had been contacted." The Investigation did not indicate the events from 5:54am until 6:15am.</p> <p>-On 5/11/13 8:20am, Group Home Staff #22 was interviewed. On 5/10/13 at 11pm she began her shift as the only staff at the group home for the overnight period. Group Home Staff #22 indicated:</p> <p>-At 11:15pm checked on clients. Client #5 was facing the wall with her right arm above her head, laying on her right side, and was repositioned.</p> <p>-At 1:15am, "Next check" was completed. Client #5 was sleeping facing towards the wall on her right side with her left thumb in her mouth. Client #5 was repositioned.</p> <p>-At "5:00am, Next check" was completed. Client #5 was facing the opposite wall towards her roommate. The client was laying on her left side, with her Left thumb in her mouth. Group Home Staff #22 stated Client #5 "still felt warm, took [Client #5's] thumb out of her mouth, and blew a puff of air in [Client #5's] face trying to wake her. No response." Group Home Staff #22 "stated she cradled [Client #5] in her arms trying to wake her and realized that [Client #5] was dead." The interview indicated</p>			

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	<p>Group Home Staff #22 called "on call immediately." Group Home Staff #22 stated "[Client #5's] tongue was hard, she had tried to put it back into her mouth and could not." Group Home Staff #22 indicated she "cradled [Client #5] until EMT personnel had shown up."</p> <p>-Group Home Staff #22 was interviewed again on 5/13/13 no time documented. Group Home Staff #22 indicated "Re verified bed checks were completed at 11:15pm, 1:15am, and 5am." Group Home Staff #22 was asked by REM agency investigators "if she knew the time frame for checks when clients were asleep or out of sight." Group Home Staff #22 stated "yes ma'am, 15 minute checks, 2 hour brief checks." Group Home Staff #22 was asked why the intervals on 5/11/13 did not show 15 minute checks. Group Home Staff #22 stated "she had forgotten." Group Home Staff #22 stated "About the DSR (Daily Service Record / staff charting notes) that had been completed on [Client #5] by Group Home Staff #22] for 5/11/13 from 12am until 9am," indicated "[Client #5] slept well thru (sic) the night, she woke up this staff done (sic) her am care, she took her am meds. Relaxed at her table, ran her AM goals, she ate her breakfast, went back to her table, flipped thru (sic) her books."</p>			

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	<p>During the 5/13/13 interview Group Home Staff #22 was asked "if she had written this up before the end of her shift, she replied yes." Group Home Staff #22 "also agreed that none of these events in the summary occurred." Group Home Staff #22 was asked if she should have pre filled her documentation, and she replied "no." Group Home Staff #22 told the REM investigator "she routinely pre documents so she can help the morning staff get the other clients ready."</p> <p>During the 5/13/13 interview Group Home Staff #22 stated she "did not initiate life saving measures or CPR because she could not get [Client #5's] tongue back in her mouth." Group Home Staff #22 stated that she "was sorry she did not and she was sorry for pre filling out her DSR."</p> <p>On 6/4/13 at 12:30pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the facility failed to report the results of client #5's death investigation.</p> <p>9-3-2(a)</p>				

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W000192	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on record review and interview, the facility failed for 1 additional client (client #5), to ensure staff who worked with clients received client specific training and retraining related to emergency procedures, contacting 9-1-1, CPR (Cardiac Pulmonary Resuscitation), and client #5's medical monitoring.</p> <p>Findings include:</p> <p>On 6/4/13 at 9:30am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 06/2012 through 06/4/13. Client #5's 5/11/13 BDDS report for an incident on 5/11/13 at 5:53am, indicated during client #5's 5:53am bed check at the group home, client #5 was not moving or responding.</p> <p>On 6/4/13 at 9:30am, the 5/17/13 investigation into client #5's death was reviewed. The 5/17/13 investigation indicated the following: -On 5/14/13 Coroner: [Name of County], "Death Certificate" indicated "Time of death 5/11/13 at 05:00AM," and the "Cause of death: Myocardial Infarction, Aortic Stenosis."</p>	W000192	<p><b>W192:</b> The facility has written policies on emergency policies and procedures as well. All new employees are trained on these procedures and on how to report emergencies. Emergency phone list are located in the houses for the staff. In addition all staff is trained in CPR/First aid for emergencies and must maintain current status on each during the course of employment. Prior to working in the houses staff must also complete client specific training which covers risk plans, healthcare, supervision levels, and behavioral plans for example. During the course of the investigation, it was verified that all staff was current in their CPR/SFA certification and that all staff had received client specific training. All staff has been trained in the specific needs for each client regarding supervision level. In addition, all staff has been trained on emergency procedures specifically including when 911 should be called (Attachment #1), initiating CPR when a client is found unresponsive, abuse, neglect, exploitation, incident reporting procedures and documentation standards prohibiting falsification of</p>	07/05/2013			

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	<p>-On 5/11/13 at 5:53am, the QIDP (Qualified Intellectual Disabilities Professional) was called by the Group Home staff person on duty from the group home and a message was left on the QIDP's answering machine to state Client #5 "was dead."</p> <p>-On 5/11/13 at 5:54am, the QIDP called back the one staff person (Group Home Staff #22) on duty at the group home. The Staff "[Group Home Staff #22] answered hysterically crying that [Client #5] was dead." The QIDP asked Group Home Staff #22 if she called 9-1-1 and the "staff had not." Group Home Staff #22 told QIDP that Client #5's "tongue that protruded was stiff and couldn't be moved." QIDP instructed Group Home Staff #22 to call 9-1-1 and QIDP was on her way to the group home.</p> <p>-On 5/11/13 at 6:15am, the QIDP arrived at group home. EMTs (Emergency Medical Transport) were present and the EMTs tried CPR, but "ruled that [Client #5] had been dead for awhile and the coroner had been contacted."</p> <p>-On 5/11/13 8:20am, Group Home Staff #22 was interviewed. On 5/10/13 at 11pm she began her shift as the only staff at the group home for the overnight</p>		<p>documentation. (Attachment #1) For the next three staff meetings emergency procedures will be covered and CPR/SFA status of all staff will be checked on a bi-weekly basis to ensure staff maintains current status. For the next three months a member of management will be doing weekly observation to ensure policies and procedures are being followed. Responsible Party: Program Director/Area Director Completion Date: 7/5/2013</p>				

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	<p>period. Group Home Staff #22 indicated:</p> <p>-At 11:15pm checked on clients. Client #5 was facing the wall with her right arm above her head, laying on her right side, and was repositioned.</p> <p>-At 1:15am, "Next check" was completed. Client #5 was sleeping towards the wall on her right side with her left thumb in her mouth. Repositioned.</p> <p>-At "5:00am, Next check" was completed. Client #5 was facing the opposite wall, towards her roommate. She was laying on her left side, with her left thumb in her mouth. Group Home Staff #22 stated Client #5 "still felt warm, took [Client #5's] thumb out of her mouth, and blew a puff of air in [Client #5's] face trying to wake her. No response." Group Home Staff #22 "stated she cradled [Client #5] in her arms trying to wake her and realized that [Client #5] was dead." The interview indicated Group Home Staff #22 called "on call immediately." Group Home Staff #22 stated "[Client #5's] tongue was hard, she had tried to put it back into her mouth and could not." Group Home Staff #22 stated she "cradled [Client #5] until EMT personnel had shown up."</p> <p>-Group Home Staff #22 was interviewed again on 5/13/13 no time documented. Group Home Staff #22 indicated "Re verified bed checks were completed at</p>						

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	<p>11:15pm, 1:15am, and 5am." Group Home Staff #22 was asked by REM agency investigators "if she knew the time frame for checks when clients were asleep or out of sight." Group Home Staff #22 stated "yes ma'am, 15 minute checks, 2 hour brief checks." Group Home Staff #22 was asked why the intervals on 5/11/13 did not show 15 minute checks. Group Home Staff #22 stated "she had forgotten."</p> <p>During the 5/13/13 no time available, interview Group Home Staff #22 stated "she did not initiate life saving measures or CPR because she could not get [Client #5's] tongue back in her mouth." Group Home Staff #22 stated "that she was sorry she did not."</p> <p>On 6/4/13 at 9:30am, Client #5's record and the 5/11/13 investigation both were reviewed and indicated the following: Client #5's "Medical File: Profound Mental Retardation, Labs WNL (Within Normal Limits), 1/7/13 Echocardiogram tracking history of Aortic valve shows severe aortic regurgitation and heavy calcification with restricted motion. Significant change since the original diagnosis back in 1999." Client #5's Physical Exam 1/30/13 indicated stable with no changes, and client #5's "Nursing quarterly" 3/26/13, was unchanged from</p>						

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	<p>previous exams. Client #5's record indicated she was a full Code and should have had CPR initiated. Client #5's record indicated she had a problem with her Aortic valve of her heart, blindness, and an enlarged tongue. Client #5's record indicated she was to be assisted by the facility staff to the bathroom every two hours during the night and was to have been checked on by the facility staff every fifteen minutes.</p> <p>On 6/4/13 at 12:30pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the facility staff failed to implement the policy and procedure on emergency care, medical care, calling 9-1-1, and client #5's medical needs. The QIDP indicated client #5 was a full code and should have had CPR immediately. The QIDP indicated the facility staff failed to initiate CPR immediately and staff had falsified her 15 minute client wellness and bed checks, had falsified documents for data recording, and had not completed every two (2) hour toileting and repositioning schedule. The QIDP indicated the group home staff were trained yearly after client #5's annual case conference and recently on 2/23/13. The QIDP indicated facility staff were trained annually on the facility's policy and procedures to include</p>						

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	<p>what to do in an emergency. No training was available for review before client #5's 5/11/13 incident. The QIDP indicated the agency nurse was not available for an interview.</p> <p>On 6/4/13 at 12:30pm, the facility's undated policy "Operating Practices: XVI. Safety" indicated "Disaster and Emergency Plans...(page 3) Severe Illness and Injury, In the event of severe Illness or injury, time is an essential factor. Within a matter of a few minutes, an individual can die from severe bleeding and/or coronary and respiratory arrest. In the event of a severe illness or injury, the procedures listed below will be followed: The employee will get the person immediate medical attention...In an extreme emergency or if unable to transport the person to the hospital, employees can call 9-1-1 or the local emergency numbers. Until the ambulance arrives, all appropriate first aid measures shall be taken. Some of the first aid points to remember in the event of illness or injury are: Keep the victim's airway open. If the person is not breathing, call 9-1-1 immediately and begin CPR. You must administer CPR until help arrives...."</p> <p>9-3-3(a)</p>			

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W000316	<p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually.</p> <p>Based on record review and interview, for 1 of 1 sampled client (client #1) who received psychotropic medications, the facility failed to evaluate client #1's status for an annual decrease or contraindication of psychotropic medication.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 6/6/13 at 9:40am. Client #1's 1/23/13 ISP (Individual Support Plan) and client #1's 3/2013 BSP (Behavior Support Plan) indicated the targeted behaviors of SIB (Self Injurious Behavior), Physical Assault, and Temper Outbursts. Client #1's plans indicated the use of Abilify 30mg (milligrams) for behaviors, Depakote 1500mg for behaviors, Lorazepam 1mg for behaviors, and Risperdal 4mg for behaviors. Client #1's 4/19/13, 2/11/13, 12/17/12, 10/22/12, and 8/27/12 "Psych Medication Reviews" did not indicate a change in client #1's psychiatric medications or a contraindication. Client #1's record did not indicate the last psychotropic medication change or contraindication. No behavior data was provided for review.</p>	W000316	<p><b>W316:</b> Indiana Mentor has policies in place to ensure individuals in service receive assistance to assist/manage in healthcare needs. This includes ensuring appointments occur in a timely manner and follow up is met. For the group homes the nurse in conjunction with the QMRP set up appointments to ensure care is met, and review them upon completion to ensure all areas of concerns have been addressed.</p> <p>For client #1 his psychiatric review completed on 2/11/2013 indicates he is on the minimal effective dose (attachment #3)</p> <p>The QMRP and Nurse will review charts for remaining individuals to ensure annually the contraindication of psychotropic medication had been noted and follow up as needed.</p> <p>On going the QMRP and Nurse will continue to monitor to ensure all recommendations are followed, and psychotropic drugs are reviewed annually if no changes in dose.</p> <p>Responsible Party: Program Director/Area Director Completion Date: 7/5/2013</p>	07/05/2013

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	<p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 6/17/13 at 11:05am. The QIDP indicated client #1's psychiatric medications had not been changed in over a year and no contraindication for client #1's psychiatric medication had been documented. The QIDP indicated client #1 had no documented evidence that a medication change had been considered for a medication reduction.</p> <p>9-3-5(a)</p>			
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W000318	<p><b>483.460</b> <b>HEALTH CARE SERVICES</b> The facility must ensure that specific health care services requirements are met. Based on record review and interview, the Condition of Participation: Health Care Services, was not met as the facility failed to provide health care services, monitoring, and oversight of nursing services for 2 of 2 sampled clients (clients #1 and #2) and 1 additional client (client #5).</p> <p>Findings include:</p> <p>Please refer to W331. The facility's nursing services failed to develop an assessment of client #2's pain and failed to ensure the facility staff initiated emergency measures, initiated CPR (Cardiac Pulmonary Resuscitation), and medical monitoring during the overnight hours for client #5.</p> <p>Please refer to W368. The facility failed to administer medications without error as prescribed by the clients' personal physician for 2 of 2 sampled clients (clients #1 and #2).</p> <p>Please refer to W192. The facility failed to ensure staff who worked with clients received client specific training related to emergency procedures, contacting 9-1-1, CPR (Cardiac Pulmonary Resuscitation),</p>	W000318	<p><b>W318</b> Refer to 192, 331, 368</p>	07/05/2013			

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	and client #5's medical monitoring for 1 additional client (client #5).  9-3-6(a)			

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W000331	<p>483.460(c) 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 2 sample clients (client #2) and 1 additional client (client #5), the facility's nursing services failed to develop an assessment of client #2's pain and failed to ensure the facility staff initiated emergency measures, initiated CPR (Cardiac Pulmonary Resuscitation), and medical monitoring during the overnight hours for client #5.</p> <p>Findings include:</p> <p>1. On 6/6/13 at 12:15pm, client #2's record was reviewed. Client #2's ISP (Individual Support Plan) and 4/1/13 "Physician's Order" both indicated client #2's diagnoses included but were not limited to: Scoliosis, Cerebral Palsy, and Osteoporosis. Both documents indicated client #2 was non verbal. Client #2's 4/1/13 "Physician's Order" indicated "Motrin (anti inflammatory) 1 tablet 400mg (milligrams) orally twice a day (Osteoporosis)" and "Nabumetone (anti inflammatory) 1 tablet 500mg orally twice a day (Osteoporosis)." Client #2's 5/24/12, 8/27/12, 11/2012, 2/20/13, and 5/20/13 "Nursing Quarterlies" did not indicate a pain assessment and did not include how staff were to monitor client</p>	W000331	<p><b>W331</b></p> <p>The facility has written policies on emergency policies and procedures as well. All new employees are trained on these procedures and on how to report emergencies. Emergency phone list are located in the houses for the staff. In addition all staff is trained in CPR/First aid for emergencies and must maintain current status on each during course of employment. Indiana Mentor also has been policies in place to ensure individuals receive assistance in managing health care needs and monitoring and their services are received in a timely a professional manner. Indiana Mentor has systems in place for monitoring including checklists done by the home managers and program directors, direct observation reports, and unannounced visits. The manager's check to ensure documentation and active treatment standards are met. A pain assessment was completed on client #2 on (attachment #4)</p> <p>The nurse and QMRP reviewed all other individuals' files to ensure no other assessments are needed, completed by 7/3/2013</p> <p>All staff was trained on emergency policies (attachment #1)</p> <p>Management will conduct</p>	07/05/2013			

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	<p>#2's pain. Client #2's 1/14/13 "Healthcare Protocol" for a history of fractured "right hip, thinning of the bones is a life long condition." Interventions...PRN (as needed) medications indicated for pain...contact supervisor if has any s/s (signs/symptoms) or severe pain...." The protocol did not include what staff should watch for to indicate client #2 was in pain.</p> <p>On 6/17/13 at 11:05am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #2 was non verbal. The QIDP indicated she had spoken to the agency nurse and client #2 did not have a completed pain assessment which identified what staff were to monitor for in regards to client #2's pain.</p> <p>2. On 6/4/13 at 9:30am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 06/2012 through 06/4/13. Client #5's 5/11/13 BDDS report for an incident on 5/11/13 at 5:53am, indicated during client #5's 5:53am bed check at the group home, client #5 was not moving or responding.</p> <p>On 6/4/13 at 9:30am, the 5/17/13 investigation into client #5's death was reviewed. The 5/17/13 investigation</p>		<p>observations during peak overnight hours twice a month for a period of six months which will include documentation reviews.</p> <p>For the next three staff meetings emergency procedures will be covered.</p> <p>Responsible Party: Program Director/Nurse</p> <p>Completion Date: 7/5/2013</p>				

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	<p>indicated the following:</p> <p>-On 5/14/13 Coroner: [Name of County], "Death Certificate" indicated "Time of death 5/11/13 at 05:00AM," and the "Cause of death: Myocardial Infarction, Aortic Stenosis."</p> <p>-On 5/11/13 at 5:53am, the QIDP (Qualified Intellectual Disabilities Professional) was called by the Group Home staff person on duty from the group home and a message was left on the QIDP's answering machine to state Client #5 "was dead."</p> <p>-On 5/11/13 at 5:54am, the QIDP called the one staff person (Group Home Staff #22) on duty at the group home back. The Staff "[Group Home Staff #22] answered hysterically crying that [Client #5] was dead." QIDP asked Group Home Staff #22 if she called 9-1-1 and the "staff had not." Group Home Staff #22 told QIDP that Client #5's "tongue that protruded was stiff and couldn't be moved." QIDP instructed Group Home Staff #22 to call 9-1-1 and the QIDP was on her way to the group home.</p> <p>-On 5/11/13 at 6:15am, the QIDP arrived at group home. EMTs (Emergency Medical Transport) were present and the EMTs tried CPR, but "ruled that [Client #5] had been dead for awhile and the</p>			

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	<p>coroner had been contacted."</p> <p>-On 5/11/13 8:20am, Group Home Staff #22 was interviewed. On 5/10/13 at 11pm she began her shift as the only staff at the group home for the overnight period. Group Home Staff #22 indicated:</p> <p>-At 11:15pm checked on clients. Client #5 was facing the wall with her right arm above her head, laying on right side, and was repositioned.</p> <p>-At 1:15am, "Next check" was completed. Client #5 was sleeping towards the wall on her right side with her left thumb in her mouth. Repositioned.</p> <p>-At "5:00am, Next check" was completed. Client #5 was facing the opposite wall, towards her roommate. She was laying on her left side, with her left thumb in her mouth. Group Home Staff #22 stated Client #5 "still felt warm, took [Client #5's] thumb out of her mouth, and blew a puff of air in [Client #5's] face trying to wake her. No response." Group Home Staff #22 "stated she cradled [Client #5] in her arms trying to wake her and realized that [Client #5] was dead." The interview indicated Group Home Staff #22 called "on call immediately." Group Home Staff #22 stated "[Client #5's] tongue was hard, she had tried to put it back into her mouth and could not." Group Home Staff #22 indicated she "cradled [Client #5] until</p>			

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	<p>EMT personnel had shown up."</p> <p>-Group Home Staff #22 was interviewed again on 5/13/13 no time documented. Group Home Staff #22 indicated "Re verified bed checks were completed at 11:15pm, 1:15am, and 5am." Group Home Staff #22 was asked by REM agency investigators "if she knew the time frame for checks when clients were asleep or out of sight." Group Home Staff #22 stated "yes ma'am, 15 minute checks, 2 hour brief checks." Group Home Staff #22 was asked why the intervals on 5/11/13 did not show 15 minute checks. Group Home Staff #22 stated "she had forgotten."</p> <p>During the 5/13/13 interview Group Home Staff #22 stated "she did not initiate life saving measures or CPR because she could not get [Client #5's] tongue back in her mouth." Group Home Staff #22 stated that she "was sorry she did not."</p> <p>On 6/4/13 at 9:30am, Client #5's record and the 5/11/13 investigation both were reviewed and indicated the following: Client #5's "Medical File: Profound Mental Retardation, Labs WNL (Within Normal Limits), 1/7/13 Echocardiogram tracking history of Aortic valve shows severe aortic regurgitation and heavy</p>			

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	<p>calcification with restricted motion. Significant change since the original diagnosis back in 1999." Client #5's Physical Exam 1/30/13 indicated stable with no changes, and client #5's "Nursing quarterly" 3/26/13, was unchanged from previous exams. Client #5's record indicated she was a full Code and should have had CPR initiated. Client #5's record indicated she had a problem with her Aortic valve of her heart, blindness, and an enlarged tongue. Client #5's record indicated she was to be assisted by the facility staff to the bathroom every two hours during the night and was to have been checked on by the facility staff every fifteen minutes.</p> <p>On 6/4/13 at 12:30pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the facility staff failed to implement the policy and procedure on emergency care, medical care, calling 9-1-1, and client #5's medical needs. The QIDP indicated client #5 was a full code and should have had CPR immediately. The QIDP indicated the facility staff failed to initiate CPR immediately and staff had falsified her 15 minute client wellness and bed checks, had falsified documents for data recording, and had not completed every two (2) hour toileting and repositioning</p>						

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	<p>schedule. The QIDP indicated the group home staff were trained yearly after client #5's annual case conference and recently on 2/23/13. The QIDP indicated facility staff were trained annually on the facility's policy and procedures to include what to do in an emergency. No training was available for review before client #5's 5/11/13 incident. The QIDP indicated the agency nurse was not available for an interview.</p> <p>On 6/4/13 at 12:30pm, the facility's undated policy "Operating Practices: XVI. Safety" indicated "Disaster and Emergency Plans...(page 3) Severe Illness and Injury, In the event of severe illness or injury, time is an essential factor. Within a matter of a few minutes, an individual can die from severe bleeding and/or coronary and respiratory arrest. In the event of a severe illness or injury, the procedures listed below will be followed: The employee will get the person immediate medical attention...In an extreme emergency or if unable to transport the person to the hospital, employees can call 9-1-1 or the local emergency numbers. Until the ambulance arrives, all appropriate first aid measures shall be taken. Some of the first aid points to remember in the event of illness or injury are: Keep the victim's airway open. If the person is not breathing, call</p>			

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	9-1-1 immediately and begin CPR. You must administer CPR until help arrives...."  9-3-6(a)			

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W000368	<p><b>483.460(k)(1)</b> <b>DRUG ADMINISTRATION</b> The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 2 of 2 sampled clients (clients #1 and #2), the facility failed to administer medications without error as prescribed by the clients' physician.</p> <p>Findings include:</p> <p>1. On 6/4/13 at 9:30am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 6/2012 through 6/4/13 and indicated the following for client #1:</p> <p>-A 3/25/13 BDDS report for a medication error on 3/25/13 at 12:00 noon, client #1 was not given his Levothyroxine medication for Thyroid disease.</p> <p>-A 3/25/13 BDDS report for a medication error on 3/24/13 at 1pm, client #1 was not administered Furosemide 20mg (milligrams) a diuretic.</p> <p>-A 1/31/13 BDDS report for a medication error on 1/31/13 at 10:30am, indicated client #1's Levothyroxine medication for Thyroid was "missed."</p> <p>-A 1/31/13 BDDS report for a medication</p>	W000368	<p><b>W368</b> Upon hire all staff are trained and certified in medication administration in guidance with state standards through Core A and B. All staff must successfully pass Core A and B prior to doing medication administration. Staff goes through annual reviews thereafter on medication administration. Staffs are trained on checking on ensuring the right medications are given at the right time and proper documentation for medications. Staff who commit medication errors are subject to corrective and retraining on medication administration. All staff was trained on medication administration. (Attachment #1) Weekly the home manager will review the MAR to ensure no errors are present. Management will conduct medication observations 4x a month for a period of 6 months. Responsible Party: Program Director/Area Director Completion Date: 7/5/2013</p>	07/05/2013

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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N LOGANSPOORT, IN 46947
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	<p>error on 1/30/13 at 7:00am, indicated client #1 received 2 of 3 capsules of Depakote medication for behaviors.</p> <p>-A 12/16/12 BDDS report for a medication error on 12/13/12 at 7:00am, indicated client #1 was not given his 7:00am dose of Lorazepam 1mg for behaviors.</p> <p>-A 11/9/12 BDDS report for a medication error on 11/8/12 at 6:00am, indicated client #1 was not given his Risperdal 4mg medication for behaviors.</p> <p>On 6/6/13 at 9:40am, client #1's record was reviewed. Client #1's 3/5/13 ISP (Individual Support Plan) and 4/1/13 "Physician's Order" both indicated client #1's diagnoses included but were not limited to: Aggressive Behavior and Downs Syndrome. Client #1's 4/1/13 "Physician's Order" indicated Depakote for behaviors, Levothyroxine for Thyroid, Lorazepam for behaviors, and Furosemide 20mg (milligrams) a diuretic.</p> <p>2. On 6/4/13 at 9:30am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 6/2012 through 6/4/13 and indicated the following for client #2:</p> <p>-A 4/22/13 BDDS report for a medication</p>			

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	<p>error on 4/21/13 at 7:00pm, indicated client #2 was not given her Nabumetone 500mg medication an anti inflammatory medication.</p> <p>-A 11/8/12 BDDS report for a medication error on 11/7/12 at 8:00pm, indicated client #2's Neurologist had increased her Dilantin to 2 tablets of 100mg and it was not given.</p> <p>-A 10/8/12 BDDS report for a medication error on 10/8/12 at 7:00am, indicated client #2 was given 200mg of Vimpat for seizures at 7:00am instead of 100mg of Vimpat.</p> <p>-A 6/12/12 BDDS report for a medication error on 6/10/12 at 8:30am, indicated client #2 was not given her Phenobarbital medication for seizures.</p> <p>On 6/6/13 at 12:15pm, client #2's record was reviewed. Client #2's ISP (Individual Support Plan) and 4/1/13 "Physician's Order" both indicated client #2's diagnoses included but were not limited to: Scoliosis, Cerebral Palsy, Seizure Disorder, and Osteoporosis. Client #2's 4/1/13 "Physician's Order" indicated "Nabumetone (anti inflammatory) 1 tablet 500mg orally twice a day (Osteoporosis), Vimpat 100mg every morning, Phenobarbital 60mg twice a day, and</p>			

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	<p>Dilantin 100mg in morning.</p> <p>On 6/6/13 at 9:10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the Agency Nurse was on vacation at this time. The QIDP indicated the agency retrained staff after the medication errors for the staff person involved in the error. The QIDP indicated clients #1 and #2 were not administered his medications according to their physician's orders. The QIDP indicated client #1 and #2's physician orders were not followed when facility staff did not administer their medications according to the physician's order.</p> <p>On 6/7/13 at 2:56pm, a record review was completed of the undated facility's policy and procedures indicated facility staff should follow physician's orders to administer medications to clients who lived in the group home.</p> <p>On 6/7/13 at 2:56pm, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p> <p>9-3-6(a)</p>			

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W000433	<p>483.470(f)(3) FLOORS The facility must have exposed floor surfaces and floor coverings that promote mobility in areas used by clients. Based on observation, record review, and interview, for 4 of 4 clients (clients #1, #2, #3, and #4), the facility failed to ensure the exposed floor surfaces on the front porch promoted a safe environment.</p> <p>Findings include:</p> <p>On 6/4/13 from 4:10pm until 6:15pm, and on 6/5/13 from 5:40am until 8:00am, observation and interview at the group home were completed and clients #1, #2, #3, and #4 walked throughout the group home and front porch. During both observation periods the wooden front porch had splintered wood seven feet by twenty-five feet (7' wide by 25' long) into the worn and chipped wood finish. The group home house number on the front of the porch had fallen off the splintered wood and was hanging upside down. During both observation periods client #3 walked barefoot onto and throughout the front porch area where broken wood had splintered from the floor area of the porch.</p> <p>On 6/6/13 at 1:40pm, the House Manager (HM) indicated no maintenance had been requested for the front porch area to be</p>	W000433	<p><b>W433</b> Indiana Mentor promotes safety by ensuring environmental checks are done throughout the month by the home manager and a monthly check by the program director. In addition a comprehensive check of the house is done every quarter. The agency also employs a maintenance staff whom staff reports concerns or issues with and who coordinates/does the repairs. The program director completed a environmental assessment of the house to ensure no other problem areas were noted. The maintenance staff is replacing boards on the porch and ensuring no further splintering by 7/5/2013. The management will conduct bi weekly environmental checks and report any concerns to maintenance. Responsible Party: Program Director/Maintenance Completion Date: 7/5/2013</p>	07/05/2013			

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	<p>repaired.</p> <p>On 6/17/13 at 11:05pm, an interview with the HM, the QIDP (Qualified Intellectual Disabilities Professional), and the Site Director (SD) was conducted. The three administrative staff indicated the maintenance man had repaired and repainted the front porch of the group home after the surveyor identified the splintered wood.</p> <p>9-3-7(a)</p>			