

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G498	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/11/2015
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947
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W 0000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 8/31, 9/1, 9/2, 9/3, 9/4, 9/10, and 9/11/2015.</p> <p>Provider Number: 15G498 Facility Number: 001012 AIM Number: 100239780</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report was completed by #09182 on 9/17/2015.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview, for 2 of 3 sampled clients (clients #1 and #2), the governing body failed to exercise operating direction over the facility to ensure clients #1 and #2 were not charged for services the facility was to provide.</p> <p>Findings include:</p> <p>On 9/3/15 at 9:00am, client #1 and #2's</p>	W 0104	<p>W104: There are certain services that are mandated to be provided by the facility. The facility will reimburse clients 1 and 2 for the cost of the 4 haircuts that the clients paid for out of their personal funds. The Program Coordinator and Program Director will be trained to ensure that the clients do not pay for services in which the facility is required to pay as part of room and board. All staff will be trained</p>	10/11/2015

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

TITLE

(X6) DATE

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

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	<p>financial records were reviewed with the Residential Manager (RM) which indicated the following:</p> <p>Client #1's financial record included a 6/14/15 "[Name of Hair Salon]" receipt for \$6.00 and a 11/19/14 "[Name of Salon]" receipt for \$3.99 from client #1's personal funds account and the use of a gift card for an additional \$6.00 charge on 11/19/14.</p> <p>Client #2's financial record included a 6/14/15 "[Name of Hair Salon]" receipt for \$13.00 and a 10/31/14 "[Name of Hair Salon]" receipt for \$7.00 from client #2's personal funds account and the use of a personal gift card for an additional \$6.00 on 10/31/14.</p> <p>On 9/3/15 at 9:20am, the RM indicated clients #1 and #2 had charges to their personal funds at the facility from hair cuts while in the community. The RM indicated clients #1 and #2 used a personal gift card from each client's personal funds. The RM stated the facility's rate was "all inclusive" and clients #1 and #2 should be reimbursed for the charges of services (hair cuts) the facility was to provide.</p> <p>9-3-1(a)</p>		<p>to ensure that the facility is required to pay for certain services such as haircuts. All client finances will be reviewed to ensure that the clients have not paid for services in which the facility is responsible to pay. If it is determined that they have, the facility will reimburse the clients. The Area Director will review a sample of client finances one time per month for the next 3 months to ensure the clients are not paying for their own haircuts. Responsible Party: Area Director</p>	

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W 0125 Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review, and interview, for 3 of 3 sampled clients (clients #1, #2, and #3) and 3 additional clients (clients #4, #5, and #6), the facility failed to ensure unimpeded access to the locked sharp objects, locked glass cups and dishes, locked food, locked lunch boxes, and locked chemicals for clients #1, #2, #3, #4, #5, and #6 at the facility owned day services for clients who did not have documented assessments for the restricted access to the locked items.</p> <p>Findings include:</p> <p>On 9/1/15 from 8:55am until 10:25am, clients #1, #2, #3, #4, #5, and #6 were observed at the facility owned day services and facility staff had the only available keys to locked sharp objects, glasses and dishes, food, lunch boxes, and chemicals. From 8:55am until 10:25am, clients #1, #2, and #3 were non verbal and were not offered or encouraged by the facility staff to access</p>	W 0125	<p>W125: The facility ensures the rights of all clients. The facility allows and encourages all clients to exercise their rights as clients of the facility and as citizens of the United States, including the right to file complaints and the right to due process.</p> <p>The kitchen at the facility owned day services has been unlocked to allow access by client's 1, 2, 3, 4, 5 and 6.</p> <p>Staff will be trained to keep the door unlocked so that clients have access per their rights. Staff will be trained in client rights to ensure an understanding of each client's rights.</p> <p>The Program Coordinator or Program Director will complete observations at the Day Service Facility 2 times per week to ensure that the clients have access to the kitchen in accordance with their rights and/or plan.</p> <p>Responsible Party: Area Director</p>	10/11/2015	

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	<p>their locked items. From 8:55am until 10:25am, client #6 walked to the locked kitchen door at the day services, tried to turn the locked kitchen door, and was encouraged by the staff to stay away from the locked kitchen door. From 8:55am until 10:25am, other clients from the workshop were observed to enter the locked kitchen with facility staff and exit carrying cups of fluid to drink. During the observation period, clients #1, #2, #3, #4, #5, and #6 were not offered and/or encouraged to drink fluids. At 10:00am, Workshop Staff (WKS) #1 indicated clients #1, #2, #3, #4, #5, and #6 did not have keys to the locked items and did not need the items locked. WKS #1 indicated the locked restrictions were for a different client from another group home. WKS #1 indicated the day services did not have a drinking fountain and/or glasses (or paper cups) available for clients to obtain a drink of water. WKS #1 stated "We give them what they bring in their lunch at lunch time" and stated "everything is locked."</p> <p>On 9/2/15 at 1:15pm, client #1's record was reviewed. Client #1's 2/8/15 ISP (Individual Support Plan) and 2015 CFA (Comprehensive Functional Assessment) did not indicate an identified need to lock sharp objects, snacks, food items, and chemicals. Client #1's record did not</p>			

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	<p>indicate consent for locked items.</p> <p>On 9/2/15 at 11:35am, client #2's record was reviewed. Client #2's 4/20/2015 ISP and undated CFA did not indicate an identified need to lock sharp objects, snacks, food items, and chemicals. Client #2's record did not indicate consent for locked items.</p> <p>On 9/2/15 at 12:25pm, client #3's record was reviewed. Client #3's 1/19/15 ISP and 2015 CFA did not indicate an identified need to lock sharp objects, snacks, food items, and chemicals. Client #3's record did not indicate consent for locked items.</p> <p>On 9/2/15 at 1:15pm, the RM (Residential Manager) was interviewed. The RM indicated clients #1, #2, #3, #4, #5, and #6's sharps, food items, glasses, and chemicals were not kept locked at the group home. The RM indicated clients #1, #2, #3, #4, #5, and #6 did not have a key to access the items at the day services site, did not have goals or a plan to decrease the restrictions of the locked items, and stated "only staff" had keys to the locked items at the day services which the agency operated. The RM indicated clients #1, #2, #3, #4, #5, and #6 had not given consent for the locked items. The RM indicated no assessments</p>			

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W 0149 Bldg. 00	<p>were completed for clients #1, #2, #3, #4, #5, and #6. The RM indicated the locked items were an issue for other clients who attended the day services site.</p> <p>On 9/11/15 at 1:30pm, an interview with the agency's Site Director (SD) was conducted. The SD indicated client #1, #2, #3, #4, #5, and #6's sharps, food items, glasses, and chemicals were not kept locked at the group home. The SD indicated clients #1, #2, #3, #4, #5, and #6 did not have a key to access the items, did not have goals or a plan to decrease the restrictions of the locked items, and stated "only staff" had keys to the locked items at the day services which the agency operated. The SD indicated clients #1, #2, #3, #4, #5, and #6 had not given consent for the locked items. The SD indicated no assessments were completed for clients #1, #2, #3, #4, #5, and #6. The SD indicated the locked items were an issue for other clients who attended the day services' site.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p>			

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	<p>Based on record review and interview, for 3 of 3 sampled clients (clients #1, #2, and #3), and for 3 additional clients (clients #4, #5, and #6) who resided in the group home, the facility neglected to immediately report an allegation of staff sleeping on duty to the administrator and in accordance with State Law for clients #1, #2, #3, #4, #5, and #6.</p> <p>Findings include:</p> <p>The facility's reportable incidents and investigations for the Bureau of Developmental Disabilities Services (BDDS) from 9/2014 through 8/31/15 were reviewed on 8/31/15 at 8:30 PM and indicated the following allegation of staff neglect:</p> <p>-A 5/29/15 BDDS report for an incident on 5/27/15 at 5:00am indicated "On 5/28/15 a staff reported that he had allegedly found midnight staff [name of staff] possibly sleeping on 5/27/15."</p> <p>-A 5/29/15 "Summary of Internal Investigation Report" indicated a staff reported to the RM (Residential Manager) on 5/28/15 that the reporting staff "allegedly found midnight staff possibly sleeping on 5/27/15." The investigation indicated clients #1, #2, #3,</p>	W 0149	<p>W149: The facility has policy and procedures in place that prohibit the mistreatment, neglect or abuse of the client.</p> <p>All staff will be trained in the facility abuse and neglect policy specifically regarding the facility policy and BDDS reporting guidelines for requirement of reporting allegations of neglect immediately to a supervisor.</p> <p>The Program Coordinator and/or Program Director will review the facility policy and BDDS reporting guidelines at the next 3 staff meetings to ensure continued understanding and compliance regarding reporting procedures.</p> <p>Responsible Party: Area Director</p>	10/11/2015	

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	<p>#4, #5, and #6 were in the group home on 5/27/15. The investigation indicated the reporting staff was asked "why he waited over 24 hours to report the allegation and [the reporting staff] stated that he couldn't prove she was sleeping." The investigation did not address the failure to immediately report allegations of abuse, neglect, and/or mistreatment. The investigation indicated clients #1, #2, #3, #4, #5, and #6 "All 6 individuals' risk management assessment plans state that the individuals are to have 24 hour awake staffing." The investigative summary did not indicate the facility staff had neglected to immediately report to the Administrator and to BDDS the allegation that staff on duty were sleeping.</p> <p>On 9/11/15 at 1:30pm, an interview with the agency's Site Director (SD) was conducted. The SD indicated the facility followed the BDDS reporting guidelines for reportable incidents and investigations. The SD indicated the facility staff did not immediately report the allegation of staff sleeping while on duty. The SD indicated clients #1, #2, #3, #4, #5, and #6 had the identified need for 24 hour a day staff supervision.</p> <p>The facility's policy and procedures were</p>			

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W 0153 Bldg. 00	<p>reviewed on 8/31/15 at 1:45pm. The facility's 4/2011 Quality and Risk Management policy indicated "Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services thorough oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The 4/2011 Quality and Risk Management Policy indicated failure to provide appropriate supervision, care or training was considered neglect. The 4/2011 Quality and Risk Management Policy indicated, "Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. (1.) Investigation findings will be submitted to the AD (Area Director) for review and development of further recommendations as needed within 5 days of the incident."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported</p>				

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	<p>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 of 1 allegation of neglect (clients #1, #2, #3, #4, #5, and #6), the facility failed to immediately report to the facility's administrator and to BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 the allegation of staff sleeping on duty for clients #1, #2, #3, #4, #5, and #6.</p> <p>Findings include:</p> <p>The facility's reportable incidents and investigations for the Bureau of Developmental Disabilities Services (BDDS) from 9/2014 through 8/31/15 were reviewed on 8/31/15 at 8:30 PM and indicated the following allegation of staff neglect:</p> <p>-A 5/29/15 BDDS report for an incident on 5/27/15 at 5:00am indicated "On 5/28/15 a staff reported that he had allegedly found midnight staff [name of staff] possibly sleeping on 5/27/15."</p> <p>-A 5/29/15 "Summary of Internal Investigation Report" indicated a staff reported to the RM (Residential Manager) on 5/28/15 that the reporting</p>	W 0153	<p>W153: The facility has policy and procedures in place that prohibit the mistreatment, neglect or abuse of the client.</p> <p>All staff will be trained in the facility abuse and neglect policy specifically regarding the facility policy and BDDS reporting guidelines for requirement of reporting allegations of neglect immediately to a supervisor.</p> <p>The Program Coordinator and/or Program Director will review the facility policy and BDDS reporting guidelines at the next 3 staff meetings to ensure continued understanding and compliance regarding reporting procedures.</p> <p>Responsible Party: Area Director</p>	10/11/2015

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	<p>staff "allegedly found midnight staff possibly sleeping on 5/27/15." The investigation indicated clients #1, #2, #3, #4, #5, and #6 were in the group home on 5/27/15. The investigation indicated the reporting staff was asked "why he waited over 24 hours to report the allegation and [the reporting staff] stated that he couldn't prove she was sleeping." The investigation did not address the failure to immediately report allegations of abuse, neglect, and/or mistreatment. The investigation indicated clients #1, #2, #3, #4, #5, and #6, "All 6 individuals' risk management assessment plans state that the individuals are to have 24 hour awake staffing." The investigative summary did not indicate the facility staff immediately reported the allegation to the Administrator and to BDDS or APS for staff sleeping while on duty at the group home.</p> <p>On 9/11/15 at 1:30pm, an interview with the agency's Site Director (SD) was conducted. The SD indicated the facility followed the BDDS reporting guidelines for reportable incidents and investigations. The SD indicated the facility staff did not immediately report the allegation of staff sleeping while on duty. The SD indicated clients #1, #2, #3, #4, #5, and #6 had the identified need for 24 hour a day staff supervision.</p>						

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W 0247 Bldg. 00	<p>9-3-2(a)</p> <p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management.</p> <p>Based on observation, record review, and interview, for 1 additional client (client #6), the facility failed to ensure client #6 was encouraged and taught to choose his meal time to eat when opportunities existed.</p> <p>Findings include:</p> <p>On 9/1/15 from 5:45am until 8:10am, client #6 was observed at the group home. During the observation period client #6 requested food to eat and/or a drink of fluid and each time was prompted to wait until breakfast. From 5:45am until 6:15am, client #6 walked up/down the hallway, stopped walking to walk into the kitchen, and GHS (Group Home Staff) #3 and the RM (Residential Manager) redirected client #6 to wait until breakfast to eat. At 6:20am, after client #6 was verbally redirected from eating/drinking in the kitchen, client #6 grabbed GHS (Group Home Staff) #14 by her hair after she removed a container of cereal he was holding after client #6</p>	W 0247	<p>W247: The facility develops the individual program plan which included opportunities for client choice and self-management. All staff will be trained that when client #6 asks for food or drink he should be offered a choice in accordance with his behavior support plan. All staff will be trained in client #6's behavior support plan. All staff will also be trained in client rights to ensure an understanding of the clients' rights.</p> <p>The Program Coordinator will observe 2 times weekly to ensure that staff is offering the clients' choices.</p> <p>Responsible Party: Area Director</p>	10/11/2015

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	<p>had taken it off the top of the refrigerator. The RM stated "Let's do something productive like carry dishes to the dining room" and the RM assisted GHS #14 to untangle her hair from client #6's fingers. From 6:20am until 7:45am, client #6 repeatedly entered the kitchen, expressed he was hungry and was verbally, then physically redirected by GHS #3, GHS #14, and the RM to leave the kitchen. Client #6 requested food and/or drink from the staff but was given none. Client #6 tried to exit the living room door into the fenced back yard, and client #6 tried to exit the living room into the enclosed garage where activity tables were set up. Each time client #6 attempted to enter the kitchen, exit the living room to the fenced back yard, and/or exit into the game room into the garage; GHS #3, GHS #14, and the RM at different times placed their bodies between client #6 and his selected destination of travel. Each time staff raised their hands toward client #6 within inches of client #6's personal space, client #6 began to push staff's hands away from his personal space, and client #6 continued to attempt to access each selected area of the group home. Client #6 grabbed the door knobs to open the doors to the garage and back yard and GHS #3 removed client #6's hands physically from the knob resulting in client #6 flailing his arms in the air. Staff</p>			

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	<p>redirected client #6 not to be aggressive. Client #6 was not offered food and/or drink by the group home staff. At 6:30am, client #6 began to hit himself in the head with his right fist after yelling (words were not identified) loudly sixteen (16) times. At 6:30am, GHS #3 stated "We have to wait." At 6:30am, the RM stated "We eat together" and indicated she meant the clients dine together for meals at the table. The RM then carried the containers of cereal client #6 had selected to the dining room table and within client #6's eye sight. From 6:30am until 6:40am, client #6 sat at the dining room table with GHS #3 staring at the container of cereal sitting in the middle of the table. At 6:40am, client #6 requested "that," pointed to the cereal, and GHS #3 told client #6 he had to wait again for food. At 6:40am, client #6 hit himself in the head with a closed right fist eight (8) additional times, was redirected by GHS #3 not to hit himself. Client #6 struck himself in the forehead fifteen (15) additional times with an open hand, and GHS #3 prompted client #6 to walk. From 6:40am until 7:45am, client #6 walked to exit the living room where he was redirected to stay inside, client #6 walked to exit the living room into the garage where he was redirected to stay inside, and client #6 was not offered food/drink. At 7:45am, client #6 ate</p>			

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	<p>breakfast with clients #1, #2, #3, #4, and #5 at the dining room table.</p> <p>Client #6's record was reviewed on 9/2/15 at 11:00am. Client #6's 1/5/15 ISP (Individual Support Plan), 1/2014 BSP (Behavior Support Plan), and 1/5/15 "Risk plan" did not indicate the restrictions from food/drink in the morning and did not include a scheduled time for dining. Client #6's BSP indicated "targeted behaviors" which included: Anxiety, Agitation, Irritability, SIB (Self Injurious Behaviors), and Temper Outbursts. Client #6's plans indicated the targeted behaviors were to enable client #6 "Escape/Avoidance." Client #6's BSP indicated "Staff will create a preferred activity/environment list that will be used both as reinforcement of positive/replacement behaviors and as an intervention of targeted behaviors." Client #6's 3/24/15 Dining Plan indicated he was on a regular diet and whole milk with meals. Client #6's plans did not include the restricted access to food/drink and did not include a choice of dining times.</p> <p>On 9/2/15 at 1:15pm, the RM (Residential Manager) was interviewed. The RM indicated client #6's plans did not include restricting him access to food in the mornings. The RM indicated</p>			

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W 0249 Bldg. 00	<p>client #6 was not offered replacement activities during the morning observation period and was not offered and/or taught to choose his own dining times.</p> <p>On 9/11/15 at 1:30pm, an interview with the agency's Site Director (SD) was conducted. The SD indicated client #6 should not have to wait for food and/or drink and should be provided food/drink when he requested the items. The SD indicated client #6 was not offered a choice as outlined in his BSP.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, for 1 additional client (client #6), the facility failed to ensure client #6's ISP (Individual Support Plan), BSP (Behavior Support Plan), and Risk Plan were implemented when formal and informal opportunities existed.</p> <p>Findings include:</p>	W 0249	W249: As soon as the interdisciplinary team has formulated a client's individual program plan, each client receives a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual support	10/11/2015

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	<p>On 9/1/15 from 5:45am until 8:10am, client #6 was observed at the group home. During the observation period, client #6 requested food to eat and/or a drink of fluid and each time was prompted to wait until breakfast. From 5:45am until 6:15am, client #6 walked up/down the hallway, stopped walking to walk into the kitchen, and GHS (Group Home Staff) #3 and the RM (Residential Manager) redirected client #6 to wait until breakfast. At 6:20am, after client #6 was verbally redirected from eating/drinking in the kitchen. Client #6 grabbed GHS (Group Home Staff) #14 by her hair after she removed a container of cereal he was holding after client #6 had taken off it the top of the refrigerator, and the RM stated "Let's do something productive like carry dishes to the dining room." From 6:20am until 7:45am, client #6 repeatedly entered the kitchen and was verbally and physically redirected by GHS #3, GHS #14, and the RM to leave the kitchen. Client #6 requested food and/or drink from the staff but was given none. Client #6 tried to exit the living room door into the fenced back yard, and client #6 tried to exit the living room into the enclosed garage where activity tables were set up. Each time client #6 attempted to enter the kitchen, exit the living room to the fenced back yard,</p>		<p>plan. All staff will be trained that when client #6 asks for food or drink he should be offered a choice in accordance with his behavior support plan. All staff will be trained in client #6's behavior support plan. All staff will also be trained in active treatment to implement training goals at formal and informal training opportunities. The Program Coordinator will observe 2 times weekly to ensure that staff provides formal and informal training opportunities to ensure continuous active treatment. Responsible Party: Area Director</p>	

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	<p>and/or exit into the game room into the garage; GHS #3, GHS #14, and the RM at different times placed their bodies between client #6 and his selected destination of travel. Each time staff raised their hands toward client #6 within inches of client #6's personal space, client #6 each time began to push staff's hands away from his personal space, and client #6 continued to attempt to access each selected area of the group home. Client #6 grabbed the door knobs to open the doors to the garage and back yard and GHS #3 removed client #6's hands physically from the knob resulting in client #6 flailing his arms in the air. Staff redirected client #6 not to be aggressive. Client #6 was not offered food and/or drink by the group home staff. At 6:30am, client #6 began to hit himself in the head with his right fist after yelling (words were not identified) loudly sixteen (16) times. At 6:30am, GHS #3 stated "We have to wait." At 6:30am, the RM stated "We eat together" and indicated she meant the clients dine together for meals at the table. The RM then carried the containers of cereal client #6 had selected to the dining room table and within client #6's eye sight. From 6:30am until 6:40am, client #6 sat at the dining room table with GHS #3 staring at the container of cereal sitting in the middle of the table. At 6:40am, client #6</p>			
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	<p>requested "that," pointed to the cereal, and GHS #3 told client #6 he had to wait again for food. At 6:40am, client #6 hit himself in the head with a closed right fist eight (8) additional times and was redirected by GHS #3 not to hit himself. Client #6 struck himself in the forehead fifteen (15) additional times with an open hand, and GHS #3 prompted client #6 to walk. From 6:40am until 7:45am, client #6 walked to exit the living room where he was redirected to stay inside, client #6 walked to exit the living room into the garage where he was redirected to stay inside, and client #6 was not offered food/drink. At 7:45am, client #6 ate breakfast with clients #1, #2, #3, #4, and #5.</p> <p>Client #6's record was reviewed on 9/2/15 at 11:00am. Client #6's 1/5/15 ISP (Individual Support Plan), 1/2014 BSP (Behavior Support Plan), and 1/5/15 "Risk plan" did not indicate the restrictions from food/drink in the morning, did not indicate the restriction to the garage and/or fenced back yard, and did not include a scheduled time for dining. Client #6's BSP indicated "targeted behaviors" which included: Anxiety, Agitation, Irritability, SIB (Self Injurious Behaviors), and Temper Outbursts. Client #6's plans indicated the targeted behaviors were to enable client</p>						

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	<p>#6 "Escape/Avoidance." Client #6's BSP indicated "Staff will create a preferred activity/environment list that will be used both as reinforcement of positive/replacement behaviors and as an intervention of targeted behaviors." PIA (Physical Intervention Alternatives) was defined in client #6's plan as "blocking" techniques to protect others and did not include blocking client #6 from physically exiting/entering a desired space. Client #6's 3/24/15 Dining Plan indicated he was on a regular diet and whole milk with meals. Client #6's plans did not include the restricted access to food/drink and did not include a choice of dining times.</p> <p>On 9/3/15 at 12:30pm, the facility's undated "Physical Intervention Alternatives (PIA)" policy and procedure located in the staff communication book was reviewed and indicated for "Physical restraint: All Indiana Mentor staff are trained upon employment and re-trained annually on these procedures. Any escorts/restraints should be released as quickly as possible. If a restraint lasts for 10 minutes, the client should be released and staff should attempt blocking/avoidance unless it is unsafe to do so. If blocking/avoidance continues to be ineffective or unsafe, reinstate physical restraint for 10 minute intervals</p>			

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	<p>attempting to release the client when it is safe to do so. If a client does not respond to proactive measures or non-restrictive measures use restrictive company approved PIA (Physical Intervention Alternatives) techniques listed in this order: Physical restraints should be used only when physical aggression will likely result in harm to oneself, others, or when property destruction might affect peoples' health and safety otherwise use blocking/avoidance. Staff may skip less restrictive measure only if health/safety is an imminent threat. Escorts: Side by side escort walking slightly behind and to the side of the person. Hand below elbow 'L' shaped hand cupping the elbow. Hand behind elbow and hand mid-back. Restraints only to be used if blocking, avoidance or escort is not safe. One arm hold uses 'L' shaped hand to restrict one of the client's arms. Two arm hold, same as one arm but uses second arm to restrain client's flailing arm to the side still only restraining one arm. One arm hold to the floor-client in sitting position. Floor hold (two person) use one arm to the floor restraint, second staff used to restrain legs of the client." The facility's undated "Hierarchy of Physical Interventions" (PIA) policy indicated "6. Physical restraint (PR) refers to the application of physical force to prevent the person from harming him/herself or</p>			

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	<p>others. PR (Physical Restraint) is not a therapeutic technique and is only utilized in emergency situations when everything else has failed. It may only be used for extreme behaviors."</p> <p>On 9/2/15 at 1:15pm, the RM (Residential Manager) was interviewed. The RM indicated client #6's plans did not include restricting him access to food in the mornings and did not include body blocking the facility's exits. The RM indicated client #6 was not offered replacement activities during the morning observation period.</p> <p>On 9/11/15 at 1:30pm, an interview with the agency's Site Director (SD) was conducted. The SD indicated client #6's access should not have been body blocked by the facility staff. The SD indicated client #6 should not have to wait for food and/or drink and should be provided food/drink when he requested the items. The SD indicated client #6 was not offered a choice as outlined in his BSP. The SD indicated the facility staff failed to implement client #6's plans when formal and informal opportunities existed.</p> <p>9-3-4(a)</p>			

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W 0331 Bldg. 00	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 1 of 3 sampled clients (client #2), the facility's nursing staff failed to ensure the facility staff followed the agency's policy and procedure for medication administration to ensure client #2's nose spray medications were administered according to acceptable practice.</p> <p>Findings include:</p> <p>On 9/1/15 at 7:35am, GHS (Group Home Staff) #7 selected client #2's unlabeled nose spray and administered two sprays into each nostril. At 7:35am, GHS #7 stated client #2's unlabeled nose spray "did not" have a cap on the spray bottle, a pharmacy label, and the medication label on the bottle to identify the name and dose of the medication "was missing." GHS #7 indicated she administered two sprays into each nostril and indicated she had no information to indicate the medication matched the "MAR (Medication Administration Record)" for the unlabeled bottle of nose spray. GHS #7 then selected client #2's "Ipratropium 0.06% (nose) spray, use 2 sprays in each nostril once a day for Allergic Rhinitis," removed the cap, and handed the second</p>	W 0331	<p>W331: The facility provides clients with nursing services in accordance with their needs. All staff will be trained by the facility nurse in medication administration. Staff will specifically be trained on administration of client #2's nose sprays and to provide sufficient amount of time in between each nose spray.</p> <p>The Program Director, Program Coordinator and Facility Nurse will observe medication passes 3 times per week for one month to ensure staff are following proper administration of medications and treatments in accordance with the physicians orders. After one month and proper administration has been demonstrated, observations will occur 2 times weekly to ensure continued compliance.</p> <p>Responsible Party: Area Director</p>	10/11/2015

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	<p>nose spray to client #2. Client #2 with GHS #7's hand over hand assistance administered two additional sprays into each nostril from the second nose spray.</p> <p>At 7:50am, client #2's 9/2015 MAR indicated "Fluticasone 50 mcg spray, give 2 sprays in each nostril once a day for Allergic Rhinitis (and) Ipratropium 0.06% (nose) spray, use 2 sprays in each nostril once a day for Allergic Rhinitis."</p> <p>Client #2's record was reviewed on 9/2/15 at 11:35am. Client #2's 6/17/15 "Physician's Order" indicated "Fluticasone 50 mcg spray, give 2 sprays in each nostril once a day for Allergic Rhinitis (and) Ipratropium 0.06% (nose) spray, use 2 sprays in each nostril once a day for Allergic Rhinitis"</p> <p>On 9/3/15 at 10:30am, an interview with the agency's Registered Nurse (RN) was conducted. The RN indicated client #2's medication did not have a pharmacy label on the medication and was not removed from use. The RN indicated client #2's nose spray medications should not have been given one medication spray after another medication spray into his nose. The RN stated the staff should have had "at least 5 to 10 minutes" lapsed time between nose sprays medications. The RN indicated the facility followed the</p>						

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W 0368 Bldg. 00	<p>Core A/Core B training for medication administration and the facility's policy and procedure for medication administration. The RN indicated client #2's nose spray medications were given in error when not administered with lapsed time between sprays. The RN stated she had not observed medication administration "for a while" at the group home.</p> <p>On 9/3/15 at 10:30am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be labeled. The Core A/Core B Medication Administration training indicated nose sprays should not be administered back to back with no lapsed time in between medications.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION 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 3 sampled clients (clients #2 and #3), and two additional clients (clients #4 and #6), the facility failed to administer</p>	W 0368	W368: The facilities system for drug administration assures that all drugs are administered in compliance with the physician's orders. All staff will be trained by	10/11/2015

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	<p>medications without error and as prescribed by clients #2, #3, #4, and #6's personal physicians.</p> <p>Findings include:</p> <p>On 8/31/15 at 8:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 1/1/2015 through 8/31/15 were reviewed and indicated the following medication administration errors:</p> <p>For client #2: -A 6/25/15 BDDS report for an incident on 6/24/15 at 7:00am indicated the facility "staff reported on 6/24/15 that they located two pills still attached to the pill crusher. The last meds (medications) passed were 7:00am on 6/24/15. The staff that passed 7:00am meds stated the last person passed meds on 6/24/15 was [client #2]. The meds were verified as 200mg (milligrams) Vimpat (for seizures) and 10mg Loratadine (for allergies)...The regimen is that the pills are in a cup and a cup is placed over the meds (and between the souffle cups inside the rims of the connecting) pill crusher, then crushed so the pill crusher does not come into contact with the pills."</p> <p>For client #3:</p>		<p>the facility nurse in medication administration procedures and to follow physician's orders. The Program Director, Program Coordinator and Facility Nurse will observe medication passes 3 times per week for one month to ensure staff are following proper administration of medications and treatments in accordance with the physicians orders. After one month and proper administration has been demonstrated, observations will occur 2 times weekly to ensure continued compliance. Responsible Party: Area Director</p>	

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	<p>-A 2/2/15 BDDS report for an incident on 2/1/15 at 7:30am indicated client #3 "did not get one of her Depakote 125mg pills."</p> <p>For client #4: -8/4/15 BDDS report for an incident on 8/2/15 at 7:00pm indicated "On 8/2/15 staff passed [client #4's] 7:00pm medications. [Staff name] only passed 1 of the 4 prescribed tabs (tablets) of 125mg Depakote (for seizures). This medication error was discovered on 8/3/15."</p> <p>For client #6: -A 3/31/15 BDDS report for an incident on 3/30/15 at 8:00pm indicated "It was discovered that [client #6's] 8:00pm medications for 3/30/15 had been popped out and placed in applesauce per his med. administration plan, but the meds were not administered (to client #6). The meds were Ambien 10mg (for sleep), Senna Laxative 8.6mg (for constipation), and Klonpin (sic) 1mg (for behaviors)." -A 2/23/15 BDDS report for an incident on 2/21/15 at 9:30pm indicated client #6 "did not get his 9:00pm Klonpin (sic) 1mg (for behaviors)."</p> <p>Client #2's record was reviewed on 9/2/15 at 11:35am. Client #2's 6/17/15 "Physician Order" and 9/2015 MAR (Medication Administration Record) both</p>			

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	<p>indicated "Loratadine 10mg, give 1 tablet by mouth once a day for allergies (and Vimpat 200mg tablet, take 1 tablet by mouth twice a day for seizure disorder."</p> <p>Client #3's record was reviewed on 9/2/15 at 12:25pm. Client #3's 6/17/15 "Physician Order" and 9/2015 MAR both indicated "Divalproex Sodium (Depakote) 125mg, take 2 tablets by mouth three times daily for seizures."</p> <p>Client #4's record was reviewed on 9/2/15 at 11:10am. Client #4's 6/17/15 "Physician Orders" and 9/2015 MAR both indicated "Divalproex Sodium (Depakote) 125mg, give 4 tabs by mouth twice daily for seizures."</p> <p>Client #6's record was reviewed on 9/2/15 at 11:00am. Client #6's 6/2015 "Physician Orders" and 9/2015 MAR both indicated "Ambien 10mg 1 time daily (for sleep), Senna Laxative 8.6mg 1 tab 1 time daily (for constipation), and Klonopin 1mg 1 tab 3 times daily (for behaviors)."</p> <p>On 9/3/15 at 10:30am, an interview with the agency's Registered Nurse (RN) was conducted. The RN indicated the facility followed the Core A/Core B training for medication administration and the facility's policy and procedure for</p>			

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W 0369 Bldg. 00	<p>medication administration. The RN indicated the facility staff should have followed clients #2, #3, #4, and #6's physician's orders for medication administration.</p> <p>On 9/3/15 at 10:30am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated staff should administer client medications according to physician's orders.</p> <p>9-3-6(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview, for 2 of 15 medications (client #2) who had medications administered during the morning medication administration, the facility failed to administer medication without error for client #2.</p> <p>Findings include:</p> <p>On 9/1/15 at 7:35am, GHS (Group Home</p>	W 0369	<p>W369: The system for drug administration assures that all drugs, including those that are self-administered, are administered without error. All staff will be trained by the facility nurse in medication administration. Staff will specifically be trained on administration of client #2's nose sprays and to provide sufficient amount of time in between each nose spray.</p> <p>The Program Director, Program</p>	10/11/2015

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	<p>Staff #7 selected client #2's unlabeled nose spray and administered two sprays into each nostril. At 7:35am, GHS #7 stated client #2's unlabeled nose spray "did not" have a cap on the spray bottle, a pharmacy label, and the medication label on the bottle to identify the name and dose of the medication "was missing." GHS #7 indicated she administered two sprays into each nostril and indicated she had no information to indicate the medication matched the "MAR (Medication Administration Record)" for the unlabeled bottle of nose spray. GHS #7 then selected client #2's "Ipratropium 0.06% (nose) spray, use 2 sprays in each nostril once a day for Allergic Rhinitis," removed the cap, and handed the second nose spray to client #2. Client #2, with GHS #7's hand over hand assistance, administered two additional sprays into each nostril from the second nose spray.</p> <p>At 7:50am, client #2's 9/2015 MAR indicated "Fluticasone 50 mcg spray, give 2 sprays in each nostril once a day for Allergic Rhinitis (and) Ipratropium 0.06% (nose) spray, use 2 sprays in each nostril once a day for Allergic Rhinitis."</p> <p>Client #2's record was reviewed on 9/2/15 at 11:35am. Client #2's 6/17/15 "Physician's Order" indicated</p>		<p>Coordinator and Facility Nurse will observe medication passes 3 times per week for one month to ensure staff are following proper administration of medications and treatments in accordance with the physicians orders. After one month and proper administration has been demonstrated, observations will occur 2 times weekly to ensure continued compliance.</p> <p>Responsible Party: Area Director</p>	

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W 0382 Bldg. 00	<p>"Fluticasone 50 mcg spray, give 2 sprays in each nostril once a day for Allergic Rhinitis (and) Ipratropium 0.06% (nose) spray, use 2 sprays in each nostril once a day for Allergic Rhinitis"</p> <p>On 9/3/15 at 10:30am, an interview with the agency's Registered Nurse (RN) was conducted. The RN indicated client #2's nose spray medications should not have been given one spray after another spray into his nose. The RN stated the staff should have had "at least 5 to 10 minutes" lapsed time between nose sprays administration. The RN indicated the facility followed the Core A/Core B training for medication administration and the facility's policy and procedure for medication administration. The RN indicated client #2's nose spray medications were given in error when not administered with lapsed time between sprays.</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. Based on observation, record review, and interview, for 3 of 3 sampled clients (#1, #2, and #3), and three additional clients</p>	W 0382	W382: The facility follows policy and procedures in regards to keeping all drugs and biologicals locked except when being	10/11/2015

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	<p>(clients #4, #5, and #6) who resided in the home, the facility failed to keep medication locked when not being administered for clients #1, #2, #3, #4, #5, and #6.</p> <p>Findings include:</p> <p>On 8/31/15 from 2:55pm until 5:50pm, observation and interview were conducted at clients #1, #2, #3, #4, #5, and #6's group home. From 2:55pm until 4:02pm, the medication closet door was not locked and could be opened without a key. At 4:02pm, the RM (Residential Manager) toured the group home following the surveyor and showing each area of the group home. The RM indicated the medication closet location, the surveyor turned the knob, and the door opened without a key. The RM indicated the medication should be kept locked and secured at all times. The RM indicated clients #1, #2, #3, #4, #5, and #6's medications were stored inside the unsecured medication closet.</p> <p>On 9/3/15 at 10:30am, an interview with the agency Registered Nurse (RN) was conducted. The RN indicated medications should be kept locked and secured when not being administered. The RN indicated the facility followed "Living in the Community" Core A/Core</p>		<p>prepared for administration. All staff will be trained by the facility nurse in medication administration, specifically on locking the medication closet when not preparing medications. The Program Director, Program Coordinator and Facility Nurse will observe medication passes 3 times per week for one month to ensure staff are following proper administration of medications and treatments in accordance with the physicians orders. After one month and proper administration has been demonstrated, observations will occur 2 times weekly to ensure continued compliance.</p> <p>Responsible Party: Area Director</p>	

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W 0391 Bldg. 00	<p>B procedures for medication administration.</p> <p>On 9/3/15 at 10:30am, 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>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 1 of 15 medications (client #2) who had medications administered during the morning medication administration, the facility failed to remove from use the medication containers without labels and/or illegible labels from the supply on 9/1/15.</p> <p>Findings include:</p> <p>On 9/1/15 at 7:35am, GHS (Group Home Staff) #7 selected client #2's unlabeled nose spray and administered two sprays into each nostril. At 7:35am, GHS #7</p>	W 0391	<p>W391: The facility follows policy and procedures in regards to removing drug containers with worn, illegible or missing labels. All staff will be trained by the facility nurse in medication administration specifically relating to labeling of medications and removing from cabinet when the label is missing, worn or illegible. The Program Coordinator will be trained to go through the medication closet on a weekly basis to ensure all medication is labeled. The medications for client #2 that are missing labels will be replaced to include a label on the container the medication is stored in and label for the bottle</p>	10/11/2015

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	<p>stated client #2's unlabeled nose spray "did not" have a cap on the spray bottle, a pharmacy label, and the medication label on the bottle "was missing." GHS #7 indicated she administered two sprays into each nostril and indicated she had no information to indicate the medication matched the "MAR (Medication Administration Record)."</p> <p>At 7:50am, client #2's 9/2015 MAR indicated "Fluticasone 50 mcg spray, give 2 sprays in each nostril once a day for allergic rhinitis."</p> <p>Client #2's record was reviewed on 9/2/15 at 11:35am. Client #2's 6/17/15 "Physician's Order" indicated "Fluticasone 50 mcg spray, give 2 sprays in each nostril once a day for allergic rhinitis."</p> <p>On 9/3/15 at 10:30am, an interview with the agency's Registered Nurse (RN) was conducted. The RN indicated client #2's medication did not have a pharmacy label on the medication and was not removed from use. The RN indicated the pharmacy label should include the client name and directions for the medication use. The RN indicated the facility followed the Core A/Core B training for medication administration and the</p>		<p>itself. The label will include the client name and directions for use. The Program Director, Program Coordinator and Facility Nurse will observe medication passes 3 times per week for one month to ensure staff are following proper administration of medications and treatments in accordance with the physicians orders. After one month and proper administration has been demonstrated, observations will occur 2 times weekly to ensure continued compliance.</p> <p>Responsible Party: Area Director</p>	

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	<p>facility's policy and procedure for medication administration. The RN indicated the medication should have had a cap on the medication, a pharmacy label, and an additional label on the bottle to identify what medication it was.</p> <p>On 9/3/15 at 10:30am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be labeled.</p> <p>9-3-6(a)</p>				