STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220	

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W000000	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: 8/18, 8/19 and 8/21/14 Facility number: 001020 Provider number: 15G506 AIM number: 100244980 Surveyor: Paula Eastmond, QIDP-TC The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/28/14 by Ruth Shackelford, QIDP.	W000000		
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 3 of 4 sampled clients (#2, #3 and #4), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility addressed the urine odor in client #2's bedroom, and to ensure the facility implemented its written policy in regard to client finances	W000104	1. The Home Manager and Program Director will work with staff to deep clean Client #2 room in an attempt to remove the urine smell. The Home Manager will work with staff to ensure that the bed and floor in Client #7 room are cleaned a minimum of daily to ensure the odor of urine is minimized.	09/20/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	to ensure accountability of clients' funds. Findings include: 1. During the 8/18/14 observation period between 4:00 PM and 6:30 PM, at the group home, client #2's bedroom smelled of urine upon entering the group home. Client #2 had a single bedroom. Dirty clothes were laying in the client's room in an uncovered hamper. Client #2's record was reviewed on 8/19/14 at 1:09 PM. Client #2's 5/5/14 ISP (Individual Support Plan) indicated client #2's diagnoses included, but were not limited to, Frequent Bladder Infections, Urinary Incontinence, Overactive Bladder and Spastic Bladder. Client #2's 12/7/13 Risk Management Assessment and Plan indicated client #2 was "Incontinent with refusals to change Attends (adult briefs)." Client #2's May 2014 Behavioral Support Plan (BSP) indicated client #2 demonstrated "Incontinence-Urinating and/or defecating in a location other than the interior of a toilet." Client #2's BSP indicated facility staff were to prompt the client to toilet every 2 hours when client #2 was awake. The BSP indicated "...If [client #2] is		Ongoing, the Program Director and/or Home Manager will complete walkthroughs of the home a minimum of weekly to evaluate the cleanliness of the home and address issues with staff as needed to ensure the house is maintained in a clean and odor-free order. Staff will receive retraining to ensure that they are assisting Client #2 in doing her laundry as soon as possible after it becomes wet to endure the odor of urine is minimized. 2. The Program Director and Home Manager will receive retraining on client finances to ensure that they are completing a full and complete accounting of clients financial transactions including collecting and documenting receipts to show how consumers money is spent and ensuring that client check register records and cash on hand ledgers are balanced and reconciled weekly by the HM and monthly by the Program Director and copies of records are provided monthly to the Client Finance Specialist. Ongoing, the Home Manger will record and balance all client	

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	incontinent, [client #2] must be held responsible for cleaning herself and any other area that may have been wet or soiled. Staff are to provide [client #2] with physical prompting and direction as needed to assure she remains on task throughout the period...1. When you discover that [client #2] has been incontinent, immediately direct her to go to the restroom and clean herself up...2. Direct [client #2] to return to the place where she became incontinent and assure that she cleans any urine or feces from the area...." Interview with staff #4 on 8/19/14 at 7:53 AM indicated client #2's bedroom would smell of urine. Staff #4 indicated facility staff used sprays/deodorizers, wiped off client #2's mattress each morning and would change the linens on client #2's bed. Staff #4 stated facility staff would open the windows to "air out" client #2's bedroom. Staff #4 stated they would leave client #2's wet clothes in her bedroom until it was time to do her laundry to "not smell up" the rest of the house. Interview with staff #1 and the QIDP (Qualified Intellectual Disabilities Professional) on 8/19/14 at 8:20 AM indicated client #2 would urinate on herself and in her bedroom. The QIDP		transactions a minimum of weekly and note this in the clients finance records. Ongoing the Program Director will review and reconcile client finances a minimum of monthly and note this in the client finance records. The Program Director will provide copies of the clients' financial transactions to the Client Finance Specialist a minimum of monthly. Monthly, the Client Finance Specialist will provide the Area Director a list of what client finances have not been turned in by the scheduled deadlines and any corrections that need to be made so the Area Director can follow up with HM and/or PD to ensure these requirements are being met. Responsible Party: Home Manager, Program Director, Client Finance Specialist, Area Director	

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	indicated the group home was not able to get the smell out of the client's bedroom. The QIDP indicated he thought the urine may be in the floor of the client's room. The QIDP indicated client #2 had an objective to clean her wheelchair. The QIDP indicated facility staff would leave the windows open to air out the client's room. The QIDP indicated client #2 needed to be reminded to toilet and/or to change her adult brief throughout the day. Staff #1 and the QIDP indicated client #2 would refuse to change her brief and/or tell staff she had been changed when asked. Staff #1 and the QIDP indicated client #2 would sit in the urine soaked brief for a period of time before changing. Staff #1 and the QIDP stated client #2's urine would have a "strong odor." 2. Client #2's financial records were reviewed on 8/19/14 at 3:58 PM. Client #2's financial records indicated the following: -Client #2 had no cash on hand at the group home staff could access as staff did not have a key to the locked safe/box. -Client #2's Cash On Hand Record (COHR) indicated client #2 had made no deposits, and/or withdrawals from her house account held at the group home as the client's COHR indicated "No			

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	Activity"and/or a zero balance since January 2014. -Client #2 had no receipts for any purchases and/or withdrawals for the past year(August 2013 to August 2014). -Client #2 had no checking account ledger to review. Client #2's attached bank statements to the COHRs indicated the following: -On 3/7/14 client #2 withdrew $60.00 from her checking account. -On 4/4/14, client #2 withdrew $40.00 from her her checking account. -On 5/5/14, client #2 withdrew $75.00 from her checking account. Client #2's bank statement and/or COHR did not indicate what items were purchased and/or indicate the facility obtained receipts for the above mentioned withdrawals. Client #3's financial records were reviewed on 8/19/14 at 3:58 PM. Client #3's financial records indicated the following: -Client #3 had no cash on hand at the group home staff could access as staff did not have a key to the locked safe/box. -Client #3's Cash On Hand Record (COHR) indicated client #3 had made no deposits, and/or withdrawals from his			

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	house account held at the group home as the client's COHR indicated "No Activity" and/or a zero balance since January 2014. -Client #3 had no receipts for any purchases and/or withdrawals for the past year (August 2013 to August 2014). -Client #3 had no checking account ledger to review. Client #3's attached bank statements to the COHRs indicated the following: -On 2/28/14, client #3 withdrew $100.00 from his checking account. -On 4/4/14, client #3 withdrew $50.00 from his checking account. -On 5/7/14, client #3 withdrew $50.00 from his checking account. Client #3's bank statement and/or COHR did not indicate what items were purchased, and/or indicate the facility obtained a receipt for the above mentioned withdrawals. Client #4's financial records were reviewed on 8/19/14 at 3:58 PM. Client #4's financial records indicated the following: -Client #4 had no cash on hand at the group home staff could access as staff did not have a key to the locked safe/box. -Client #4's Cash On Hand Record			

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	(COHR) indicated client #4 had made no deposits, and/or withdrawals from his house account held at the group home as the client's COHR indicated "No Activity" and/or a zero balance since January 2014. -Client #4 had no receipts for any purchases and/or withdrawals for the past year (August 2013 to August 2014). -Client #4 had no checking account ledger to review. Client #4's attached bank statements to the COHRs indicated the following: -On 4/4/14, client #4 withdrew $30.00 from his checking account. -On 4/18/14, client #4 withdrew $20.00 from his checking account. -On 5/7/14, client #4 withdrew $25.00 from his checking account. -On 6/20/14, client #4 withdrew $10.00 from his checking account. Client #4's bank statement and/or COHR did not indicate what items were purchased, and/or indicate the facility obtained a receipt for the above mentioned withdrawals. The facility's policy and procedures were reviewed on 8/19/14 at 11:21 AM and at 4:32 PM. The facility's 12/07 Redwood Operating Group Procedure for Managing an Individual's Funds indicated			

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	"monthly reviews and reconciliations at least quarterly" would be done of clients' funds. The 12/07 policy indicated client's funds would be documented by using the following (not all inclusive): "-Checkbook Register... -Individual Monthly Financial Report-summary of monthly financial activity. -Individual Petty Cash Record-used to manage individual petty cash in home and summarize monthly petty cash spent. -Receipts for each expenditure (unless otherwise indicated on the Financial Transaction Consent Form). -Receipts for every deposit and withdrawal. -Bank Statements (typically monthly-may vary per bank)...." The policy indicated "All purchases made in the presence of staff or on behalf of the individual shall be documented with an appropriate receipt. Each receipt shall contain the name of the item purchased, place of purchase, date of purchase, total purchase price, initials of the individual and signature of accompanying staff. Receipts must be turned in immediately following the the activity....." The 12/07 policy indicated clients' financial records/funds would be audited quarterly by a person who was not primarily responsible for the clients' accounts.			

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	Interview with the Area Director (AD), the Qualified Intellectual Disabilities Professional (QIDP) and staff #1 on 8/19/14 at 4:33 PM indicated the group home had a safe where clients #2, #3 and #4's money was kept in. The QIDP and staff #1 indicated they were not able to access the funds as the previous home manager had the key to the safe and was no longer at the group home. The QIDP and staff #1 indicated they were not able to find any additional receipts and/or documentation in regard to client #2, #3 and #4's finances. The QIDP and the AD indicated clients #2, #3 and #4 had a checking account in the community. The AD, the QIDP and staff #1 did not know why money was withdrawn from client #2, #3 and #4's checking accounts as there were no check ledgers and/or receipts. The QIDP indicated clients #2, #3 and #4 had checks at the group home which still needed to be deposited into their accounts. The QIDP and the AD indicated the funds withdrawn from the clients' checking accounts should have been deposited into the clients' petty cash account at the group home and then withdrawn from the COHR for purchases. The AD indicated the group home did not follow the facility's policy in regard to client finances.			

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	9-3-1(a)			
W000136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. Based on interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to allow and/or document clients' participation in outings/activities in the community. Findings include: Client #2's record was reviewed on 8/19/14 at 1:09 PM. Client #2's record and/or Daily Support Records (DSRs) from 7/1/14 to the present, indicated client #2 did not participate in any community activities and/or outings as there were no outings documented. Client #3's record was reviewed on 8/19/14 at 1:53 PM. Client #3's DSRs from 7/1/14 to the present, indicated client #3 did not participate in any community activities and/or outings as there were no outings documented. Client #1's record was reviewed on 8/19/14 at 2:27 PM. Client #1's DSRs from 7/1/14 to the present, indicated	W000136	A community outing calendar will be developed so that it is scheduled for each consumer to go on a community outing a minimum of weekly. Home Manager will assist staff in planning activities for all consumers to attend. All direct care staff, HM and PD will receive retraining to include ensuring that all consumers are provided with opportunities to attend community outings a minimum of weekly. Retraining will also include ensuring documentation is present in the DSRs of any community outings that consumers attend. If scheduled outings are not able to be completed, the Direct Support staff will notify the HM and/or PD as to the reason why and develop a plan for them to be rescheduled. Ongoing, the Home Manager will complete the community outing calendar a minimum of monthly to schedule each client times for community outings. The Home Manager will submit the calendar	09/20/2014

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	client #1 did not participate in any community activities and/or outings as there were no outings documented. Client #4's record was reviewed on 8/19/14 at 3:00 PM. Client #4's 8/10/14 DSR indicated client #4 went to church. Client #4's DSRs from 7/1/14 to the present, indicated client #4 did not participate in any additional community activities and/or outings. Interview with client #2 on 8/18/14 at 5:42 PM stated they did not "hardly get to go out into the community due to [client #4's] behavior." Client #2 indicated she liked doing activities out in the community. Interview with staff #4 on 8/19/14 at 7:53 AM stated she would take clients #2 and #4 to church with her "every other weekend." Interview with staff #1 and the Qualified Intellectual Disabilities Professional (QIDP) on 8/19/14 at 8:20 AM indicated clients did activities out in the community. Staff #1 and the QIDP indicated the facility staff did not document the activities/outings clients #1, #2, #3 and #4 participated in. 9-3-2(a)		for review to the Program Director. The Home Manager and Program Director will review the DSRs a minimum of weekly to ensure that staff are taking the consumers out on community outings as scheduled. If outing are not occurring as scheduled the Home manager and/or PD will address with staff. Responsible Party: Home Manager, Program Director	

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W000137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation, interview and record review for 1 of 4 sampled clients (#1), the facility failed to ensure client #1 had access her to hearing aids which were being locked by the facility. Findings include: During the 8/19/14 observation period between 6:20 AM and 8:10 AM, staff #4 retrieved a small container with client #1's hearing aids from a locked medication cabinet. Staff #4 placed a hearing aid in each ear of client #1. Client #1's record was reviewed on 8/19/14 at 2:27 PM. Client #1's 1/22/14 Individual Support Plan (ISP) did not indicate client #1 had a need to have her hearing aids locked. Client #1's ISP indicated client #1 had a guardian. The ISP and/or record did not indicate the client's guardian gave written consent to lock the client's hearing aids. Client #1's 1/22/14 ISP also did not indicate the facility's Human Rights Committee (HRC) reviewed and/or approved the	W000137	An IDT will be held for Client #1 to discuss if her hearing aids should be locked up. If the team agrees they need to be locked, this restriction will be added to her Behavior Support Plan. Once it is added to her Behavior Support Plan, guardian and Human Rights Committee approval will need to be obtained. Home Manager and Program Director will receive retraining to include ensuring that consumers have ready access to their adaptive equipment and it is not locked up unless indicated in their Behavior Support Plan and Human Rights Committee approval is obtained. Ongoing the Home Manager and PD will ensure that consumer are not restricted from access to any of their adaptive equipment unless specifically indicated in their Behavior Support Plan and Human Rights Committee approval is obtained. For the next 3 months, the Program Director will submit all Behavior Plans to the Area Director for review to ensure that any	09/20/2014

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	practice of locking client #1's hearing aids. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 8/19/14 at 8:20 AM indicated the group home was locking client #1's hearing aids as this was the second pair of hearing aids the client had received since her admission to the group home in 2013. The QIDP indicated the client would lose/misplace the hearing aids. The QIDP indicated he was not aware this was considered a restriction. The QIDP indicated client #1's guardian wanted the group home to lock the hearing aids. The QIDP indicated he did not have the facility's HRC review and/or approve the locking of client #1's hearing aids. 9-3-2(a)		restrictions in place for consumers are specifically outlined in their Behavior Support Plans and Human Rights Committee approval is present. Responsible Party: Home Manage, Program Director, Area Director	
W000140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on interview and record review for 3 of 4 sampled clients (#2, #3 and #4), the facility failed to maintain a complete accounting of the clients' withdrawals/expenses subtracted from the clients' checking accounts.	W000140	The Program Director and Home Manager will receive retraining on client finances to ensure that they are completing a full and complete accounting of clients financial transactions including collecting and documenting receipts to show how consumers	09/20/2014

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	Findings include: 1. Client #2's financial records were reviewed on 8/19/14 at 3:58 PM. Client #2's financial records indicated the following: -Client #2 had no cash on hand at the group home staff could access as staff did not have a key to the locked safe/box. -Client #2's Cash On Hand Record (COHR) indicated client #2 had made no deposits, and/or withdrawals from her house account held at the group home as the client's COHR indicated "No Activity"and/or a zero balance since January 2014. -Client #2 had no receipts for any purchases and/or withdrawals for the past year(August 2013 to August 2014). -Client #2 had no checking account ledger to review. Client #2's attached bank statements to the COHRs indicated the following: -On 3/7/14 client #2 withdrew $60.00 from her checking account. -On 4/4/14, client #2 withdrew $40.00 from her her checking account. -On 5/5/14, client #2 withdrew $75.00 from her checking account. Client #2's bank statement and/or COHR did not		money is spent and ensuring that client check register records and cash on hand ledgers are balanced and reconciled weekly by the HM and monthly by the Program Director and copies of records are provided monthly to the Client Finance Specialist. Ongoing, the Home Manger will record and balance all client transactions a minimum of weekly and note this in the clients finance records. Ongoing the Program Director will review and reconcile client finances a minimum of monthly and note this in the client finance records. The Program Director will provide copies of the clients' financial transactions to the Client Finance Specialist a minimum of monthly. Monthly, the Client Finance Specialist will provide the Area Director a list of what client finances have not been turned in by the scheduled deadlines and any corrections that need to be made so the Area Director can follow up with HM and/or PD to ensure these requirements are being met. Responsible Party: Home Manager, Program Director, Client Finance Specialist, Area Director	

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	indicate what items were purchased and/or indicate the facility obtained receipts for the above mentioned withdrawals. 2. Client #3's financial records were reviewed on 8/19/14 at 3:58 PM. Client #3's financial records indicated the following: -Client #3 had no cash on hand at the group home staff could access as staff did not have a key to the locked safe/box. -Client #3's Cash On Hand Record (COHR) indicated client #3 had made no deposits, and/or withdrawals from his house account held at the group home as the client's COHR indicated "No Activity" and/or a zero balance since January 2014. -Client #3 had no receipts for any purchases and/or withdrawals for the past year (August 2013 to August 2014). -Client #3 had no checking account ledger to review. Client #3's attached bank statements to the COHRs indicated the following: -On 2/28/14, client #3 withdrew $100.00 from his checking account. -On 4/4/14, client #3 withdrew $50.00 from his checking account. -On 5/7/14, client #3 withdrew $50.00			

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	from his checking account. Client #3's bank statement and/or COHR did not indicate what items were purchased, and/or indicate the facility obtained a receipt for the above mentioned withdrawals. 3. Client #4's financial records were reviewed on 8/19/14 at 3:58 PM. Client #4's financial records indicated the following: -Client #4 had no cash on hand at the group home staff could access as staff did not have a key to the locked safe/box. -Client #4's Cash On Hand Record (COHR) indicated client #4 had made no deposits, and/or withdrawals from his house account held at the group home as the client's COHR indicated 'No Activity" and/or a zero balance since January 2014. -Client #4 had no receipts for any purchases and/or withdrawals for the past year (August 2013 to August 2014). -Client #4 had no checking account ledger to review. Client #4's attached bank statements to the COHRs indicated the following: -On 4/4/14, client #4 withdrew $30.00 from his checking account. -On 4/18/14, client #4 withdrew $20.00 from his checking account.			

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	-On 5/7/14, client #4 withdrew $25.00 from his checking account. -On 6/20/14, client #4 withdrew $10.00 from his checking account. Client #4's bank statement and/or COHR did not indicate what items were purchased, and/or indicate the facility obtained a receipt for the above mentioned withdrawals. Interview with the Area Director (AD), the Qualified Intellectual Disabilities Professional (QIDP) and staff #1 on 8/19/14 at 4:33 PM indicated the group home had a safe where clients #2, #3 and #4's money was kept in. The QIDP and staff #1 indicated they were not able to access the funds as the previous home manager had the key to the safe and was no longer at the group home. The QIDP and staff #1 indicated they were not able to find any additional receipts and/or documentation in regard to client #2, #3 and #4's finances. The QIDP and the AD indicated clients #2, #3 and #4 had a checking account in the community. The AD, the QIDP and staff #1 did not know why money was withdrawn from client #2, #3 and #4's checking accounts as there were no check ledgers and/or receipts. The QIDP indicated clients #2, #3 and #4 had checks at the group home which still needed to be deposited to their accounts. The QIDP and the AD			

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	indicated the funds withdrawn from the clients' checking accounts should have been deposited into the clients' petty cash account at the group home and then withdrawn from the COHR for purchases. The AD indicated the group home did not follow the facility's policy in regard to client finances. 9-3-2(a)			
W000227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on interview and record review for 1 of 4 sampled clients (#1), the client's Individual Support Plan (ISP) failed to address the client's identified health and safety/behavioral need in regard to wearing a seat belt. Findings include: Client #1's record was reviewed on 8/19/14 at 2:27 PM. Client #1's BPR (Behavior Progress Notes)-Narrative Notes indicated the following (not all inclusive): -6/26/14 Client #1 unbuckled her seatbelt while the van was on the way to the day	W000227	An IDT will be held for Client #1 to address the issue of her continually removing her seatbelt while the vehicle is moving. Based on the IDT recommendations Client #1ISP and Behavior Support plan will be updated to reflect how the issue will be addressed. Program Director will develop goal/objectives to address Client #1 removing her seatbelt while the vehicle is moving. Program Director and Home Manager will ensure that all staff are trained on the goal/objective to encourage Client #1 to wear her seatbelt at all times. Ongoing the Program Director will ensure that if there is a pattern of	09/20/2014

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	service program. The BPR indicated client #1 refused to re-buckle her seatbelt. -6/25/14 Client #1 unbuckled her seatbelt while staff was driving the van on the highway. The BPR indicated "...Staff asked her to sit back and buckle up. She said she's getting out of here. The other staff buckled her back up...." -6/6/14 "Everyone in van getting to work and staff heard a seat belt unclick and another client stated 'She (client #1) took her belt off.' She took her belt off while the van was in motion. She was saying I'm going to tell [name of guardian]." The BPR indicated the staff had to pull the van over and rebuckle client #1's seatbelt. -6/5/14 Client #1 was riding in the van with staff and another client. The BPR indicated client #1 "...unhooked her seat belt. Staff had to pull over 10 x's (times) to put [client #1's] seat belt on and explain why it is important...." Client #1's 1/22/14 ISP indicated the client's interdisciplinary team had not addressed the client's identified health and safety/behavioral need of wearing her seat belt when in a moving vehicle.		behavior is identified that the IDT will meet to determine the best way to proceed with addressing the behavior and that the ISP and Behavior plan will be amended to reflect the IDT recommendations. For the next 3 months, the Program Director will submit copies of all ISPs for this home for review so that the Area Director can ensure that all consumers identified behavior needs are addressed in the ISP and/or BSP as needed. Responsible Party: Program Director, Area Director	

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	Interview with staff #1 and the Qualified Intellectual Disabilities Professional (QIDP) on 8/19/14 at 8:20 AM indicated client #1 would remove her seat belt when in the van. The QIDP and staff #1 indicated the staff would have to pull over the van and get client #1 to buckle her seatbelt. The QIDP indicated client #1's ISP did not address the client's identified need. 9-3-4(a)			
W000262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on observation, interview and record review for 3 of 4 sampled clients (#2, #3 and #4), the facility failed to have its Human Rights Committee (HRC) review and/or approve the clients' restrictive programs. Findings include: 1. Client #2's record was reviewed on 8/19/14 at 1:09 PM. Client #2's 7/15/14 physician's orders indicated client #2 received Venlafaxine HCL ER (extended release) 75 milligrams every night at	W000262	Human Rights Committee Approval will be obtained for Client #2, #3 and #4 psychotropic medications and any restrictions in the Behavior Support Plan. The Home Manager and Program Director will receive retraining to include ensuring that all psychotropic medications and restrictions have Human Rights Committee approval before use of any psychotropic medications or restrictions are implemented. Training will include ensuring that documentation is available for review of Human Rights	09/20/2014

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	bedtime for Depression. Client #2's physician's orders also indicated client #2 received Venlafaxine ER 150 milligrams every night for depression as well. Client #2's physician's orders indicated client #2 received Abilify 20 milligrams daily with a 5 milligram tablet to equal 25 milligrams for the client's Bipolar Disorder. Client #2's May 2014 Behavioral Support Plan (BSP) indicated client #2 demonstrated Incontinence, Irritability, Verbal Aggression, and "Manipulative Behavior." Client #2's BSP indicated the client would also demonstrate property destruction. The BSP indicated "...If [client #2] damages or destroys/ingests the item and it cannot be returned to the owner, [client #2's] IST (Individual Support team) may decide that the person must reimburse the owner for all or part of the cost. If [client #2] is requested to pay for damages to property or replace items of value, the IDT (interdisciplinary team) must meet to discuss reasonable terms of repayment." Client #2's BSP and/or ISP (Individual Support Plan) indicated the facility's HRC did not review and/or approve the client's restrictive program. Interview with the Qualified Intellectual Disabilities Professional (QIDP) and the		Committee approvals of any additions or increases to psychotropic medications and restrictive measures. For the next 3 months, the Program Director will provide documentation to the Area Director that Human Rights Committee approval has been obtained for any additions or increases to consumers' psychotropic medications or restrictions prior to their implementation. After the 3 month period, the Area Director will review the documentation that Human Rights Committee has approved any additions or increases to consumers' psychotropic medications or restrictions a minimum of quarterly to ensure that these requirements continue to be met. Responsible Party: Home Manager, Program Director, Area Director	

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	Area Director (AD) on 8/19/14 at 4:33 PM indicated they were not able to locate any documentation where the facility's HRC had reviewed and/or approved client #2's restrictive BSP. 2. Client #3's record was reviewed on 8/19/14 at 1:53 PM. Client #3's 7/24/14 physician's orders indicated client #3 received Zyprexa 20 milligrams two times a day for the client's Bipolar Disorder. Client #3's May 2014 BSP indicated client #3 demonstrated "Irritability, Verbal Aggression, Repetitive Verbalizations and Isolation." Client #3's BSP indicated the use of the behavior controlling medication (Abilify)/restricted program had not been reviewed and/or approved by the facility's HRC. Interview with the QIDP and the AD on 8/19/14 at 4:33 PM indicated they were not able to locate any documentation where the facility's HRC had reviewed and/or approved client #3's restrictive BSP. 3. Client #4's record was reviewed on 8/19/14 at 3:00 PM. Client #4's 7/15/14 physician's order indicated client #4 received Abilify 30 milligrams every			

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	morning for aggression, Seroquel 300 milligrams twice daily for aggression and Haldol 1 milligram twice daily for "Impulsiveness Disorder." Client #4's April 2014 BSP indicated client #4 demonstrated verbal aggression, property destruction, self-injurious behavior (SIB), physical aggression and irritability. Client #4's BSP indicated if client #4 demonstrated physical aggression, SIB and/or property destruction, facility staff could utilize PIA (physical restraint technique) to assist the client to calm down and/or stop the behaviors. Client #4's BSP and/or 7/29/14 ISP indicated the facility's HRC had not reviewed and/or approved the restrictive program. Interview with the QIDP and the AD on 8/19/14 at 4:33 PM indicated they were not able to locate any documentation where the facility's HRC had reviewed and/or approved client #4's restrictive BSP. 9-3-4(a)			
W000263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client,			

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	parents (if the client is a minor) or legal guardian. Based on interview and record review for 3 of 4 sampled clients (#2, #3 and #4), the client and/or the client's legal representative failed to give written informed consent for the clients' restrictive programs prior to use. Findings include: 1. Client #2's record was reviewed on 8/19/14 at 1:09 PM. Client #2's 7/15/14 physician's orders indicated client #2 received Venlafaxine HCL ER (extended release) 75 milligrams every night at bedtime for Depression. Client #2's physician's orders also indicated client #2 received Venlafaxine ER 150 milligrams every night for depression as well. Client #2's physician's orders indicated client #2 received Abilify 20 milligrams daily with a 5 milligram tablet to equal 25 milligrams for the client's Bipolar Disorder. Client #2's May 2014 Behavioral Support Plan (BSP) indicated client #2 demonstrated Incontinence, Irritability, Verbal Aggression, and "Manipulative Behavior." Client #2's BSP indicated the client would also demonstrate property destruction. The BSP indicated "...If [client #2] damages or destroys/ingests	W000263	The Program Director will receive retraining on ensuring that any updates or changes to consumers' Behavior Support Plans are reviewed and written consent is obtained by the consumers Guardian or Health Care Representative or the consumer if they are emancipated prior to getting HRC approval. Ongoing the Program Director will ensure any updates or changes to consumers' Behavior Support Plans are reviewed and written consent is obtained by the consumers Guardian or Health Care Representative or the consumer if they are emancipated prior to getting HRC approval. Program Director will ensure that documentation of guardian or client approval is available for review. Prior to any future Human Rights Committee meetings, the HRC will be reminded that they should not approve any changes to Behavior Support Plans without ensuring that guardian or client, if emancipated, approvals have been obtained. Responsible Party: Home Manager, Program Director	09/20/2014

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	the item and it cannot be returned to the owner, [client #2's] IST (Individual Support team) may decide that the person must reimburse the owner for all or part of the cost. If [client #2] is requested to pay for damages to property or replace items of value, the IDT (interdisciplinary team) must meet to discuss reasonable terms of repayment." Client #2's 5/5/14 ISP (Individual Support Plan) indicated client was her own guardian. Client #2's ISP and/or BSP indicated client #2 did not give written informed consent for her restrictive program. Interview with the Qualified Intellectual Disabilities Professional (QIDP) and the Area Director (AD) on 8/19/14 at 4:33 PM indicated they were not able to locate any documentation where client #2 gave written informed consent for her restrictive program. 2. Client #3's record was reviewed on 8/19/14 at 1:53 PM. Client #3's 7/24/14 physician's orders indicated client #3 received Zyprexa 20 milligrams two times a day for the client's Bipolar Disorder. Client #3's May 2014 BSP indicated client #3 demonstrated "Irritability, Verbal Aggression, Repetitive Verbalizations and Isolation." Client #3's			

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	BSP indicated the use of the behavior controlling medication (Abilify)/restricted program had not been reviewed and/or approved by the facility's HRC. Client #3's 5/14/14 ISP indicated client #3 had a guardian. Client #3's ISP indicated the client's guardian did not give written informed consent for the client's restrictive program. Interview with the QIDP and the AD on 8/19/14 at 4:33 PM indicated they were not able to locate any documentation where client #3's guardian gave written informed consent for the client's restrictive program. The QIDP indicated client #3's guardian had not returned the BSP. 3. Client #4's record was reviewed on 8/19/14 at 3:00 PM. Client #4's 7/15/14 physician's order indicated client #4 received Abilify 30 milligrams every morning for aggression, Seroquel 300 milligrams twice daily for aggression and Haldol 1 milligram twice daily for "Impulsiveness Disorder." Client #4's April 2014 BSP indicated client #4 demonstrated verbal aggression, property destruction, self-injurious behavior (SIB) physical aggression and			

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	irritability. Client #4's BSP indicated if client #4 demonstrated physical aggression, SIB and/or property destruction, facility staff could utilize PIA (physical restraint technique) to assist the client to calm down and/or stop the behaviors. Client #4's 7/29/14 ISP indicated the client was his own guardian. Client #4's BSP and/or 7/29/14 ISP indicated client #4 did not give written informed consent for the client's restrictive program. Interview with the QIDP and the AD on 8/19/14 at 4:33 PM indicated they were not able to locate any documentation client #4 gave written informed consent for his restrictive program. 9-3-4(a)			
W000264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Based on observation, interview and record review for 1 of 4 sampled clients	W000264	The Program Director will review the need for Client #1 restricted	09/20/2014

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	(#1), the facility failed to ensure its Human Rights Committee reviewed and/or approved the restrictive practice of locking the client's hearing aids. Findings include: During the 8/19/14 observation period between 6:20 AM and 8:10 AM, staff #4 retrieved a small container with client #1's hearing aids from a locked medication cabinet. Staff #4 placed a hearing aid in each ear of client #1. Client #1's record was reviewed on 8/19/14 at 2:27 PM. Client #1's 1/22/14 Individual Support Plan (ISP) did not indicate client #1 had a need to have her hearing aids locked. Client #1's ISP indicated client #1 had a guardian. The ISP and/or record did not indicate the client's guardian gave written consent to lock the client's hearing aids. Client #1's 1/22/14 ISP also did not indicate the facility's Human Rights Committee (HRC) reviewed and/or approved the practice of locking client #1's hearing aids. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 8/19/14 at 8:20 AM indicated the group home was locking client #1's hearing aids as this was the second pair of hearing		access to her hearing aids. If it is determined that she needs restricted access, the Program Director will ensure that the restriction is put into the consumers Behavior Support Plan and guardian and Human Rights Committee Approval is obtained. The Program Director will receive retraining on the need to ensure that Human Rights Committee Approvals are obtained for any restrictions recommended for any consumer prior to the restrictions being implemented. Ongoing, the Program Director will ensure that Human Rights Committee Approvals are obtained for any restrictions recommended for any consumer prior to the restrictions being implemented. Responsible Staff: Program Director, Area Director	

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	aids the client had received since her admission to the group home in 2013. The QIDP indicated the client would lose/misplace the hearing aids. The QIDP indicated he was not aware this was considered a restriction. The QIDP indicated client #1's guardian wanted the group home to lock the hearing aids. The QIDP indicated he did not have the facility's HRC review and/or approve the locking of client #1's hearing aids. 9-3-4(a)			
W000268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, interview and record review for 1 of 2 sampled clients (#2) and for 1 additional client (#5), the facility failed to ensure the clients' dignity in regards to incontinence issues. Findings include: 1. During the 8/18/14 observation period between 4:00 PM and 6:30 PM, at the group home, client #5 arrived at the group home at 4:51 PM. Client #5 had on a long blue jean jumper dress. Client #5's dress had a 3 wet spots on the front of her dress/jumper in various sizes.	W000268	All direct care staff will receive retraining on client dignity in regard to incontinence of Client #2 and #5. Training will include ensuring that consumers are directed and/or assisted as needed to change their clothing and/or incontinence products as soon as it is discovered that they are wet and/or soiled. If a pattern is observed that clients are refusing to change IDT will convene to develop a goal/objective to assist consumers with changing clothing/incontinence products regularly. For four weeks, the HM and/or	09/20/2014

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	Client #5 had a large wet spot on the back of her dress/jumper. Client #5 walked around the group home past staff #1, #2 and #3 without redirection to change. At 5:00 PM, client #5 went to the bathroom. Client #5 came out of the bathroom with the same dress on that was wet. Client #5 walked up to staff #1 and indicated her dress was wet. Staff #1 did not prompt and/or redirect the client to change her dress. At 5:46 PM, client #5 walked past the Qualified Intellectual Disabilities Professional (QIDP). The QIDP then directed staff #1 to change client #5 as the back of her dress was wet. Client #5 was allowed to wear a wet dress/jumper from 4:51 PM until 5:46 PM before being changed. Client #5's record was reviewed on 8/19/14 at 12:39 PM. Client #5's 7/15/14 physician's orders indicated client #5's diagnosis included, but was not limited to, Urinary Incontinence. Interview with the QIDP on 8/19/14 at 8:20 AM indicated clients should not sit wet and be encouraged to change their clothes when wet. 2. During the 8/18/14 observation period between 4:00 PM and 6:30 PM, at the group home, client #2's bedroom smelled of urine upon entering the group		PD will complete active treatment observations a minimum of twice weekly to ensure staff are directing consumers to change their clothing and/or incontinence products as soon as it is discovered that they are wet and/or soiled. Ongoing after the 4 weeks the HM and/or PD will complete active treatment observations a minimum of weekly to ensure staff are directing consumers to change their clothing and/or incontinence products as soon as it is discovered that they are wet and/or soiled. Responsible Party: Home Manager, Program Director	

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	home. At 4:51 PM, client #2 arrived home and client #2 and/or her wheelchair had a strong urine smell. Client #2 continued to smell of urine throughout the entire observation period. Staff #1, #2 and #3 did not prompt and/or encourage client #2 to toilet and/or change her depend (adult brief). Client #2's hair was uncombed/oily and the client looked unkempt as the client had on lime green pants with a blue and white striped shirt. Client #2's record was reviewed on 8/19/14 at 1:09 PM. Client #2's 5/5/14 ISP (Individual Support Plan) indicated client #2's diagnoses included, but were not limited to, Frequent Bladder Infections, Urinary Incontinence, Overactive Bladder and Spastic Bladder. Client #2's ISP indicated the client had an objective to "spray down and clean her wheelchair." Client #2's 12/7/13 Risk Management Assessment and Plan indicated client #2 was "Incontinent with refusals to change Attends (adult briefs)." Interview with staff #1 and the QIDP on 8/19/14 at 8:20 AM indicated client #2 would urinate on herself and in her bedroom. The QIDP indicated client #2 had received her new wheelchair last			

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	week. The QIDP indicated client #2 needed to be reminded to toilet and/or to change her adult brief throughout the day. Staff #1 and the QIDP indicated client #2 would refuse to change her brief and/or tell staff she had been changed when asked. Staff #1 and the QIDP indicated client #2 would sit in the urine soaked brief for a period of time before changing. Staff #1 and the QIDP stated client #2's urine would have a "strong smell." 9-3-5(a)			
W000312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 1 of 3 sampled clients with behavior controlling medications (#2), the facility failed to have an active treatment program for the use of Venlafaxine HCL which was being used to treat the client's Depression, and which included a plan of reduction based on the behaviors for which the client was prescribed the medication for. Findings include:	W000312	The QIDP will convene the IDT for client #2. The IDT will assess the behaviors for which client #2 is prescribed medication and develop an appropriate titration plan. The IDT will develop a behavior plan for Client #2 to assist with decreasing the need for medication for her depression. The Behavior plan will include a plan of reduction for the use of the Venlafaxine HCL. The QIDP will be retrained on the requirement to ensure that all	09/20/2014

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	Client #2's record was reviewed on 8/19/14 at 1:09 PM. Client #2's 7/15/14 physician's orders indicated client #2 received Venlafaxine HCL ER (extended release) 75 milligrams every night at bedtime for Depression. Client #2's physician's orders also indicated client #2 received Venlafaxine ER 150 milligrams every night for depression as well. Client #2's May 2014 Behavioral Support Plan (BSP) did not indicate client #2's Depression was clearly defined. Client #2's May 2014 BSP did not indicate client #2 had an active treatment program for the use of the Venlafaxine for Depression which included a plan of reduction based on the behaviors for which the medication was prescribed. Interview with the Qualified Intellectual Disabilities Professional (QIDP) and the Area Director (AD) on 8/19/14 at 4:33 PM indicated client #2 had a diagnosis of Depression. The QIDP and the AD indicated client #2's BSP did not clearly define the client's depression and/or include a specific active treatment program for Depression for which client #2 received the Venlafaxine for. 9-3-5(a)		clients that take psychotropic medications have a Behavior Support Plan that includes an appropriate plan to address medication withdrawal based on behaviors. The QIDP will revise the Behavior Plans to include the titration plans developed by the IDT. The QIDP will obtain required approvals as soon as the plan is available. The QIDP will also ensure the staff is trained on the implementation of the plan The QIDP will review each client's files to ensure each client that receives medication to manage behavior has a Behavior Support plan to monitor the use of the medications and that includes appropriate titration plans. Responsible Staff: Program Director, Area Director, Behavior Consultant	

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 2 of 4 sampled clients (#2 and #3) and for 1 additional client (#5), the facility's nursing services failed to meet the nursing needs of clients in regard to clarifying diet orders, developing risk plans and/or to ensure ordered treatments/supplements were at the group home to be used as prescribed. Findings include: 1. During the 8/19/14 observation period between 6:20 AM and 8:10 AM, at the group home, staff #4 administered client #5's morning medications. Interview with staff #4 on 8/19/14 at 7:26 AM indicated client #5 did not have any Chlorhexidine Rinse to administer. Staff #4 stated "She is out. It has not come in yet." Staff #4 indicated the group home had been out of the Chlorhexidine Rinse before but it had come in at the last of the month and she was out again. Client #5's record was reviewed on 8/19/14 at 12:39 PM. Client #5's 7/15/14 physician's orders indicated client #5 was to receive Chlorhexidine Rinse 0.12% liquid and swish for 30 seconds and spit	W000331	1. All direct care staff will receive retraining to ensure that if consumers are getting low on their medications or dietary supplements that the Home Manager and/or Program Nurse will be notified so that additional medication or supplements can be ordered. Home Manager, Program Nurse and Program Director will receive retraining to include ensuring that the consumers medication and dietary supplement stock is gone through a minimum of weekly to ensure that any medications that are getting low are ordered ahead of time so that the consumer does not have to do without. Ongoing, the Home Manager, Program Director and/or Program Nurse will review each consumers medication stock a minimum of weekly to ensure that any medications and dietary supplements that are getting low are ordered ahead of time so that the consumer does not have to do without. 2. Program Nurse will get clarification from Client #3 physician as to his diet orders.	09/20/2014

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	out twice daily as mouth rinse. Client #5's 7/15/14 physician's orders indicated client #5 received "Metamucil Powder Orange Mix 1 tablespoonful in 8 oz (ounces) fluid and take by mouth daily to increase fiber." Client #5's August 2014 Medication Administration Record (MAR) indicated client #5 did not receive the Chlorhexidine Rinse on 8/1, 8/2, 8/3, /84, 8/5 and 8/6/14. The back of client #2's August 2014 MAR indicated "Out." Client #5's July 2014 MAR indicated client #5 was out of the Chlorhexidine Rinse at the 7:00 AM medication pass (only) on 7/26, 7/27, 7/28, 7/29, 7/30 and 7/31/14. The July 2014 MAR indicated client #5 was out of her Fiber Powder on 7/19, 7/20, 7/21, 7/22, 7/23, 7/24, 7/25, 7/26, 7/27, 7/28, 7/29, 7/30 and 7/31/14. Interview with the Qualified Intellectual Disabilities Professional (QIDP) and staff #1 on 8/19/14 at 8:20 AM indicated they were not aware client #5 was out of the Chlorhexidine Rinse. The QIDP indicated she gets a 30 day supply and should not be out of it. Interview with the Area Director (AD) on 8/19/14 at 4:33 PM indicated the facility's nurse was responsible to ensure the		Once the clarification is received all direct care staff will receive retraining on Client #3 diet orders and how to appropriately prepare the diet. Training will include ensuring that all consumers' diet orders are prepared as directed by the physician and/or dietician. Program nurse will receive retraining to include ensuring that all consumers diet orders are clarified with the physician and/or dietician and all staff are trained to accurately prepare food and drink according to the specified orders. For 4 weeks the HM and/or Program director will complete mealtime observations a minimum of twice weekly to ensure that direct care staff are preparing all consumers food and beverages as directed by their Physician and/or dietician. Ongoing after the 4 weeks the HM and/or Program director will complete mealtime observations a minimum of weekly to ensure that direct care staff are preparing all consumers food and beverages as directed by their Physician and/or dietician. 3. All direct care staff will receive retraining to include ensuring that all consumers, including Client #2 toileting goals are run as directed. Program Nurse will develop a protocol to address Client #2	

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	clients had their ordered medications, treatments and/or supplements. The AD indicated client #5 should not have gone without her ordered Metamucil and Chlorhexidine rinse. 2. During the 8/18/14 observation period between 4:00 PM and 6:30 PM, at the group home, client #3 was served pureed Salisbury steak with ground rice for his dinner meal. Client #3's record was reviewed on 8/19/14 at 1:53 PM. Client #3's 7/24/14 physician's orders indicated client #3 was to receive a "Soft Chopped (diet) w/ (with) Nectar Liquids* Remain upright during & (and) 30 min (minutes) after eating...." Client #3's physician's order indicated the diet was ordered on 5/9/13. The 7/24/14 physician's order also indicated client #3 was to receive Boost 1 can three times daily after meals as a supplement for the client's weight. Client #3's 6/1/14 Choking Protocol indicated client #3 was at risk for choking and aspiration. Client #3's 6/1/14 Dysphagia/Dining Plan indicated client #3 was to receive a soft chopped diet with nectar thick liquids. Client #3's record, physician's orders and/or Individual Support Plan (ISP) did		incontinence. Program Nurse will receive retraining to include ensuring that Client Specific Protocols are developed for each client as needed to address recurring issues and/or risk and how to prevent recurrences, such as incontinence. Responsible Party: Home Manager, Program Director, Program Nurse	

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	not indicate the facility's nurse clarified what texture/diet the client was to receive to ensure uniformity. Client #3's June 2014 MAR indicated client #3 did not receive his Boost on 6/18, 6/19, 6/20, 6/21, 6/22, 6/23, 6/24, 6/25, 6/26, 6/27, 6/28, 6/29 and on 6/30/14. Client #3's May 2014 MAR indicated client #3 did not receive his Boost on 5/10, 5/11, 5/12, 5/13, 5/14, 5/15, 5/16. 5/17, 5/18 and 5/25/14. The client's MARs for 65/14 and 6/14 indicated ""Boost not given. Not in house." Interview with the Area Director (AD), the Qualified Intellectual Disabilities Professional (QIDP) and staff #1 on 8/19/14 at 4:33 PM indicated client #3's physician order was for soft chopped diet. The QIDP and staff #1 indicated they thought client #3 was on a pureed diet texture. Staff #1 indicated the staff used the "grinder" to puree client #3's rice. The QIDP and staff #1 indicated the rice was not pureed. The AD, the QIDP and staff #1 indicated they did not know what a soft chopped diet was. The AD indicated the facility's nurse should have sought clarification on what a soft chopped diet was. The AD indicated the group home should not run out of Boost			

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	for client #3. The AD indicated it was the facility's nurse's responsibility to ensure the supplement was in the group home for staff to administer/use. 3. During the 8/18/14 observation period between 4:00 PM and 6:30 PM, at the group home, client #2's bedroom smelled of urine upon entering the group home. At 4:51 PM, client #2 arrived home and client #2 and/or her wheelchair had a strong urine smell. Client #2 continued to smell of urine throughout the entire observation period. Staff #1, #2 and #3 did not prompt and/or encourage client #2 to toilet and/or change her depend (adult brief). Client #2's record was reviewed on 8/19/14 at 1:09 PM. Client #2's 5/5/14 ISP (Individual Support Plan) indicated client #2's diagnoses included, but were not limited to, Frequent Bladder Infections, Urinary Incontinence, Overactive Bladder and Spastic Bladder. Client #2's 12/7/13 Risk Management Assessment and Plan indicated client #2 was "Incontinent with refusals to change Attends (adult briefs)." Client #2's May 2014 Behavioral Support Plan (BSP) indicated client #2 demonstrated "Incontinence-Urinating			

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	and/or defecating in a location other than the interior of a toilet." Client #2's BSP indicated facility staff were to prompt the client to toilet every 2 hours when client #2 was awake. The BSP indicated "...If [client #2] is incontinent, [client #2] must be held responsible for cleaning herself and any other area that may have been wet or soiled. Staff are to provide [client #2] with physical prompting and direction as needed to assure she remains on task throughout the period...1. When you discover that [client #2] has been incontinent, immediately direct her to go to the restroom and clean herself up...2. Direct [client #2] to return to the place where she became incontinent and assure that she cleans any urine or feces from the area...." Client #2's 5/5/14 ISP indicated the facility's nurse failed to develop a risk plan which addressed the client's Urinary Incontinence, Overactive Bladder, Frequent Bladder Infections and/or the client's Spastic Bladder. Interview with staff #1 and the QIDP on 8/19/14 at 8:20 AM indicated client #2 would urinate on herself and in her bedroom. The QIDP indicated client #2 needed to be reminded to toilet and/or to change her adult brief throughout the day.			

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	Staff #1 and the QIDP indicated client #2 would refuse to change her brief and/or tell staff she had been changed when asked. Staff #1 and the QIDP indicated client #2 would sit in the urine soaked brief for a period of time before changing. Staff #1 and the QIDP stated client #2's urine would have a "strong odor." Interview with the AD on 8/19/14 at 4:33 PM indicated client #2's ISP did not include any nursing measures/guidelines/risk plan for the client's Frequent Bladder Infections and/or diagnoses in regard to the client's bladder. 9-3-6(a)			
W000369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, interview and record review for 1 of 22 medications administered, the facility failed to ensure client #5's Chlorhexidine rinse (medicated mouthwash) was available in the group home to administer as ordered. Findings include:	W000369	All direct care staff will receive retraining to ensure that if consumers are getting low on their medications that the Home Manager and/or Program Nurse will be notified so that additional medication can be ordered. Home Manager, Program Nurse and Program Director will receive retraining to include ensuring that	09/20/2014

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	During the 8/19/14 observation period between 6:20 AM and 8:10 AM, at the group home, staff #4 administered client #5's morning medications. Interview with staff #4 on 8/19/14 at 7:26 AM indicated client #5 did not have any Chlorhexidine Rinse to administer. Staff #4 stated "She is out. It has not come in yet." Staff #4 indicated the group home had been out of the Chlorhexidine Rinse before but it had come in at the last of the month and she was out again. Client #5's record was reviewed on 8/19/14 at 12:39 PM. Client #5's 7/15/14 physician's orders indicated client #5 was to receive Chlorhexidine Rinse 0.12% liquid and swish for 30 seconds and spit out twice daily as mouth rinse. Interview with the Qualified Intellectual Disabilities Professional (QIDP) and staff #1 on 8/19/14 at 8:20 AM indicated they were not aware client #5 was out of the Chlorhexidine Rinse. The QIDP indicated she gets a 30 day supply and should not be out of it. 9-3-6(a)		the consumers medication stock is gone through a minimum of weekly to ensure that any medications that are getting low are ordered ahead of time so that the consumer does not have to do without. Ongoing, the Home Manager, Program Director and/or Program Nurse will review each consumers medication stock a minimum of weekly to ensure that any medications that are getting low are ordered ahead of time so that the consumer does not have to do without. Responsible Party: Home Manager, Program Director, Program Nurse	
W000460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing,			

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	well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 2 of 4 sampled clients (#2 and #3), the facility failed to ensure the client ate a diet as prescribed by the client's doctor, and to ensure sugar/sweetener was available for use if requested. Findings include: 1. During the 8/18/14 observation period between 4:00 PM and 6:30 PM, at the group home, client #3 was served pureed Salisbury steak with ground rice for his dinner meal. The client was not given vegetables and/or offered a substitute. Client #3 drank regular thin liquids of flavored bottle water/drinks. Facility staff #2 and/or #3 did not thicken client #3's liquids. Client #3's record was reviewed on 8/19/14 at 1:53 PM. Client #3's 7/24/14 physician's orders indicated client #3 was to receive a "Soft Chopped (diet) w/ (with) Nectar Liquids* Remain upright during & (and) 30 min (minutes) after eating...." Client #3's 6/1/14 Choking Protocol indicated client #3 was at risk for choking and aspiration.	W000460	1. Program Nurse will get clarification from Client #3 physician as to his diet orders. Once the clarification is received all direct care staff will receive retraining on Client #3 diet orders and how to appropriately prepare the diet. Training will include ensuring that all consumers diet orders are prepared as directed by the physician and/or dietician. Program nurse will receive retraining to include ensuring that all consumers diet orders are clarified with the physician and/or dietician and all staff are trained to accurately prepare food and drink according to the specified orders. For 4 weeks the HM and/or Program director will complete mealtime observations a minimum of twice weekly to ensure that direct care staff are preparing all consumers food and beverages as directed by their Physician and/or dietician. Ongoing after the 4 weeks the HM and/or Program director will complete mealtime observations a minimum of weekly to ensure that direct care staff are preparing all consumers food and beverages as directed by their Physician and/or dietician. 2. Home Manager and	09/20/2014

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	Client #3's 6/1/14 Dysphagia/Dining Plan indicated client #3 was to receive a soft chopped diet with nectar thick liquids. Interview with the Area Director (AD), the Qualified Intellectual Disabilities Professional (QIDP) and staff #1 on 8/19/14 at 4:33 PM indicated client #3's physician order was for soft chopped diet. The QIDP and staff #1 indicated they thought client #3 was on a pureed diet texture. Staff #1 indicated the staff used the "grinder" to puree client #3's rice. The QIDP and staff #1 indicated the rice was not pureed. The AD, the QIDP and staff #1 indicated they did not know what a soft chopped diet was. The AD indicated the facility's nurse should have sought clarification on what a soft chopped diet was. Staff #1 stated facility staff should have placed "thick it" in client #3's liquids/drinks to nectar consistency. 2. During the 8/19/14 observation period between 6:20 AM and 8:10 AM, at the group home, staff #5 fixed client #2 Cheerios for breakfast to eat. Client #2 did not eat the bowl of cereal. Client #2 asked staff #3 for a different cereal. Client #2 had a cup of coffee but did not drink the coffee as well.		Program Director will receive retraining to include ensuring that there is adequate food supply is maintained for the clients in the home at all times. Ongoing, the Home Manager and/or Program Director will do an inventory of the food supply in the home a minimum of weekly to ensure that an adequate supply of food is available for the clients. In addition, the Home Manager and/or Program Director will ensure that food supply in the home includes items for the dietician approved menus each week in addition to extra food for substitutions as needed. Responsible Party: Home Manager, Program Director, Program Nurse	

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	Interview with client #2 on 8/19/14 at 7:07 AM indicated she did not like Cheerios as they did not have any sugar to put on the cereal. Client #2 stated she did not like "black coffee." Client #2 indicated she would drink the coffee if she had sugar to put in it. Client #2 indicated the group home was out of sugar. Client #2's record was reviewed on 8/19/14 at 1:09 PM. Client #2's 7/15/14 physician's order indicated client #2 was on a regular diet with no extra portions, no added salt and no concentrated sweets. Interview with staff #1 and the Qualified Intellectual Disabilities Professional (QIDP) on 8/19/14 at 8:20 AM indicated client #2 was on a regular diet. The QIDP and staff #1 indicated the group home went grocery shopping on 8/18/14. The QIDP indicated the group home was out of sugar after the QIDP went to the kitchen to see if the group home had any sugar. 9-3-8(a)			
W000488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.			

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	Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and for 1 additional client (#7), the failed to ensure the facility allowed clients to participate in all aspects of meal preparation, and/or to ensure clients ate in a manner consistent to their developmental levels. Findings include: During the 8/18/14 observation period between 4:00 PM and 6:30 PM, at the group home, staff #2 opened frozen Salisbury steak packages and placed them in glass cooking dishes and placed the items in the oven while client #3 stood and talked to staff #2. Staff #2 then opened a package of mixed vegetables and placed the mixed vegetables in a pan as client #3 started to set the table. Staff #2 did not encourage client #3 to assist/help cook the dinner meal. Staff #2 also custodially prepared rice without involving clients #1, #2, #3, #4, #5, #6 and #7. At 4:40 PM, client #3 independently poured a packet of flavored drink into a bottle of water and set the bottle of water on the dining room table. Staff #2 then placed flavored packets into a pitcher and poured 3 bottles of water into the pitcher while client #3 stood and watched. Client #2 independently poured himself a drink	W000488	All direct care staff will receive retraining to include allowing and encouraging all consumers to assist with meal preparation, setting the table, cleaning up after the meal, etc. In addition, retraining will include ensuring that all consumers are allowed to eat in a way consistent with developmental levels. Retraining will include ensuring that consumers are allowed to serve themselves at mealtime or are provided had over hand assistance as needed. Staff training will also include ensuring that consumers mealtime objectives are being run as directed including encouraging Client #4 to take small drinks between bites to prevent choking. For 4 weeks the Home Manager and/or Program director will complete mealtime observations a minimum of twice weekly to ensure that direct care staff are allowing and encouraging consumers to assist with meal preparation and clean up; are eating in a way consistent with developmental levels and are running consumers mealtime objectives. Ongoing after the 4 weeks the HM and/or Program director will complete mealtime observations a minimum of weekly to ensure that direct care staff are allowing and encouraging consumers to	09/20/2014

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	from the pitcher into a cup. During the above mentioned meal observation, staff #2 fixed client #1, #2, #3, #4, #5, #6 and #7's plates as the clients set at the table. Staff #2 and #3 did not allow the clients to serve themselves and/or assist with hand over hand training even though clients #1, #2, #3 #4, #5, #6 and #7 could feed themselves. Staff #2 and #3 poured drinks into each client's cup. Client #4 took large bites of food without redirection, and client #1 took 3 large bites of food into her mouth consecutively without redirection. Client #1 then chewed a couple of times and swallowed. Staff #1, #2 and #3 who were in the dining room area did not redirect the client to chew her food before taking another bite. Client #2 also took large bites of food without redirection by staff. Clients #1, #2, #3, #4, #5, #6 and #7 independently took their dishes to the sink to rinse/place in the dishwasher, and/or were verbally prompted to remove their dishes from the table. Facility staff #3 cleaned up the kitchen and wiped off the table. Client #5 was asked to get the broom but staff #3 did not encourage the client to sweep the floor as staff #3 swept the kitchen floor. Client #4's record was reviewed on 8/19/14 at 3:00 PM. Client #4's 7/29/14 Individual Support Plan (ISP) indicated		assist with meal preparation and clean up; are eating in a way consistent with developmental levels and are running consumers mealtime objectives.	

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	client #4 had an objective to take small drinks between each bite of food. Interview with staff #1 and the Qualified Intellectual Disabilities Professional (QIDP) on 8/19/14 at 8:20 AM indicated facility staff should involve clients #1, #2, #3, #4, #5, #6 and #7 in meal preparation and clean up. The QIDP indicated facility staff encourage clients to serve themselves and/or provide hand over hand assistance with the clients. The QIDP indicated facility staff should redirect clients from taking large bites of food. 9-3-8(a)			
W009999	STATE FINDINGS: The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met. (1) 460 IAC 9-3-3 Facility Staffing (e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin (TB) test or chest x-ray was completed. The result of the	W009999	Program Director and Area Director will review Mantoux records for all staff. Program Director and Area Director will notify any staff if their Mantoux is outdated and provided them with the list of next clinic dates and deadline for completion. Program Director and Area Director will monitor expiration dates for Mantoux for all staff no less than monthly and notify staff as needed of completion. Responsible Party: Program Director, Area Director	09/20/2014

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	Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician. THE STATE RULE WAS NOT MET AS EVIDENCED BY: Based on record review and interview for 1 of 3 personnel records reviewed (staff #2), the facility failed to obtain yearly PPD and/or a chest x-ray for an employed staff. Findings include: Staff #2's personnel record was reviewed on 8/19/14 at 3:47 PM. Staff #2's personnel record indicated staff #2 last had a Mantoux/Tuberculosis skin test on 8/15/12. Staff #2's personnel record indicated the staff person did not have a current chest x-ray and/or Mantoux test to ensure the staff person was free of TB. Interview with the Area Director (AD) on 8/19/14 at 4:00 PM indicated she was			

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	made aware staff #2 did not have a current TB test. Administrative staff #4 indicated staff #2 did not have a current TB test. 9-3-3(e)			