

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2014
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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N LOGANSPORT, IN 46947
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W000000	<p>This visit was for the investigation of complaint #IN00144083.</p> <p>Complaint #IN00144083: SUBSTANTIATED, Federal and state deficiencies related to the allegations are cited at W125, W149, W240, and W249.</p> <p>Unrelated deficiency cited at W154.</p> <p>Dates of Survey: 3/6, 3/7, and 3/10, 2014.</p> <p>Provider Number: 15G538 Facility Number: 001052 AIM Number: 100239830</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 27, 2014 by Dotty Walton, QIDP.</p>	W000000		
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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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W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS 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 A, B, and C) and 3 additional clients (clients D, E, and F), the facility failed to ensure the rights of all clients by prohibiting access to the facility's oven and refrigerator without the clients' (or surrogates) consent for clients A, B, C, D, E, and F based on their assessments.</p> <p>Findings include:</p> <p>On 3/6/14 at 1:45pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 12/01/2013 through 03/06/2014 for client A.</p> <p>-A 2/2/14 BDDS report for an incident on 2/1/14 at 2:05pm, indicated client A "opened the oven door and there were still fish sticks in there from lunch. [Client A] took one and shoved it in his throat."</p> <p>-A 2/8/14 "Internal Investigation" indicated client A "grabbed a fish stick and started to put (sic) in his mouth.</p>	W000125	<p>All staff at Indiana Mentor are trained on clients rights upon hire and annually there after. Indiana Mentor also has policies in procedures in place in restrictions to client's right which include HRC consents and approvals. The QMRP are trained on obtaining these consents prior to restrictions going in place.</p> <p>The QMRP, Home Manager, and Area Director completed assessments for clients A-F for the locks. The Area Director put the completed formal assessments in each clients files and the QMRP developed formal goals for food access for clients A-F. The QMRP sent out a revised HRC request and guardian approval to all members and got approval for the necessary restrictions.</p> <p>The agency has revised the HRC form to provide better clarity and accuracy for requests. Manager had training on use of form and to ensuring assessments completed for each individual prior to household</p>	04/09/2014			

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	<p>[Client A] started gagging on it, but was able to cough it up." The investigation indicated "[Client A] is on a modified diet due to aspiration history and shouldn't eat whole foods...." The investigation indicated witness statements from GHS (Group Home Staff) #4, GHS #5, and GHS #6. The witness statements indicated lunch ended "around 1:30pm" GHS #4's witness statement indicated "they (the staff) had put the fish sticks in the shut off oven in case someone wanted seconds" during lunch. GHS #5 "stated he headed to (the) back area to start laundry. [Client A] was following but had run to the kitchen as they were going. Staff immediately followed and intervened when [client A] grabbed the fish sticks and [client A] handed most over before putting one in his (client A's) mouth...[Client A] started to cough and they (the staff) encouraged [client A] to cough/spit out the stick...." The investigation indicated "Evidence supports that [client A] took some leftover fish sticks from the oven which was off and attempted to eat them."</p> <p>On 3/6/14 from 3:30pm until 5:35pm, clients A, B, C, D, E, and F were observed at the group home and had independent access to the living rooms, hallway, bedrooms, dining room, and bathroom. Clients A, B, C, D, E, and F</p>		<p>restrictions being put in place. QMRP is sending future HRC requests and as needed assessments to Area Director prior to implementation.</p> <p>Responsible Party: Shalan Baker-Program Director</p> <p>Completion Date: 4/9/2014</p>	
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	<p>were with a facility staff each time a client went into the kitchen area. From 3:30pm until 5:35pm, the refrigerator and stove oven were locked securing the oven and refrigerator doors, the key was stored inside an upper cabinet, and the items were unable to be independently opened by any client. At 5:35pm, the Residential Manager (RM) stated "no" clients A, B, C, D, E, and F did not have independent access to the locked refrigerator and stove oven.</p> <p>Confidential Interview #1 (CI #1) indicated client A could have gotten into the snack cupboard, the cereal cupboard, and garage freezer and refrigerator if client A wanted. CI #1 indicated client A scoots himself on the floor and could walk independently when client A chose before the refrigerator and stove oven were locked.</p> <p>On 3/7/14 at 8:15 AM, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and Area Director (AD) was conducted. The QIDP indicated client A should have been supervised by eye sight supervision at the group home. The QIDP indicated GHS #5 walked in front of client A when going to the laundry room at the group home and client A turned then went into the kitchen. The QIDP indicated client A</p>				

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	<p>accessed the oven without facility staff, opened the oven, removed fish sticks which were left from lunch, stuffed them into his mouth, and choked. The QIDP indicated client A had not been assessed for locked food items, but had demonstrated that he needed the items locked based on the incidents and client A's recurrent aspiration pneumonia.</p> <p>On 3/7/14 at 8:15am, and on 3/10/14 at 10:30am, the AD and QIDP both indicated clients A, B, C, D, E, and F had not been assessed for the locked refrigerator and stove oven. The AD and the QIDP both indicated clients B, C, D, E, and F did not have an identified need for the locked refrigerator and stove oven at the group home. The QIDP indicated clients A, B, C, E, and F's families/guardians/advocates had given consent for the locked refrigerator but had not included the locked stove oven.</p> <p>Client A's record was reviewed on 3/6/14 at 2:50pm and on 3/7/14 at 9:15pm. Client A's 11/25/13 ISP (Individual Support Plan) and 2/2014 BSP (Behavior Support Plan) both indicated client A needed twenty-four hour staff supervision. Client A's BSP indicated "Sit [client A] in a seat away from others...also to help prevent food theft and [client A] taking food that he is</p>			

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	<p>unable to eat and may choke on. [Client A] has been taking food from the oven and refrigerator and has choked when trying to consume the food. An oven guard and refrigerator guard will be used to reduce the chances of [client A] opening them and taking food without caregiver knowledge. Stealing: Taking, using ingesting another's or house belongings and/or food without permission or with permission coerced. Including taking food from refrigerator, cupboards, or storage areas. [Client A] has taken food items and attempts to ingest them request that [client A] hand you the food items or spit them out. If he complies thank him...[Client A] should be monitored during all meals and snacks to help prevent him from taking food from other's and reduce the risk of him choking on food that he should not consume...Safety guards should be utilized on cupboards, stove, and refrigerator to help prevent food theft and accidentally choking." Client A's 11/25/13 "Risk Management Assessment and Plan" indicated "Presents a Risk: Swallowing/Dysphagia, Aspiration protocol in affect...Choking Risk: Stuffs food in mouth and has had choking incident in past...[Client A] has eaten raw chicken in the past, [Client A] needs monitored while in the kitchen. [Client A] will eat anything that is a food</p>			

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	<p>substance, even if not cooked or not part of his dining plan. [Client A] has 24 hour awake staff, a one-on-one protocol and has a choking plan in place...Staff are to have [client A] in eye site (sic) at all times." Client A's plans included locking the cupboards where food was stored. Client A's record indicated he had incidents of recurrent aspiration pneumonia requiring hospitalization, physician's follow up visits, and continuing treatment. Client A's record did not indicate how/when client A would access food items inside the oven and kitchen refrigerator. Client A's record did not include a consent for the locked oven.</p> <p>Client B's record was reviewed on 3/7/14 at 8:45am. Client B's 7/5/13 ISP, 7/5/13 "Risk Management and Plan," and 7/2013 BSP indicated client B was non verbal, did not recognize dangers, and client B's "Risk Management and Plan" indicated "...staff will supervise 24/7...If [client B] is observed standing in front of something she is communicating she wants something in that area. Staff will try to determine what she wants and attempt to satisfy her need..." Client B's record did not indicate client B had the identified need for locked refrigerator and the stove oven at the group home. Client B's record did not indicate a consent for</p>			
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	<p>the locked oven.</p> <p>Client C's record was reviewed on 3/7/14 at 9:30am. Client C's 8/6/13 ISP and 1/14/13 "Risk Management and Plan" both indicated client C had limited verbal skills, did not recognize dangers, and required line of sight supervision by the facility staff. Client C's record did not indicate client C had the identified need for locked refrigerator and the stove oven at the group home. Client C's record did not indicate a consent for the locked oven.</p> <p>This federal tag relates to complaint #IN00144083.</p> <p>9-3-2(a)</p>			
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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview, for 2 of 3 sampled clients (client A and B) and for 3 additional clients (clients D, E, and F), the facility neglected to implement their policy and procedure to prevent abuse, neglect, and/or mistreatment to protect client A from his behavior of ingesting non modified food according to his identified need and neglected to provide sufficient staff supervision for clients A, B, D, E, and F.</p> <p>Findings include:</p> <p>1. On 3/6/14 at 1:45pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 12/01/2013 through 03/06/2014 for client A.</p> <p>-A 2/2/14 BDDS report for an incident on 2/1/14 at 2:05pm, indicated client A "opened the oven door and there were still fish sticks in there from lunch. [Client A] took one and shoved it in his throat." The report indicated staff "immediately got part of it out. [Client A] was coughing and staff said his color was</p>	W000149	Indiana Mentor has policies and procedures in place for abuse, neglect, and exploitation. Every employee is trained on these polices upon hire which includes identifying signs of abuse and neglect, defining them, and how to report such incidents. Each employee recieves at least annual training thereafter on these subjects.For any allegation an immediate investigation is started once the allegation was reported. The alleged staff involved was suspended in both instances while investigation took place. Staff recieved additional training in regards to supervision level for clients A-F and additional training in regards to abuse and neglect policies. For the next 6 staff meetings additional training in regards to abuse and neglect will be completed. Thereafter abuse and neglect will be trained on quaterly for the remainder of the year and annually on an on going basis after that. Additionally direct staff observations will be completed by management at least 8x per month for the next 6 months to ensure staff are following agent policy and procedures. After 6 months at least 4 observations will be conducted each month and will be reviewed by the Area Director.	04/09/2014			

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	<p>changing. They called 9-1-1. The EMTs (Emergency Medical Technicians) came and said that [client A] had coughed it all up. They took his vitals and listened to his lungs. The lungs sounded clear. [Client A's] oxygen was 96 percent. No fever, and [client A's] color was good. They said they did not need to take him to ER (Emergency Room)."</p> <p>-A 2/8/14 "Internal Investigation" indicated client A "grabbed a fish stick and started to put in his mouth. [Client A] started gagging on it, but was able to cough it up." The investigation indicated "[Client A] is on a modified diet due to aspiration history and shouldn't eat whole foods. [Client A] is non verbal and could not respond to investigation." The investigation indicated witness statements from GHS (Group Home Staff) #4, GHS #5, and GHS #6. The witness statements indicated lunch ended "around 1:30pm" GHS #4's witness statement indicated "they (the staff) had put the fish sticks in the shut off oven in case someone wanted seconds" during lunch. GHS #5 "stated he headed to (the) back area to start laundry. [Client A] was following but had run to the kitchen as they were going. Staff immediately followed and intervened when [client A] grabbed the fish sticks and [client A] handed most over before putting one in his [client A's]</p>		<p>Responsible Party: Shalan Baker-Program Director, Brandon Watson-Area Director Completion Date: 4/9/2014</p>				

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	<p>mouth...[Client A] started to cough and they (the staff) encouraged [client A] to cough/spit out the stick. The other staff called 9-1-1 when [client A] was coughing..." The investigation indicated "Evidence supports that [client A] took some leftover fish sticks from the oven which was off and attempted to eat them. Evidence supports that staff intervened and [client A] gave the fish sticks to staff but put one in his mouth...Evidence supports that staff had followed [client A's] dining plan during lunch (time)."</p> <p>On 3/6/14 from 3:30pm until 5:35pm, clients A, B, C, D, E, and F were observed at the group home, had independent access to the living rooms, hallway, bedrooms, dining room, and bathroom. Clients A, B, C, D, E, and F were with a facility staff each time a client went into the kitchen area. From 3:30pm until 5:35pm, the refrigerator and stove were locked and could not be independently accessed. From 3:30pm until 5:35pm, the garage refrigerator, garage freezer, upper kitchen snack cupboard, and lower kitchen cupboard where dry cereal, noodles, and mixes were stored were not secured and could have been independently accessed.</p> <p>At 5:35pm, the Residential Manager (RM) stated "no" the lower kitchen</p>			
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	<p>cupboards, the upper kitchen snack cupboard, and the garage refrigerator and freezer were not secured from client A.</p> <p>Confidential Interview #1 (CI #1) indicated client A could have gotten into the snack cupboard, the cereal cupboard, and garage freezer and refrigerator if client A wanted to. CI #1 indicated client A scoots himself on the floor and could walk independently when client A chose to.</p> <p>Client A's record was reviewed on 3/6/14 at 2:50pm and on 3/7/14 at 9:15pm. Client A's 11/25/13 ISP (Individual Support Plan) and 2/2014 BSP (Behavior Support Plan) both indicated client A needed twenty-four hour staff supervision. Client A's BSP indicated "Sit [client A] in a seat away from others...also to help prevent food theft and [client A] taking food that he is unable to eat and may choke on. [Client A] has been taking food from the oven and refrigerator and has choked when trying to consume the food. An oven guard and refrigerator guard will be used to reduce the chances of [client A] opening them and taking food without caregiver knowledge. Stealing: Taking, using ingesting another's or house belongings and/or food without permission or with permission coerced.</p>			
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	<p>Including taking food from refrigerator, cupboards, or storage areas. [Client A] has taken food items and attempts to ingest them request that [client A] hand you the food items or spit them out. If he complies thank him...[Client A] should be monitored during all meals and snacks to help prevent him from taking food from other's and reduce the risk of him choking on food that he should not consume...Safety guards should be utilized on cupboards, stove, and refrigerator to help prevent food theft and accidentally choking." Client A's 11/25/13 "Risk Management Assessment and Plan" indicated "Presents a Risk: Swallowing/Dysphagia, Aspiration protocol in affect...Choking Risk: Stuffs food in mouth and has had choking incident in past...Needs to sit upright for 30 minutes after eating and sit at a 90 degree angle at the table...[Client A] has eaten raw chicken in the past, [Client A] needs monitored while in the kitchen. [Client A] will eat anything that is a food substance, even if not cooked or not part of his dining plan. [Client A] has 24 hour awake staff, a one-on-one protocol and has a choking plan in place...Staff are to have [client A] in eye site (sic) at all times and are in arms reach distance of [client A] at all times in the community."</p> <p>On 3/7/14 at 8:15 AM, an interview with</p>			
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	<p>the QIDP (Qualified Intellectual Disabilities Professional) and Area Director (AD) was conducted. The QIDP indicated the facility neglected to implement their policy and procedure to supervise client A based on his identified needs on 2/1/14 at 2:05pm when the staff were not within eye sight of client A. The QIDP indicated client A should have been supervised by eye sight supervision at the group home. The QIDP indicated GHS #5 walked in front of client A when going to the laundry room at the group home and client A turned then went into the kitchen. The QIDP indicated client A accessed the oven without facility staff, opened the oven, removed fish sticks which were left from lunch, stuffed them into his mouth, and choked. The QIDP indicated client A required line of sight supervision while in the kitchen and was not supervised by the staff at the group home according to client A's identified need which was documented on client A's BSP (Behavior Support Plan). When asked if the staff neglected to supervise client A with eye sight supervision, the QIDP stated the group home staff "failed to supervise" client A according to client A's identified needs and BSP. The AD indicated the facility followed the BDDS reportable guidelines for incidents and the definitions of abuse, neglect, and/or mistreatment.</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2014
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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N LOGANSPORT, IN 46947
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	<p>On 3/10/14 at 10:30am, the AD and QIDP both stated "it was neglect" when client A was not supervised according to his identified need in the kitchen of the group home and client A choked.</p> <p>2. On 3/6/14 at 1:45pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 12/01/2013 through 03/06/2014 for clients A, B, C, D, E, and F.</p> <p>-A 12/28/13 BDDS report for an incident on 12/28/13 at 12:30pm, indicated Group Home Staff (GHS) #1 and GHS #2 made an allegation of GHS #3 sleeping on duty and not supervising clients A, B, C, D, E, and F.</p> <p>-A 1/2/14 "Internal Investigation" indicated GHS #1 and GHS #2 made an allegation that GHS #3 was sleeping on duty at the group home and not supervising clients A, B, D, E, and F at the group home on 12/28/13 at 12:30pm. The investigation indicated "All individuals live in a basic developmental group home in [name of city] which requires 24/7 (twenty-four hours seven days per week) awake staff. All individuals present with communication disorder or are non verbal and couldn't</p>			
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	<p>contribute information for the investigation." The investigation indicated witness statements from GHS #1 and GHS #2 which indicated GHS #3 "was sitting on couch...mentioned [GHS #3] had a migraine...." The investigation indicated GHS #3 indicated she "had a bad sinus pressure headache onset during her shift...[GHS #3] stated she sat down for a few minutes on the couch but was not asleep. [GHS #3] stated she put her hoodie up to try to block the light as that affects her headache as well. [GHS #3] stated she responded (sic) to couple text from a friend at 11:19 and 1:30 (no am/pm indicated). [GHS #3] stated she hear [GHS #1] ask about lunch and responded with huh because she didn't hear all [GHS #1] asked (sic)...[GHS #3] stated she didn't respond to anything else because she figured they weren't talking to her (GHS #3). [GHS #3] stated she heard one of the clients brush against the couch but didn't think she needed to respond to it. [GHS #3] stated she could hear conversation in the kitchen between the other (two) staff...[GHS #3] stated she got off the couch around 11:35 (am)...." The investigation conclusion indicated "Evidence does not support the allegation that staff fell asleep during her shift." The investigation did not indicate the investigation included consideration for neglecting to supervise clients according</p>			
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	<p>to their identified needs for eye sight supervision.</p> <p>On 3/7/14 at 8:15 AM, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and Area Director (AD) was conducted. The QIDP stated clients A, B, D, E, and F "required" eye sight supervision by the facility staff when not in their bedrooms. The QIDP indicated when clients were in their bedrooms the clients should be checked on by the facility staff every fifteen minutes. When asked if the staff neglected to supervise clients A, B, D, E, and F with eye sight supervision, the QIDP stated the group home staff "failed to supervise" clients A, B, D, E, and F according to their identified needs. The AD indicated the facility followed the BDDS reportable guidelines for incidents and the definitions of abuse, neglect, and/or mistreatment. The AD and the QIDP indicated three staff were present at the group home on 12/28/13 when the incident occurred. The AD and QIDP both indicated the staff patterned "required" three staff persons to supervise and to implement clients A, B, D, E, and F's ISPs (Individual Support Plans) and BSPs (Behavior Support Plans).</p> <p>On 3/7/14 at 10:00 AM, the AD and the QIDP both stated "it was not acceptable</p>			
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	<p>conduct" for GHS #3 on 12/28/13 when GHS #3 sat on the couch with her hoodie up and was not attentive to clients A, B, D, E, and F who were present at the group home.</p> <p>On 3/10/14 at 10:30am, the AD and QIDP both stated "it was neglect" when clients A, B, D, E, and F were not supervised according to their identified needs in the group home.</p> <p>Client A's record was reviewed on 3/6/14 at 2:50pm and on 3/7/14 at 9:15pm. Client A's 11/25/13 ISP (Individual Support Plan), 11/25/13 "Risk Management and Plan," and 2/2014 BSP (Behavior Support Plan) both indicated client A needed twenty-four hour staff supervision. Client A's 11/25/13 "Risk Management Assessment and Plan" indicated "Presents a Risk: Swallowing/Dysphagia, Aspiration protocol in affect...Choking Risk: Stuffs food in mouth and has had choking incident in past...[Client A] needs monitored while in the kitchen...Staff are to have [client A] in eye site (sic) at all times and are in arms reach distance of [client A] at all times in the community."</p> <p>Client B's record was reviewed on 3/7/14 at 8:45am. Client B's 7/5/13 ISP, 7/5/13 "Risk Management and Plan," and 7/2013</p>			

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	<p>BSP indicated client B was non verbal, did not recognize dangers, and "...staff will supervise 24/7. All Staff are awake staff and will do 15 minute checks if client is out of immediate eye sight or asleep. Behaviors as indicated in the Behavior Support Plan...If [client B] is observed standing in front of something she is communicating she wants something in that area. Staff will try to determine what she wants and attempt to satisfy her need. [Client B] will smile when you have met her request. Mentor staff will supervise 24/7. All Staff are awake staff and will do 15 minute checks if client is out of immediate eye sight or asleep...." Client B's plans indicated she needed staff to assist her with balance while walking, taking her medications, communicating, toileting on a schedule, and initiating a task to complete.</p> <p>On 3/6/14 at 1:30pm, a review of the 7/2006 "Quality and Risk Management" policy and procedure was conducted. The policy and procedure indicated the facility prohibited abuse, neglect, and/or mistreatment of clients. The policy and procedure indicated the facility followed the BDDS reportable policy and procedures. The policy and procedure indicated the facility "seeks to protect individuals receiving Indiana Mentor services through oversight of</p>			
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	<p>management and procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating, and reducing the risk to which individuals are exposed." The policy and procedure indicated "K. Inadequate staff support for an individual, including inadequate supervision, with the potential for: 1) significant harm or injury to an individual...."</p> <p>On 3/6/14 at 1:30pm, a record review was completed of the 6/11/2002 BDDS "Incident Reporting" policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...."</p> <p>This federal tag relates to complaint #IN00144083.</p> <p>9-3-2(a)</p>				

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on observation, record review, and interview, for 2 of 3 sampled clients (client A and B) and for 3 additional clients (clients D, E, and F), the facility failed to implement their policy and procedure to thoroughly investigate allegations of abuse, neglect, and/or mistreatment to ensure supervision of clients A, B, C, D, E, and F according to their identified needs.</p> <p>Findings include:</p> <p>On 3/6/14 at 1:45pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 12/01/2013 through 03/06/2014 for clients A, B, C, D, E, and F.</p> <p>-A 12/28/13 BDDS report for an incident on 12/28/13 at 12:30pm, indicated Group Home Staff (GHS) #1 and GHS #2 made an allegation of GHS #3 sleeping on duty and not supervising clients A, B, C, D, E, and F.</p> <p>-A 1/2/14 "Internal Investigation" indicated GHS #1 and GHS #2 made an allegation that GHS #3 was sleeping on</p>	W000154	<p>Upon hire and annually thereafter all staff are trained on policies and procedures in regards to reporting abuse and neglect. All investigators receive training in regards how to conduct accurate and complete investigations including developing a conclusion and ensuring follow up is completed. The managers for the regions received additional training in regards to investigation procedures and agency has revised format in regards to specific types of investigations to aide in enhancing the quality of them. Any staff abuse and neglect investigations will be reviewed by the area director, quality assurance, and HR to ensure the conclusions and recommendations are fitting and aide in monitoring to ensure proper training and or/corrective action has been completed. The area director will continue to track all BDDS reports and review them to ensure no additional measures are needed Responsible Party: Shalan Baker-PD, Brandon Watson AD Completion Date: 4/9/2014</p>	04/09/2014			

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	duty at the group home and not supervising clients A, B, D, E, and F at the group home on 12/28/13 at 12:30pm. The investigation indicated "All individuals live in a basic developmental group home in [name of city] which requires 24/7 (twenty-four hours seven days per week) awake staff. All individuals present with communication disorder or are non verbal and couldn't contribute information for the investigation." The investigation indicated witness statements from GHS #1 and GHS #2 which indicated GHS #3 "was sitting on couch...mentioned [GHS #3] had a migraine...." The investigation indicated GHS #3 indicated she "had a bad sinus pressure headache onset during her shift...[GHS #3] stated she sat down for a few minutes on the couch but was not asleep. [GHS #3] stated she put her hoodie up to try to block the light as that affects her headache as well. [GHS #3] stated she responded (sic) to couple text from a friend at 11:19 and 1:30 (no am/pm indicated). [GHS #3] stated she hear [GHS #1] ask about lunch and responded with huh because she didn't hear all [GHS #1] asked (sic)...[GHS #3] stated she didn't respond to anything else because she figured they weren't talking to her (GHS #3). [GHS #3] stated she heard one of the clients brush against the couch but didn't think she needed to			
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	<p>respond to it. [GHS #3] stated she could hear conversation in the kitchen between the other (two) staff...[GHS #3] stated she got off the couch around 11:35 (am)...."</p> <p>The investigation conclusion indicated "Evidence does not support the allegation that staff fell asleep during her shift." The investigation did not indicate the investigation included consideration for neglecting to supervise clients according to their identified needs for eye sight supervision.</p> <p>On 3/7/14 at 8:15 AM, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and Area Director (AD) was conducted. The QIDP stated clients A, B, D, E, and F "required" eye sight supervision by the facility staff when not in their bedrooms. The QIDP indicated when clients were in their bedrooms the clients should be checked on by the facility staff every fifteen minutes. When asked if the staff neglected to supervise clients A, B, D, E, and F with eye sight supervision, the QIDP stated the group home staff "failed to supervise" clients A, B, D, E, and F according to their identified needs. The AD indicated the facility followed the BDDS reportable guidelines for incidents and the definitions of abuse, neglect, and/or mistreatment. The AD and the QIDP indicated three staff were present at</p>			
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	<p>the group home on 12/28/13 when the incident occurred. The AD and QIDP both indicated the staff patterned "required" three staff persons to supervise and to implement clients A, B, D, E, and F's ISPs (Individual Support Plans) and BSPs (Behavior Support Plans).</p> <p>On 3/7/14 at 10:00 AM, the AD and the QIDP both stated "it was not acceptable conduct" for GHS #3 on 12/28/13 when GHS #3 sat on the couch with her hoodie up and was not attentive to clients A, B, D, E, and F who were present at the group home.</p> <p>On 3/10/14 at 10:30am, the AD and QIDP both stated "it was neglect" when clients A, B, D, E, and F were not supervised according to their identified needs in the group home.</p> <p>Client A's record was reviewed on 3/6/14 at 2:50pm and on 3/7/14 at 9:15pm. Client A's 11/25/13 ISP (Individual Support Plan), 11/25/13 "Risk Management and Plan," and 2/2014 BSP (Behavior Support Plan) both indicated client A needed twenty-four hour staff supervision. Client A's 11/25/13 "Risk Management Assessment and Plan" indicated "Presents a Risk: Swallowing/Dysphagia, Aspiration protocol in affect...Choking Risk: Stuffs</p>			
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	<p>food in mouth and has had choking incident in past...[Client A] needs monitored while in the kitchen...Staff are to have [client A] in eye site (sic) at all times and are in arms reach distance of [client A] at all times in the community."</p> <p>Client B's record was reviewed on 3/7/14 at 8:45am. Client B's 7/5/13 ISP, 7/5/13 "Risk Management and Plan," and 7/2013 BSP indicated client B was non verbal, did not recognize dangers, and "...staff will supervise 24/7. All Staff are awake staff and will do 15 minute checks if client is out of immediate eye sight or asleep. Behaviors as indicated in the Behavior Support Plan...If [client B] is observed standing in front of something she is communicating she wants something in that area. Staff will try to determine what she wants and attempt to satisfy her need. [Client B] will smile when you have met her request. Mentor staff will supervise 24/7. All Staff are awake staff and will do 15 minute checks if client is out of immediate eye sight or asleep...." Client B's plans indicated she needed staff to assist her with balance while walking, taking her medications, communicating, toileting on a schedule, and initiating a task to complete.</p> <p>On 3/6/14 at 1:30pm, a review of the 7/2006 "Quality and Risk Management"</p>				

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	<p>policy and procedure was conducted. The policy and procedure indicated the facility prohibited abuse, neglect, and/or mistreatment of clients. The policy and procedure indicated the facility followed the BDDS reportable policy and procedures. The policy and procedure indicated the facility "seeks to protect individuals receiving Indiana Mentor services through oversight of management and procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating, and reducing the risk to which individuals are exposed." The policy and procedure indicated "K. Inadequate staff support for an individual, including inadequate supervision, with the potential for: 1) significant harm or injury to an individual...."</p> <p>On 3/6/14 at 1:30pm, a record review was completed of the 6/11/2002 BDDS "Incident Reporting" policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...."</p> <p>9-3-2(a)</p>				

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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients A, B, and C) and 3 additional clients (clients D, E, and F), the facility failed to include how and when clients A, B, C, D, E, and F were to access the locked refrigerator and stove in their program plans.</p> <p>Findings include:</p> <p>On 3/6/14 at 1:45pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 12/01/2013 through 03/06/2014 for client A.</p> <p>-A 2/2/14 BDDS report for an incident on 2/1/14 at 2:05pm, indicated client A "opened the oven door and there were still fish sticks in there from lunch. [Client A] took one and shoved it in his throat."</p> <p>-A 2/8/14 "Internal Investigation" indicated client A "grabbed a fish stick and started to put in his mouth. [Client A] started gagging on it, but was able to cough it up." The investigation indicated "[Client A] is on a modified diet due to</p>	W000240	<p>The QMRP helps facilities each individuals ISP to ensure appropriate goals are in place to meet the needs of the individuals. These goals are agreed upon by the IDT and implemented, monitored, and tracked by the program director. Procedures are in place for the QMRP to addendum the ISP to add, remove, or edit the ISP as needed based on clients need. The Area Director, Home Manager, and Program Director administered the Camelot Assessment for the individuals A-F with particular emphasis on the lock skill component. After assessment a write up was completed and filed for each individual outlying their skill with locks and a formal goal was put in place for clients A-F in regards to accessibility of locked items. All ISPs are to be reviewed by the Area Director prior to being implemented by the Area Director. The QMRP will be sending summaries to the Area Director as well to ensure proper goal implementation is being followed. A new HRC request form is being implemented as well to better track any restrictions in the home and to help ensure proper programming is in place if its needed. Management will conduct at least quarterly</p>	04/09/2014
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	<p>aspiration history and shouldn't eat whole foods...." The investigation indicated witness statements from GHS (Group Home Staff) #4, GHS #5, and GHS #6. The witness statements indicated lunch ended "around 1:30pm" GHS #4's witness statement indicated "they (the staff) had put the fish sticks in the shut off oven in case someone wanted seconds" during lunch. GHS #5 "stated he headed to (the) back area to start laundry. [Client A] was following but had run to the kitchen as they were going. Staff immediately followed and intervened when [client A] grabbed the fish sticks and [client A] handed most over before putting one in his [client A's] mouth...[Client A] started to cough and they (the staff) encouraged [client A] to cough/spit out the stick...." The investigation indicated "Evidence supports that [client A] took some leftover fish sticks from the oven which was off and attempted to eat them.</p> <p>On 3/6/14 from 3:30pm until 5:35pm, clients A, B, C, D, E, and F were observed at the group home, had independent access to the living rooms, hallway, bedrooms, dining room, and bathroom. Clients A, B, C, D, E, and F were with a facility staff each time a client went into the kitchen area. From 3:30pm until 5:35pm, the refrigerator and</p>		<p>programming audits to ensure goals have been implemented and tracked properly.</p> <p>Responsible Party: Shalan Baker-PD, Brandon Watson AD Completion Date: 4/9/2014</p>				

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	<p>stove were locked. The key was stored inside an upper cabinet, and the items were unable to be independently opened by all clients.</p> <p>On 3/7/14 at 8:15am, and on 3/10/14 at 10:30am, the AD and QIDP both indicated clients A, B, D, E, and F had not been assessed for the locked refrigerator and oven. The AD and QIDP both indicated clients A, B, C, D, E, and F's records did not include how and/or when clients A, B, C, D, E, and F were to have accessed the locked refrigerator and stove oven. The AD and QIDP both indicated clients B, C, D, E, and F's program plans did not include methodology to teach clients to access locked appliances such as the refrigerator and oven.</p> <p>Client A's record was reviewed on 3/6/14 at 2:50pm and on 3/7/14 at 9:15pm. Client A's 11/25/13 ISP (Individual Support Plan) and 2/2014 BSP (Behavior Support Plan) both indicated client A needed twenty-four hour staff supervision. Client A's plans included locking the cupboards where food was stored. Client A's record indicated he had incidents of recurrent aspiration pneumonia requiring hospitalization, physician's follow up visits, and continuing treatment. Client A's record</p>						

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	<p>did not indicate how/when client A would access food items inside the oven and kitchen refrigerator.</p> <p>Client B's record was reviewed on 3/7/14 at 8:45am. Client B's 7/5/13 ISP, 7/5/13 "Risk Management and Plan," and 7/2013 BSP indicated client B was non verbal and did not recognize dangers.</p> <p>Client B's record did not identify the need for the refrigerator/stove oven to be locked, and did not indicate how/when client B would access food items inside the oven and kitchen refrigerator.</p> <p>Client C's record was reviewed on 3/7/14 at 9:30am. Client C's 8/6/13 ISP and 1/14/13 "Risk Management and Plan" both indicated client C had limited verbal skills, did not recognize dangers, and required line of sight supervision by the facility staff. Client C's record did not identify the need for the refrigerator/stove oven to be locked, and did not indicate how/when client C would access food items inside the oven and kitchen refrigerator.</p> <p>This federal tag relates to complaint #IN00144083.</p> <p>9-3-4(a)</p>			

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W000249	<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 of 3 sampled clients (client A), the facility failed to implement clients A's ISP (Individual Support Plan) and BSP (Behavior Support Plan) to protect client A from his identified behavior of ingesting food which was not modified according to dietary prescription and led to choking.</p> <p>Findings include:</p> <p>On 3/6/14 at 1:45pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 12/01/2013 through 03/06/2014 for client A.</p> <p>-A 2/2/14 BDDS report for an incident on 2/1/14 at 2:05pm, indicated client A "opened the oven door and there were still fish sticks in there from lunch. [Client A] took one and shoved it in his throat." The report indicated staff "immediately got part of it out. [Client A] was coughing and staff said his color was</p>	W000249	<p>The QMRP helps facilities each individuals ISP to ensure appropriate goals are in place to meet the needs of the individuals. These goals are agreed upon by the IDT and implemented, monitored, and tracked by the program director. Procedures are in place for the QMRP to addendum the ISP to add, remove, or edit the ISP as needed based on clients need.</p> <p>The Area Director, Home Manager, and Program Director administered the Camelot Assessment for the individuals A-F with particular emphasis on the lock skill component. After assessment a write up was completed and filed for each individual outlying their skill with locks and a formal goal was put in place for clients A-F in regards to accessibility of locked items.</p> <p>All ISPs are to be reviewed by the Area Director prior to being implemented by the Area Director. The QMRP will be sending summaries to the Area Director as well to ensure proper goal implementation is being followed. A new HRC request form is being</p>	04/09/2014			

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	<p>changing. They called 9-1-1. The EMTs (Emergency Medical Technicians) came and said that [client A] had coughed it all up. They took his vitals and listened to his lungs. The lungs sounded clear. [Client A's] oxygen was 96 percent. No fever, and [client A's] color was good. They said they did not need to take him to ER (Emergency Room)."</p> <p>-A 2/8/14 "Internal Investigation" indicated client A "grabbed a fish stick and started to put in his mouth. [Client A] started gagging on it, but was able to cough it up." The investigation indicated "[Client A] is on a modified diet due to aspiration history and shouldn't eat whole foods. [Client A] is non verbal and could not respond to investigation." The investigation indicated witness statements from GHS (Group Home Staff) #4, GHS #5, and GHS #6. The witness statements indicated lunch ended "around 1:30pm" GHS #4's witness statement indicated "they (the staff) had put the fish sticks in the shut off oven in case someone wanted seconds" during lunch. GHS #5 "stated he headed to (the) back area to start laundry. [Client A] was following but had run to the kitchen as they were going. Staff immediately followed and intervened when [client A] grabbed the fish sticks and [client A] handed most over before putting one in his [client A's]</p>		<p>implemented as well to better track any restrictions in the home and to help ensure proper programming is in place if its needed. Management will conduct at least quarterly programming audits to ensure goals have been implemented and tracked properly.</p> <p>Responsible Party: Shalan Baker-PD, Brandon Watson AD Completion Date: 4/9/2014</p>	

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	<p>mouth...[Client A] started to cough and they (the staff) encouraged [client A] to cough/spit out the stick. The other staff called 9-1-1 when [client A] was coughing..." The investigation indicated "Evidence supports that [client A] took some leftover fish sticks from the oven which was off and attempted to eat them. Evidence supports that staff intervened and [client A] gave the fish sticks to staff but put one in his mouth...Evidence supports that staff had followed [client A's] dining plan during lunch (time)."</p> <p>On 3/6/14 from 3:30pm until 5:35pm, clients A, B, C, D, E, and F were observed at the group home, had independent access to the living rooms, hallway, bedrooms, dining room, and bathroom. Clients A, B, C, D, E, and F were with a facility staff each time a client went into the kitchen area. From 3:30pm until 5:35pm, the refrigerator and stove were all locked. The key was stored inside an upper cabinet, and the items were unable to be independently opened by all clients. From 3:30pm until 5:35pm, the garage refrigerator, garage freezer, upper kitchen snack cupboard, and lower kitchen cupboard where dry cereal, noodles, and mixes were stored were not secured and could have been independently accessed.</p>						

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	<p>At 5:35pm, the Residential Manager (RM) stated "no" the lower kitchen cupboards, the upper kitchen snack cupboard, and the garage refrigerator and freezer were not secured from client A.</p> <p>Confidential Interview #1 (CI #1) indicated client A could have gotten into the snack cupboard, the cereal cupboard, and garage freezer and refrigerator if client A wanted to. CI #1 indicated client A scoots himself on the floor and could walk independently when client A chose to.</p> <p>Client A's record was reviewed on 3/6/14 at 2:50pm and on 3/7/14 at 9:15pm. Client A's 11/25/13 ISP (Individual Support Plan) and 2/2014 BSP (Behavior Support Plan) both indicated client A needed twenty-four hour staff supervision. Client A's BSP indicated "Sit [client A] in a seat away from others...also to help prevent food theft and [client A] taking food that he is unable to eat and may choke on. [Client A] has been taking food from the oven and refrigerator and has choked when trying to consume the food. An oven guard and refrigerator guard will be used to reduce the chances of [client A] opening them and taking food without caregiver knowledge. Stealing: Taking, using ingesting another's or house</p>			

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	<p>belongings and/or food without permission or with permission coerced. Including taking food from refrigerator, cupboards, or storage areas. [Client A] has taken food items and attempts to ingest them request that [client A] hand you the food items or spit them out. If he complies thank him...[Client A] should be monitored during all meals and snacks to help prevent him from taking food from other's and reduce the risk of him choking on food that he should not consume...Safety guards should be utilized on cupboards, stove, and refrigerator to help prevent food theft and accidentally choking." Client A's 11/25/13 "Risk Management Assessment and Plan" indicated "Presents a Risk: Swallowing/Dysphagia, Aspiration protocol in affect...Choking Risk: Stuffs food in mouth and has had choking incident in past...Needs to sit upright for 30 minutes after eating and sit at a 90 degree angle at the table...[Client A] has eaten raw chicken in the past, [Client A] needs monitored while in the kitchen. [Client A] will eat anything that is a food substance, even if not cooked or not part of his dining plan. [Client A] has 24 hour awake staff, a one-on-one protocol and has a choking plan in place...Staff are to have [client A] in eye site (sic) at all times and are in arms reach distance of [client A] at all times in the community."</p>			
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	<p>On 3/7/14 at 8:15 AM, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and Area Director (AD) was conducted. The QIDP indicated the facility neglected to implement their policy and procedure to supervise client A based on his identified needs on 2/1/14 at 2:05pm when the staff were not within eye sight of client A as per his 11/25/13 ISP. The QIDP indicated client A should have been supervised by eye sight supervision at the group home. The QIDP stated the group home staff "failed to supervise" client A according to client A's identified needs and BSP.</p> <p>On 3/10/14 at 10:30am, the AD and QIDP both indicated client A was not supervised according to his identified need in the kitchen of the group home and client A able to access fish sticks.</p> <p>This federal tag relates to complaint #IN00144083.</p> <p>9-3-4(a)</p>				