

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2015
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
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W000000	<p>This visit was for the fundamental annual recertification and licensure survey.</p> <p>Survey Dates: February 3, 4, 5 and 6, 2015</p> <p>Facility Number: 000824 Provider Number: 15G305 AIM Number: 100249060</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/13/15 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the governing body failed to exercise operating direction over the facility by failing to replace the heating and air conditioning vent covers throughout the home due to rust and damage to the vent</p>	W000104	<p>All heating and air vent covers in the home were checked and any in disrepair were replaced. A checklist has been developed and will be completed at least weekly by the Home Manager to ensure that the needs identified for the home are monitored and corrected as required on an ongoing basis. The</p>	03/08/2015

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

TITLE

(X6) DATE

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

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W000148	<p>covers.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/3/15 from 3:42 PM to 5:58 PM and 2/4/15 from 6:00 AM to 7:26 AM. During the observations, the heating and air conditioning metal vent covers on the floors of the group home were rusty, discolored, bent, dented and cracked. The vent covers throughout the group home were in this condition. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>On 2/4/15 at 7:11 AM, the Home Manager (HM) indicated he was aware of the vent covers needing to be replaced. The HM indicated he needed to submit a work order to have the vent covers replaced. The HM stated the vent covers were "...old, we do need to get those replaced."</p> <p>9-3-1(a)</p> <p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness,</p>		<p>Program Director will review and follow up with the Home Manager to ensure the home is in good repair for all clients and will complete monthly inspections on an ongoing basis to ensure compliance. This checklist will be reviewed with the Area Director at least weekly at the Program Director/ Area Director weekly meeting.</p>				

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	<p>accident, death, abuse, or unauthorized absence.</p> <p>Based on interview and record review for 1 of 4 clients in the sample (#3), the facility failed to ensure client #3's guardian was promptly notified of any significant changes in the client's condition.</p> <p>Findings include:</p> <p>On 2/3/15 at 1:56 PM, client #3's guardian stated there was a "struggle" with communication with the group home. The guardian indicated she was not informed of upcoming doctor's appointments or the outcomes of doctor's appointments. The guardian indicated she had never been asked if she wanted to attend doctor's appointments or informed when doctor's appointments were scheduled. The guardian indicated she had not heard from the new Program Director (PD). The guardian indicated the PD never called her to introduce herself and she was not informed of a change in the PD position. The guardian indicated she found out about the change from client #3. The guardian indicated she wanted to know when doctor's appointments were scheduled, what the outcome of the appointment was and wanted to be informed when there was a change in the administration at the group</p>	W000148	<p>The Program Director and Home Manager were trained on contact of guardians and documentation of this contact on 2/26/15. Contact with all guardians must be made at least monthly, but more often if incidents or other activities occur. A form for documenting this contact was developed and will be completed anytime contact is made.</p> <p>The Program Director will review guardian contact weekly with the Area Director at the weekly Program Director/Area Director meeting to ensure contact is being made. Corrective action will be completed if this contact is not made according to the guidelines established.</p> <p>Responsible Party: Home Manager, Program Director, Area Director</p>	03/08/2015
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W000149	<p>home.</p> <p>On 2/4/15 at 12:30 PM, the Home Manager indicated the facility did not have documentation when staff contacted client #3's guardian.</p> <p>On 2/4/15 at 12:30 PM, the Program Director indicated she did not have documentation of her contact with client #3's guardian. The PD indicated the client's guardian should be notified of the things she wanted to know about. The PD indicated the facility needed to discuss, with each client's guardian, what they wanted to be notified of.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 5 of 10 incident/investigative reports reviewed affecting clients #2, #4, #5 and #8, the facility neglected to implement its policies and procedures to prevent client to client abuse, submit a Bureau of Developmental Disabilities Services (BDDS) incident report in a timely manner, conduct thorough investigations</p>	W000149	<p>Staff in the home were re-trained 2-24-15 on preventing client to client abuse. Further incidents that occur where it is determined that staff fail to prevent client to client abuse will result in corrective action up to termination.</p> <p>Observations will be continued at least weekly by administrative staff to monitor that staff are following</p>	03/08/2015			

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	<p>and implement corrective actions indicated in an investigation.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/3/15 at 10:57 AM and indicated the following:</p> <p>1) On 1/3/15 at 6:30 PM, client #4 was prompted to go downstairs to eat dinner. After client #4 went downstairs, he asked a staff #11 for a drink. Staff #11 asked client #4 where his cup was and client #4 indicated client #6 took his cup. Staff #11 went to get client #4's drink and when she came back, client #4 stated, "I'm sorry, I bit [client #6]." Staff examined client #6 and found a bite mark on his left wrist, which was red and swollen. There were two areas where client #4's teeth scratched the skin. Staff took client #6 to the walk-in clinic to be examined. Client #6 received a tetanus shot and oral antibiotics.</p> <p>On 2/3/15 at 11:49 AM, the Area Director (AD) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p>		<p>client plans and are preventing client to client incidents.</p> <p>The Program Director was retrained on immediately notifying designated state agencies of reportable incidents in accordance with State law, on 2-26-15.</p> <p>The Program Director will meet with the Area Director weekly to review all incidents to ensure that all incidents that occurred in the home were reported and reported timely. All reportable incidents will be sent to BDDS within the required timelines. Area Director and Quality Assurance will monitor to ensure incident reports are being submitted in a timely manner and any necessary corrective action will be taken as needed.</p> <p>The Program Director was retrained on completing and administering corrective actions as determined following the findings of investigations within 3 business days of the investigation completion on 2/26/15.</p> <p>All corrective actions completed will be reviewed with the Area Director weekly at the Program Director/Area Director weekly meeting and corrective action for the Program Director will be completed if the established timelines are not met, barring extenuating circumstances.</p> <p>The Program Director was retrained on completing investigations and submitting findings to the Administrator within 5 working days of the date of the incident on</p>	

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	<p>2) On 1/1/15 at 3:00 PM, client #4 went into client #8's bedroom looking for a video game. Client #8 asked client #4 to leave. The BDDS report, dated 1/2/15, indicated, "[Client #4] became agitated and accused [client #8] of 'stealing' his game. [Client #4] became physically aggressive toward [client #8]. Staff intervened and redirected [client #4] to his room. A body check was done on [client #8] and staff discovered that he had a bite mark on his chest on the right side. The skin was not broken, but staff reported that there is a quarter sized bruise on [client #8's] chest. [Client #4] was not physically assaulted during this altercation."</p> <p>On 2/3/15 at 11:49 AM, the Area Director (AD) indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>3) On 12/30/14 at 9:40 AM, client #4 asked for a piece of candy. The BDDS report, dated 12/30/14, indicated, "Staff explained to [client #4] that he was running late and that he could have some candy after he arrived home from work. According to staff, [client #4] became</p>		<p>2/26/15. The Program Director received additional training on how to conduct a thorough investigation on 2/26/15. The training was conducted by Steve Corya. The Area Director will review all investigations to ensure they are submitted timely at weekly PD/AD meeting. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area Director and/or Quality Assurance Specialists or other designee. Responsible Party: Home Manager, Program Director, Area Director, Quality Assurance Specialist</p>				

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	<p>agitated and lunged toward her. He began chasing her. Staff ran out the back door in an attempt to avoid physical aggression. [Client #4] followed her out the door and began chasing her down the street. [Client #4] picked up a large rock and chased her with it. Staff attempted to redirect, but [client #4] continued to show signs of being physically aggressive. Staff contacted the local police. By the time the police arrived [client #4] had calmed down, but was refusing to be transported by staff to [name of day program]. The police office (sic) asked [client #4] if he would like to ride with him. [Client #4] agreed and got into the vehicle. The police accompanied [client #4] to [name of day program] and dropped him off. Staff will receive extra training on [client #4's] behavior plan." There was no documentation the staff received the training.</p> <p>The investigation, dated 1/7/15, indicated the staff involved were staff #3 and #6. Staff #3 indicated in the investigation she heard client #4 ask for candy. Staff #3 indicated she heard staff #6 indicate he could not have candy because he was running late for work. Staff #3 stated in the investigation, "We don't reward him when he is running late for work." Staff #3 observed staff #6 run out through the</p>			

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	<p>side door with client #4 following her. Staff #3 observed client #4 pick up a large rock. Staff #3 prompted client #4 to put the rock down and client #4 "charged toward " staff #3 and #6. The staff ran up the alley with client #4 following them. Client #4 threw the rock at staff and then picked up a stick and chased the staff. Client #4 threw the stick at the staff. The investigation indicated, "We couldn't get [client #4] to calm down and we couldn't get ahold (sic) of anyone so we called the police."</p> <p>The investigation indicated, "[Staff #6] explained that when [client #4] is running late for work he doesn't get treats. She told him that he was running late and that he could have some candy when he arrived home from work." The investigation indicated, "[Client #4] put his hand up and 'charged at me like he was going to hit me.' [Staff #6] ran out the door closest to her, which was side door, off of the kitchen. [Client #4] followed her out the door. [Client #4] ran after her. He stopped and grabbed a large rock. 'I ran toward [staff #3], at that point he started chasing us both. We kept trying to get him to calm down and redirect him, but he wouldn't stop.' [Staff #6] reported that [staff #3] tried to call [name of Program Director] and [name of Home Manager] while outside with her,</p>			

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	<p>but didn't get an answer. [Client #4] chased them down the alley and around the house. 'At some point he threw the rock, but it didn't hit anyone. He picked up a stick and continued coming after us.' The police were called after being outside for 'a long time, probably 20 minutes.'"</p> <p>The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately. Evidence supports staff implemented BSP (Behavior Support Plan) appropriately."</p> <p>On 2/5/15 at 11:45 AM, a review of client #4's Behavior Support Plan, dated 10/21/14, indicated the BSP had not been revised since the incident on 12/30/14. There was no documentation in client #4's plan indicating client #4 could not have a piece of candy when he was running late for work. The plan indicated in the excessive consumption section, "If [client #4] is asking for a snack he should be offered health (sic) choices. If he refuses he should (sic) When [client #4] is food seeking or asking for an excessive amount of food, he should be redirected to engage in a preferred activity." There was no reactive strategy in client #4's BSP indicating staff should contact the police. There was no reactive strategy in the plan indicating staff should run away from client #4 when he was physically aggressive. The plan indicated, in the</p>			

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	<p>low to high intensity physical section, "[Client #4] historically becomes physically aggressive when he is being redirected or prompted to complete an undesired activities. When redirecting, prompting him to complete an undesired activity, or questioning him about topics that have been known to cause physical aggression, staff should stay at least an arms length away from him. Staff should use resources in the environment, when they are available, to place distance between themselves and [client #4]... Remove all other consumers and staff, including yourself, to eliminate targets...."</p> <p>The Recommendations/Corrective Measures to Prevent the Likelihood of Future Occurrences section indicated, "Staff will be retrained on who to contact in case of emergency and possible prevention measures. The BSP will be revised to reflect when it is appropriate to contact the police." There was no documentation presented during the survey indicating the staff was retrained. The BSP was not revised to reflect when it was appropriate to contact the police.</p> <p>On 2/3/15 at 11:38 AM, the Area Director (AD) indicated calling the police was not part of client #4's plan. The AD stated there was "no reason for calling the</p>			

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	<p>police. Situation was under control. Wasn't breaking anything or going into anyone's home (as he had done in the past)." The AD indicated the BSP indicated if the staff felt they couldn't control the situation they could call 911. The AD indicated the staff were in control. The AD indicated the facility should conduct a thorough investigation and take corrective actions as indicated in the investigation.</p> <p>4) On 7/2/14 at 3:30 PM (reported to BDDS on 7/4/14), the BDDS report, dated 7/4/14, indicated, "On 7/1/14 [client #2] had made a withdrawal (sic) of \$500 from his savings account to take money with him on his family vacation. On 7/2/14 Home Manager (HM) [name] was assisting [client #2] to prepare to leave with his parents for vacation. [HM] was gathering his medications and money for his trip. [HM] got out [client #2's] financial pouch which was under double lock and was getting out his money and as he was counting the money [client #2] was \$290 short from the \$500 he had. [HM] immediately contacted the program director, [name], who in turn immediately contacted [name of Area Director]. [HM] also told [name of guardian] who had come to pick [client #2] up for vacation about the situation and that the money would be reimbursed</p>			

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	<p>by the agency and this incident would be investigated."</p> <p>The investigation, dated 7/9/14, indicated in the brief summary of the incident section, "[Client #2] has \$300 missing from his cash on hand account in the home." The Conclusion indicated, "There is no evidence to prove where [client #2's] missing money went. It is likely that the money went missing between 6/30/14 in the morning and 7/2/14 around 3pm." The Recommendations Resulting from an Investigation indicated, "Reimburse [client #2] \$300 that is missing from his COH (cash on hand) account in the home." The Request for Payment, dated 8/20/14, indicated the amount requested to be reimbursed was \$310.00. The check client #2 received was in the amount of \$310.00. There was no documentation indicating the reason the facility reimbursed client #2 \$310.00 instead of \$300.00 as indicated in the investigation. The investigation was not thorough based on the amount indicated as missing and the amount client #2 was reimbursed.</p> <p>On 2/3/15 at 11:41 AM, the Area Director (AD) indicated he was not sure why the amount of money client #2 was reimbursed was different than what was</p>			

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	<p>indicated in the investigation. The AD indicated the facility did not identify who took the money during the investigation.</p> <p>5) A review of the facility's incident/investigative reports was conducted on 2/3/15 at 10:57 AM and indicated the following incident was not documented on BDDS reports or an investigation. The following incident was located while conducting a review of client #5's record on 2/4/15 at 10:15 AM: An Indiana Mentor/TSI Medical Appointment Form, dated 4/25/14, indicated the reason for the visit was a "bruise of left forearm." The diagnosis section indicated, in part, "Soft tissue injury left elbow/contusion with mild cellulitis. X-ray shows no fracture - soft tissue calcification (word illegible) - appear chronic. Rx (prescription) Keflex (antibiotic) 500 mg (milligrams) 3 times daily for 7 days. Recheck 1 week if not back to normal." The Clinical Summary Report, dated 4/25/14, indicated, in part, "Patient comes in today for a contusion. Pt (patient) caregiver complains of a bruise of Lt (left) forearm x 1 day, no known injury. Pt is on blood thinner medication." The Discharge Instructions indicated client #5 had a contusion and cellulitis. There was no documentation the facility conducted an investigation into the origin of client #5's injury of</p>			

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	<p>unknown origin.</p> <p>An Indiana Mentor/TSI Medical Appointment Form, dated 5/5/14, indicated the reason for the visit was a "follow-up from appointment for bruise of left elbow." The Provider Recommendations/Results section indicated, "Contusion (left) forearm - appears to be resolving. Continue routine care." The Clinical Summary, dated 5/5/14, indicated, "Patient's care giver stated they did not know what happened (sic) to patient's arm. Patient was seen [name of clinic] and put on Keflex for 10 days. The patient is a 46 year old male who presents with a complaint of arm pain. The onset of the arm pain has been sudden and has been occurring in a persistent pattern for 11 days. The course has been decreasing. The arm pain is described as mild. His group home caregivers noticed that he had (sic) large bruise on his inner left forearm. There was no evidence for injury or fall..."</p> <p>On 2/4/15 at 12:25 PM, the Program Director (PD) indicated an injury of unknown origin should be investigated.</p> <p>The facility's policy and procedures related to abuse and neglect were reviewed on 2/3/15 at 10:54 AM. The facility's Quality and Risk Management</p>			

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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460
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	<p>policy dated April 2011 indicated, "Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The April 2011 policy indicated, "Indiana Mentor follows the BDDS Incident Reporting policy as outlined in the Provider Standards. An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS: Alleged, suspected, or actual abuse, neglect, or exploitation of an individual. An incident in this category shall also be reported to Adult Protective Services or Child Protective Services as applicable. The provider shall suspend staff involved in an incident from duty pending investigation by the provider. This may include: (a.) physical abuse, including but not limited to: (i.) intentionally touching another person in a rude, insolent, or angry manner.... (e.) Failure to provide appropriate supervision, care or training...". The April 2011 policy indicated, "(f.) Event with the potential for causing significant harm or injury.... (p.) Inadequate staff support for an individual including inadequate</p>			

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	supervision, with the potential for (1.) Significant harm or injury to an individual." The policy indicated, "An initial report regarding an incident shall be submitted within twenty four (24) hours of: (a.) the occurrence of the incident; or (b.) the reporter becoming aware of or receiving information about an incident." The policy indicated the following, "Any allegation of abuse or human rights violation is thoroughly investigated by the Area Director in consultation with Human Resources Department and/or Quality Assurance/Risk Management Department." The policy indicated, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e. Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment... o. The following actions are prohibited by employees of Indiana MENTOR: 1) abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds. 2) violation of an individual's rights." The policy indicated, "Indiana MENTOR is committed to completing a thorough investigation for any event out of the ordinary which			

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W000153	<p>jeopardizes the health and safety of any individual served or other employee."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 of 10 incident/investigative reports reviewed affecting clients #2 and #5, the facility failed to submit Bureau of Developmental Disabilities Services (BDDS) incident reports within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/3/15 at 10:57 AM and indicated the following:</p> <p>1) On 7/2/14 at 3:30 PM (reported to BDDS on 7/4/14), the BDDS report, dated 7/4/14, indicated, "On 7/1/14 [client #2] had made a withdrawal (sic) of \$500 from his savings account to take</p>	W000153	<p>Staff in the home were re-trained on 2-24-15 on preventing client to client abuse. Further incidents that occur where it is determined that staff fail to prevent client to client abuse will result in corrective action up to termination.</p> <p>Observations will be continued at least weekly by administrative staff to monitor that staff are following client plans and are preventing client to client incidents.</p> <p>The Program Director was retrained on immediately notifying designated state agencies of reportable incidents in accordance with State law, on 2-26-15.</p> <p>The Program Director will meet with the Area Director weekly to review</p>	03/08/2015			

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	<p>money with him on his family vacation. On 7/2/14 Home Manager (HM) [name] was assisting [client #2] to prepare to leave with his parents for vacation. [HM] was gathering his medications and money for his trip. [HM] got out [client #2's] financial pouch which was under double lock and was getting out his money and as he was counting the money [client #2] was \$290 short from the \$500 he had. [HM] immediately contacted the program director, [name], who in turn immediately contacted [name of Area Director]. [HM] also told [name of guardian] who had come to pick [client #2] up for vacation about the situation and that the money would be reimbursed by the agency and this incident would be investigated."</p> <p>On 2/3/15 at 11:41 AM, the Area Director (AD) indicated the BDDS report should have been submitted within 24 hours.</p> <p>2) A review of the facility's incident/investigative reports was conducted on 2/3/15 at 10:57 AM and indicated the following incident was not documented on BDDS reports. The following incident was located while conducting a review of client #5's record on 2/4/15 at 10:15 AM: An Indiana Mentor/TSI Medical</p>		<p>all incidents to ensure that all incidents that occurred in the home were reported and reported timely. All reportable incidents will be sent to BDDS within the required timelines. Area Director and Quality Assurance will monitor to ensure incident reports are being submitted in a timely manner and any necessary corrective action will be taken as needed.</p> <p>The Program Director was retrained on completing and administering corrective actions as determined following the findings of investigations within 3 business days of the investigation completion on 2/26/15. All corrective actions completed will be reviewed with the Area Director weekly at the Program Director/Area Director weekly meeting and corrective action for the Program Director will be completed if the established timelines are not met, barring extenuating circumstances. The Program Director was retrained on completing investigations and submitting findings to the Administrator within 5 working days of the date of the incident on 2/26/15. The Program Director received additional training on how to conduct a thorough investigation on 2/26/15. The training was conducted by Steve Corya. The Area Director will review all investigations to ensure they are</p>				

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	<p>Appointment Form, dated 4/25/14, indicated the reason for the visit was a "bruise of left forearm." The diagnosis section indicated, in part, "Soft tissue injury left elbow/contusion with mild cellulitis. X-ray shows no fracture - soft tissue calcification (word illegible) - appear chronic. Rx (prescription) Keflex (antibiotic) 500 mg (milligrams) 3 times daily for 7 days. Recheck 1 week if not back to normal." The Clinical Summary Report, dated 4/25/14, indicated, in part, "Patient comes in today for a contusion. Pt (patient) caregiver complains of a bruise of Lt (left) forearm x 1 day, no known injury. Pt is on blood thinner medication." The Discharge Instructions indicated client #5 had a contusion and cellulitis.</p> <p>An Indiana Mentor/TSI Medical Appointment Form, dated 5/5/14, indicated the reason for the visit was a "follow-up from appointment for bruise of left elbow." The Provider Recommendations/Results section indicated, "Contusion (left) forearm - appears to be resolving. Continue routine care." The Clinical Summary, dated 5/5/14, indicated, "Patient's care giver stated they did not know what happened (sic) to patient's arm. Patient was seen [name of clinic] and put on Keflex for 10 days. The patient is a 46 year old male</p>		<p>submitted timely at weekly PD/AD meeting. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area Director and/or Quality Assurance Specialists or other designee. Responsible Party: Home Manager, Program Director, Area Director, Quality Assurance Specialist</p>				

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W000154	<p>who presents with a complaint of arm pain. The onset of the arm pain has been sudden and has been occurring in a persistent pattern for 11 days. The course has been decreasing. The arm pain is described as mild. His group home caregivers noticed that he had (sic) large bruise on his inner left forearm. There was no evidence for injury or fall..."</p> <p>On 2/3/15 at 11:41 AM, the Area Director (AD) indicated the BDDS report should have been submitted within 24 hours.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 2 of 10 incident/investigative reports reviewed affecting clients #2, #4 and #5, the facility failed to conduct thorough investigations.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was</p>	W000154	<p>The Program Director was retrained on completing investigations and submitting findings to the Administrator within 5 working days of the date of the incident on 2/26/15.</p> <p>The Program Director received additional training on how to conduct a thorough investigation on 2/26/15. The training was</p>	03/08/2015	

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	<p>conducted on 2/3/15 at 10:57 AM and indicated the following:</p> <p>1) On 12/30/14 at 9:40 AM, client #4 asked for a piece of candy. The BDDS report, dated 12/30/14, indicated, "Staff explained to [client #4] that he was running late and that he could have some candy after he arrived home from work. According to staff, [client #4] became agitated and lunged toward her. He began chasing her. Staff ran out the back door in an attempt to avoid physical aggression. [Client #4] followed her out the door and began chasing her down the street. [Client #4] picked up a large rock and chased her with it. Staff attempted to redirect, but [client #4] continued to show signs of being physically aggressive. Staff contacted the local police. By the time the police arrived [client #4] had calmed down, but was refusing to be transported by staff to [name of day program]. The police office (sic) asked [client #4] if he would like to ride with him. [Client #4] agreed and got into the vehicle. The police accompanied [client #4] to [name of day program] and dropped him off. Staff will receive extra training on [client #4's] behavior plan." There was no documentation the staff received the training.</p>		<p>conducted by Steve Corya. The Area Director will review all investigations to ensure they are submitted timely at weekly PD/AD meeting. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area Director and/or Quality Assurance Specialists or other designee.</p> <p>Responsible Party: Program Director, Area Director, Quality Assurance Specialist</p>	

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	<p>The investigation, dated 1/7/15, indicated the staff involved were staff #3 and #6. Staff #3 indicated in the investigation she heard client #4 ask for candy. Staff #3 indicated she heard staff #6 indicate he could not have candy because he was running late for work. Staff #3 stated in the investigation, "We don't reward him when he is running late for work." Staff #3 observed staff #6 run out through the side door with client #4 following her. Staff #3 observed client #4 pick up a large rock. Staff #3 prompted client #4 to put the rock down and client #4 "charged toward " staff #3 and #6. The staff ran up the alley with client #4 following them. Client #4 threw the rock at staff and then picked up a stick and chased the staff. Client #4 threw the stick at the staff. The investigation indicated, "We couldn't get [client #4] to calm down and we couldn't get ahold (sic) of anyone so we called the police."</p> <p>The investigation indicated, "[Staff #6] explained that when [client #4] is running late for work he doesn't get treats. She told him that he was running late and that he could have some candy when he arrived home from work." The investigation indicated, "[Client #4] put his hand up and 'charged at me like he was going to hit me.' [Staff #6] ran out the door closest to her, which was side</p>			

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	<p>door, off of the kitchen. [Client #4] followed her out the door. [Client #4] ran after her. He stopped and grabbed a large rock. 'I ran toward [staff #3], at that point he started chasing us both. We kept trying to get him to calm down and redirect him, but he wouldn't stop.' [Staff #6] reported that [staff #3] tried to call [name of Program Director] and [name of Home Manager] while outside with her, but didn't get an answer. [Client #4] chased them down the alley and around the house. 'At some point he threw the rock, but it didn't hit anyone. He picked up a stick and continued coming after us.' The police were called after being outside for 'a long time, probably 20 minutes.'"</p> <p>The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately. Evidence supports staff implemented BSP (Behavior Support Plan) appropriately."</p> <p>The Recommendations/Corrective Measures to Prevent the Likelihood of Future Occurrences section indicated, "Staff will be retrained on who to contact in case of emergency and possible prevention measures. The BSP will be revised to reflect when it is appropriate to contact the police."</p> <p>On 2/5/15 at 11:45 AM, a review of client #4's Behavior Support Plan, dated</p>			

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	<p>10/21/14, indicated the BSP had not been revised since the incident on 12/30/14. There was no documentation in client #4's plan indicating client #4 could not have a piece of candy when he was running late for work. The plan indicated in the excessive consumption section, "If [client #4] is asking for a snack he should be offered health (sic) choices. If he refuses he should (sic) When [client #4] is food seeking or asking for an excessive amount of food, he should be redirected to engage in a preferred activity." There was no reactive strategy in client #4's BSP indicating staff should contact the police. There was no reactive strategy in the plan indicating staff should run away from client #4 when he was physically aggressive. The plan indicated, in the low to high intensity physical section, "[Client #4] historically becomes physically aggressive when he is being redirected or prompted to complete an undesired activities. When redirecting, prompting him to complete an undesired activity, or questioning him about topics that have been known to cause physical aggression, staff should stay at least an arms length away from him. Staff should use resources in the environment, when they are available, to place distance between themselves and [client #4]... Remove all other consumers and staff, including yourself, to eliminate</p>			

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	<p>targets...."</p> <p>On 2/3/15 at 11:38 AM, the Area Director (AD) indicated calling the police was not part of client #4's plan. The AD stated there was "no reason for calling the police. Situation was under control. Wasn't breaking anything or going into anyone's home (as he had done in the past)." The AD indicated the BSP indicated if the staff felt they couldn't control the situation they could call 911. The AD indicated the staff were in control. The AD indicated the facility should conduct a thorough investigation and take corrective actions as indicated in the investigation.</p> <p>2) On 7/2/14 at 3:30 PM (reported to BDDS on 7/4/14), the BDDS report, dated 7/4/14, indicated, "On 7/1/14 [client #2] had made a withdrawal (sic) of \$500 from his savings account to take money with him on his family vacation. On 7/2/14 Home Manager (HM) [name] was assisting [client #2] to prepare to leave with his parents for vacation. [HM] was gathering his medications and money for his trip. [HM] got out [client #2's] financial pouch which was under double lock and was getting out his money and as he was counting the money [client #2] was \$290 short from the \$500 he had. [HM] immediately contacted the</p>			

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	<p>program director, [name], who in turn immediately contacted [name of Area Director]. [HM] also told [name of guardian] who had come to pick [client #2] up for vacation about the situation and that the money would be reimbursed by the agency and this incident would be investigated."</p> <p>The investigation, dated 7/9/14, indicated in the brief summary of the incident section, "[Client #2] has \$300 missing from his cash on hand account in the home." The Conclusion indicated, "There is no evidence to prove where [client #2's] missing money went. It is likely that the money went missing between 6/30/14 in the morning and 7/2/14 around 3pm." The Recommendations Resulting from an Investigation indicated, "Reimburse [client #2] \$300 that is missing from his COH (cash on hand) account in the home." The Request for Payment, dated 8/20/14, indicated the amount requested to be reimbursed was \$310.00. The check client #2 received was in the amount of \$310.00. There was no documentation indicating the reason the facility reimbursed client #2 \$310.00 instead of \$300.00 as indicated in the investigation. The investigation was not thorough based on the amount indicated as missing and the amount client #2 was</p>						

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	<p>reimbursed.</p> <p>On 2/3/15 at 11:41 AM, the Area Director (AD) indicated he was not sure why the amount of money client #2 was reimbursed was different than what was indicated in the investigation. The AD indicated the facility did not identify who took the money during the investigation.</p> <p>3) A review of the facility's incident/investigative reports was conducted on 2/3/15 at 10:57 AM and indicated the following incident was not documented on BDDS reports or an investigation. The following incident was located while conducting a review of client #5's record on 2/4/15 at 10:15 AM: An Indiana Mentor/TSI Medical Appointment Form, dated 4/25/14, indicated the reason for the visit was a "bruise of left forearm." The diagnosis section indicated, in part, "Soft tissue injury left elbow/contusion with mild cellulitis. X-ray shows no fracture - soft tissue calcification (word illegible) - appear chronic. Rx (prescription) Keflex (antibiotic) 500 mg (milligrams) 3 times daily for 7 days. Recheck 1 week if not back to normal." The Clinical Summary Report, dated 4/25/14, indicated, in part, "Patient comes in today for a contusion. Pt (patient) caregiver complains of a bruise of Lt (left) forearm x 1 day, no</p>				

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	<p>known injury. Pt is on blood thinner medication." The Discharge Instructions indicated client #5 had a contusion and cellulitis. There was no documentation the facility conducted an investigation into the origin of client #5's injury of unknown origin.</p> <p>An Indiana Mentor/TSI Medical Appointment Form, dated 5/5/14, indicated the reason for the visit was a "follow-up from appointment for bruise of left elbow." The Provider Recommendations/Results section indicated, "Contusion (left) forearm - appears to be resolving. Continue routine care." The Clinical Summary, dated 5/5/14, indicated, "Patient's care giver stated they did not know what happened (sic) to patient's arm. Patient was seen [name of clinic] and put on Keflex for 10 days. The patient is a 46 year old male who presents with a complaint of arm pain. The onset of the arm pain has been sudden and has been occurring in a persistent pattern for 11 days. The course has been decreasing. The arm pain is described as mild. His group home caregivers noticed that he had (sic) large bruise on his inner left forearm. There was no evidence for injury or fall...."</p> <p>On 2/4/15 at 12:25 PM, the Program Director (PD) indicated an injury of</p>						

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W000157	<p>unknown origin should be investigated.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 10 incident/investigative reports reviewed affecting client #4, the facility failed to implement the corrective action identified in an investigation.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/3/15 at 10:57 AM and indicated the following: On 12/30/14 at 9:40 AM, client #4 asked for a piece of candy. The BDDS report, dated 12/30/14, indicated, "Staff explained to [client #4] that he was running late and that he could have some candy after he arrived home from work. According to staff, [client #4] became agitated and lunged toward her. He began chasing her. Staff ran out the back door in an attempt to avoid physical aggression. [Client #4] followed her out the door and began chasing her down the street. [Client #4] picked up a large rock and</p>	W000157	<p>The Program Director was retrained on completing and administering corrective actions as determined following the findings of investigations within 3 business days of the investigation completion on 2/26/15.</p> <p>All corrective actions completed will be reviewed with the Area Director weekly at the Program Director/Area Director weekly meeting and corrective action for the Program Director will be completed if the established timelines are not met, barring extenuating circumstances. Responsible Party: Program Director, Area Director</p>	03/08/2015

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	<p>chased her with it. Staff attempted to redirect, but [client #4] continued to show signs of being physically aggressive. Staff contacted the local police. By the time the police arrived [client #4] had calmed down, but was refusing to be transported by staff to [name of day program]. The police office (sic) asked [client #4] if he would like to ride with him. [Client #4] agreed and got into the vehicle. The police accompanied [client #4] to [name of day program] and dropped him off. Staff will receive extra training on [client #4's] behavior plan." There was no documentation the staff received the training.</p> <p>The investigation, dated 1/7/15, indicated the staff involved were staff #3 and #6. Staff #3 indicated in the investigation she heard client #4 ask for candy. Staff #3 indicated she heard staff #6 indicate he could not have candy because he was running late for work. Staff #3 stated in the investigation, "We don't reward him when he is running late for work." Staff #3 observed staff #6 run out through the side door with client #4 following her. Staff #3 observed client #4 pick up a large rock. Staff #3 prompted client #4 to put the rock down and client #4 "charged toward " staff #3 and #6. The staff ran up the alley with client #4</p>			

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	<p>following them. Client #4 threw the rock at staff and then picked up a stick and chased the staff. Client #4 threw the stick at the staff. The investigation indicated, "We couldn't get [client #4] to calm down and we couldn't get ahold (sic) of anyone so we called the police."</p> <p>The investigation indicated, "[Staff #6] explained that when [client #4] is running late for work he doesn't get treats. She told him that he was running late and that he could have some candy when he arrived home from work." The investigation indicated, "[Client #4] put his hand up and 'charged at me like he was going to hit me.' [Staff #6] ran out the door closest to her, which was side door, off of the kitchen. [Client #4] followed her out the door. [Client #4] ran after her. He stopped and grabbed a large rock. 'I ran toward [staff #3], at that point he started chasing us both. We kept trying to get him to calm down and redirect him, but he wouldn't stop.' [Staff #6] reported that [staff #3] tried to call [name of Program Director] and [name of Home Manager] while outside with her, but didn't get an answer. [Client #4] chased them down the alley and around the house. 'At some point he threw the rock, but it didn't hit anyone. He picked up a stick and continued coming after us.' The police were called after being outside</p>			

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	<p>for 'a long time, probably 20 minutes.'" The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately. Evidence supports staff implemented BSP (Behavior Support Plan) appropriately."</p> <p>On 2/5/15 at 11:45 AM, a review of client #4's Behavior Support Plan, dated 10/21/14, indicated the BSP had not been revised since the incident on 12/30/14. There was no documentation in client #4's plan indicating client #4 could not have a piece of candy when he was running late for work. The plan indicated in the excessive consumption section, "If [client #4] is asking for a snack he should be offered health (sic) choices. If he refuses he should (sic) When [client #4] is food seeking or asking for an excessive amount of food, he should be redirected to engage in a preferred activity." There was no reactive strategy in client #4's BSP indicating staff should contact the police. There was no reactive strategy in the plan indicating staff should run away from client #4 when he was physically aggressive. The plan indicated, in the low to high intensity physical section, "[Client #4] historically becomes physically aggressive when he is being redirected or prompted to complete an undesired activities. When redirecting, prompting him to complete an undesired</p>			

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	<p>activity, or questioning him about topics that have been known to cause physical aggression, staff should stay at least an arms length away from him. Staff should use resources in the environment, when they are available, to place distance between themselves and [client #4]... Remove all other consumers and staff, including yourself, to eliminate targets...."</p> <p>The Recommendations/Corrective Measures to Prevent the Likelihood of Future Occurrences section indicated, "Staff will be retrained on who to contact in case of emergency and possible prevention measures. The BSP will be revised to reflect when it is appropriate to contact the police." There was no documentation presented during the survey indicating the staff was retrained. The BSP was not revised to reflect when it was appropriate to contact the police.</p> <p>On 2/3/15 at 11:38 AM, the Area Director (AD) indicated calling the police was not part of client #4's plan. The AD stated there was "no reason for calling the police. Situation was under control. Wasn't breaking anything or going into anyone's home (as he had done in the past)." The AD indicated the BSP indicated if the staff felt they couldn't control the situation they could call 911.</p>			

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W000225	<p>The AD indicated the staff was in control of the situation. The AD indicated the facility should take corrective actions as indicated in the investigation.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on record review and interview for 3 of 4 clients in the sample (#3, #7 and #8), the facility failed to assess the clients' vocational skills.</p> <p>Findings include:</p> <p>On 2/4/15 at 9:53 AM, a review of client #3's record was conducted. Client #3's Vocational Profile Summary (VPS) in his record was blank. There was no documentation on the form including a date.</p> <p>On 2/4/15 at 10:50 AM, a review of client #7's record was conducted. Client #7's VPS was dated 4/4/12. There was no documentation on client #7's VPS indicating the facility reviewed the assessment annually to ensure the information was correct.</p>	W000225	<p>Vocational Assessments for all clients living in the home were reviewed and updates were made as needed on 2/18/15.</p> <p>Assessments will be completed reviewed and updated or revised at least annually. The Program Director and Area Director will meet weekly and at these meetings will discuss annuals that have been completed to monitor that all assessments are completed. Responsible Party: Home Manager, Program Director</p>	03/08/2015

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	<p>On 2/4/15 at 11:12 AM, a review of client #8's record was conducted. Client #8's VPS, not dated, included client #8's name, indicated his mother and father were involved (in the Support System section), and indicated he had worked in a kitchen as a dishwasher. The remainder of the assessment was blank (Availability/Schedule, Physical Capabilities, Socialization Capabilities, Academic Achievement Level, Job Interests, Any Other Relevant Information, and Greatest Strength for a Job).</p> <p>On 2/4/15 at 11:53 AM, the Program Director (PD) indicated when she located the VPS in client #3's record it was not completed. The PD indicated the facility may have an electronic copy of the completed assessment but a completed assessment was not provided for review during the survey. The PD indicated client #7's vocational assessment should be reviewed annually. The PD indicated client #8 was assessed during his intake at Vocational Rehabilitation (VR) recently. The PD indicated she did not have a copy of the assessment of client #8's assessment completed by VR.</p> <p>9-3-4(a)</p>						

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION 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, interview and record review for 2 of 4 clients (#2 and #3) observed to receive their medications, the facility failed to ensure staff implemented the clients' medication administration training objectives as written.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 2/4/15 from 6:00 AM to 7:26 AM. At 6:04 AM, client #3 received his medication from staff #3. Client #3 received Carbamazepine (seizures). Client #3 was asked to state the name of his medication however he could not recall the name of the medication. Client #3 was not asked to state the purpose of the medication.</p> <p>On 2/4/15 at 9:53 AM, a review of client #3's record was conducted. Client #3's 10/31/14 Individual Support Plan (ISP) indicated he had a training objective to</p>	W000249	<p>Staff in the home were retrained on 2-24-15 implementing all training objectives for all clients and ensuring medication administration training objectives at each medication pass.</p> <p>Administrative staff will complete three observations a week for a one month during medication administration to ensure that staff are completing training objectives. Observations will then be conducted once a week for a month, then at least monthly on an ongoing basis.</p> <p>Responsible party: Home Manager, Program Director, Area Director, Nurse, Quality Assurance Specialist</p>	03/08/2015			

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	<p>increase his independence with medication skills. The objective indicated, "Daily, [client #3] will state the name of at least one of his prescribed medications and the reason for taking the medication...."</p> <p>An observation was conducted at the group home on 2/4/15 from 6:00 AM to 7:26 AM. At 6:08 AM, client #2 received his medication (Ensure as a nutritional supplement, Fluoxetine for depression and Loratadine for allergies) from staff #3. Staff #3 prompted client #2 to state the names of his medications. Client #2 indicated he did not know the names of his medications. Staff #3 did not prompt client #2 to state the purpose of each of his medications.</p> <p>On 2/4/15 at 9:38 AM, a review of client #2's medication training objectives was conducted. Client #2's 10/21/14 ISP indicated he had a training objective to increase his independence with medication skills. The training objective indicated, "Daily, [client #2] will state the name of each medication that he is prescribed and what the purpose of each medication is...."</p> <p>On 2/4/15 at 12:21 PM, the Home Manager indicated the clients' medication training objectives should be</p>			

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W000259	<p>implemented at every medication pass.</p> <p>On 2/4/15 at 9:40 AM, the Area Director stated the staff should "always" implement the goals at every medication pass.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p> <p>Based on record review and interview for 1 of 4 clients in the sample (#7), the facility failed to ensure, at least annually, client #7's comprehensive functional assessment (CFA) was reviewed by the interdisciplinary team for relevancy and updated as needed.</p> <p>Findings include:</p> <p>On 2/4/15 at 10:50 AM, client #7's record was reviewed. Client #7's most recent CFA was dated 6/15/12. There was no documentation client #7's CFA was reviewed and updated annually since 6/15/12.</p> <p>On 2/4/15 at 11:53 AM, the Program</p>	W000259	<p>The Functional Assessments of all clients living in the home were reviewed and updates were made as needed on 2/18/15. The assessments will be reviewed and updated as needed at least annually.</p> <p>The Program Director and Area Director will review annuals at the weekly PD/AD meeting to ensure that all assessments are completed as required.</p> <p>Responsible Party: Program Director, Area Director</p>	03/08/2015

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W000262	<p>Director indicated client #7's CFA should be reviewed and updated annually.</p> <p>9-3-4(a)</p> <p>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 record review and interview for 1 of 4 clients in the sample (#8), the facility's specially constituted committee (HRC - Human Rights Committee) failed to review, approve and monitor the client's behavior support plan (BSP) to manage inappropriate behavior.</p> <p>Findings include:</p> <p>On 2/4/15 at 11:12 AM, a review of client #8's record was conducted. Client #8's 12/14/14 BSP included the use of psychotropic medications (Haldol, Trazodone and Seroquel for schizoaffective disorder, Depakote for pervasive developmental disorder and Vyvanse for attention deficit hyperactivity disorder). The plan included the use of door alarms and the sharps being locked due to a peer's</p>	W000262	<p>The Program Director was retrained on process of getting Human Rights Committee approvals for Behavior Support Plans prior to implementation in the home, on 2/26/15.</p> <p>The Program Director will continue to monitor the HRC process for all clients on an ongoing basis. The Program Director and Area Director will meet weekly to review request for HRC and approvals of HRC to ensure approval is given prior to training and implementation in the home.</p> <p>Responsible Party: Program Director, Area Director</p>	03/08/2015

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W000263	<p>behavior. There was no documentation the facility's HRC reviewed, approved and monitored client #8's restrictive BSP.</p> <p>On 2/4/15 at 12:24 PM, the Program Director indicated the facility did not have HRC consent for client #8's BSP. The PD indicated the facility's HRC should review, approve and monitor the client's BSP.</p> <p>9-3-4(a)</p> <p>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, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 2 of 4 clients in the sample (#3 and #8), the facility's specially constituted committee (HRC - Human Rights Committee) failed to ensure written informed consent was obtained for the clients' restrictive program plans.</p> <p>Findings include:</p> <p>On 2/4/15 at 9:53 AM a review of client #3's record was conducted. Client #3's 10/31/14 Individual Support Plan (ISP) indicated client #3 had a guardian. Client</p>	W000263	<p>The Program Director was retrained on process of getting clients and guardians approvals prior to HRC approval, on 2/26/15</p> <p>The Program Director will continue to monitor the HRC process for all clients on an ongoing basis. HRC committee will ensure that clients and/or guardians have been notified prior to signing off on HRC approvals. Program Director and Area Director will meet weekly to review request for HRC and approvals of HRC.</p>	03/08/2015			

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	<p>#3's ISP included restrictions indicating, "Due to a housemate ' s elopement behavior and per the housemate ' s plan, the doors in the home have activated door alarms and backup alarms installed." Client #3's ISP indicated he took psychotropic medications. The plan indicated, "Assessment of his/her supervision needs: Requires 24-hour supervision." There was no documentation the facility obtained written informed consent from client #3's guardian for his ISP. Client #3's Behavior Support Plan (BSP), dated 10/27/14, included the use of psychotropic medications (Carbamazepine as an anticonvulsant, Seroquel and Cymbalta as antidepressants and Tylenol PM as a sleep aid). The facility did not have documentation of written informed consent from client #3's guardian for the implementation of the BSP.</p> <p>On 2/4/15 at 11:53 AM, the Home Manager (HM) indicated during client #3's annual meeting, he did not have a copy of the consent page at the meeting for client #3's guardian to sign. The HM indicated he would have the guardian sign the consents on Sunday (2/8/15) when she visited the group home.</p> <p>On 2/4/15 at 11:53 AM, the Program</p>		Responsible Party: Program Director, Area Director				

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	<p>Director (PD) indicated the facility should have guardian consent for the restrictive plans. The PD indicated the guardian participated in the meeting but the facility did not obtain her signatures on the forms indicating she gave consent.</p> <p>On 2/4/15 at 11:12 AM a review of client #8's record was conducted. Client #8's 12/14/14 BSP included the use of psychotropic medications (Haldol, Trazodone and Seroquel for schizoaffective disorder, Depakote for pervasive developmental disorder and Vyvanse for attention deficit hyperactivity disorder). The plan included the use of door alarms and the sharps being locked due to a peer's behavior. Client #8's ISP, dated 5/15/14, indicated client #8 had a guardian. There was no documentation the facility obtained written informed consent from client #8's guardian for the restrictive BSP.</p> <p>On 2/4/15 at 12:24 PM, the Program Director indicated the facility did not obtain written informed consent for client #8's restrictive behavior plan. The PD indicated the facility should have written informed consent.</p> <p>9-3-4(a)</p>				

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W000312	<p>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 record review and interview for 1 of 4 clients in the sample (#8), the facility failed to ensure client #8's medication reduction plan was attainable.</p> <p>Findings include:</p> <p>On 2/4/15 at 11:12 AM a review of client #8's record was conducted. Client #8's Medication Management Plan, not dated, indicated, "Description of Criteria for Medication Reduction. Behavior to Decrease: Resistance to instruction. Criteria for reduction: 10% below baseline for 60 days. Current Medication Targeted if Achieved: Depakote. Reduction Amount if Achieved: Clinical opinion of psychiatrist." There was no documentation in client #8's plan indicating what his baseline was.</p> <p>On 2/4/15 at 12:25 PM, the Program Director indicated the plan did not indicate client #8's baseline of resistance to instruction. The PD indicated the facility could not measure a 10%</p>	W000312	<p>Client #8's medication reduction plan was revised on 2/20/15, based on behavior data and updated in order to ensure it contains criteria that makes it attainable.</p> <p>The Program Director and Area Director will review any updates of behavior support plans that occurred during annual meetings held, at weekly meetings to ensure compliance.</p> <p>Responsible Party: Program Director, Area Director</p>	03/08/2015

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W009999	<p>reduction in the baseline to consider a reduction. The PD indicated the plan was not attainable since there was no baseline.</p> <p>9-3-5(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p> <p>460 IAC 9-3-1 Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 14. A significant injury to an individual that includes but is not limited to: g. any injury requiring more than basic first aid.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 10 incident/investigative reports reviewed affecting client #5, the facility</p>	W009999	The Program Director was retrained on immediately notifying designated state agencies of reportable incidents in accordance with State law, on 2-26-15. The Program Director will meet with the Area Director weekly to review all incidents to ensure that all incidents that occurred in the home were reported and reported timely. All reportable incidents will be sent to BDDS within the required timelines. Area Director and Quality Assurance will monitor to ensure incident reports are being submitted in a timely manner and any necessary corrective action will be taken as needed. The Program Director was retrained on completing and administering corrective actions as determined following the findings of investigations within 3 business days of the investigation completion on 2/26/15. All corrective actions completed will be reviewed with the Area Director weekly at the Program	03/08/2015	

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	<p>failed to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) for an emergency intervention for a puncture wound to client #5's heel.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/3/15 at 10:57 AM and indicated the incidents were not reported to BDDS. The following incidents were located while conducting a review of client #5's record on 2/4/15 at 10:15 AM:</p> <p>An Indiana Mentor/TSI (Transitional Services, Inc.) Medical Appointment Form, dated 12/4/14, indicated the reason for the visit was a "puncture wound left heel." The Clinical Summary, dated 12/4/14, indicated, "Patient's care giver stated patient stepped on a piece off a chair leg. Patient's care giver stated it was approximately one inch long. Group home is requesting patient get a tetanus shot." There was no additional information in the record for review. The facility did not provide documentation the incident was reported to BDDS.</p> <p>On 2/3/15 at 11:49 AM, the Area Director indicated BDDS reports should be submitted within 24 hours.</p>		<p>Director/Area Director weekly meeting and corrective action for the Program Director will be completed if the established timelines are not met, barring extenuating circumstances. The Program Director was retrained on completing investigations and submitting findings to the Administrator within 5 working days of the date of the incident on 2/26/15. The Program Director received additional training on how to conduct a thorough investigation on 2/26/15. The training was conducted by Steve Corya. The Area Director will review all investigations to ensure they are submitted timely at weekly PD/AD meeting. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area Director and/or Quality Assurance Specialists or other designee. Responsible Party: Home Manager, Program Director, Area Director, Quality Assurance Specialist</p>				

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	<p>On 2/4/15 at 10:28 AM, the Program Director (PD) indicated client #5 went to a walk-in clinic and not the emergency room. The PD indicated the incident did not need to be reported to BDDS.</p> <p>9-3-1(b)</p>				