

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G438	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2012
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7555 GRANDVIEW DR INDIANAPOLIS, IN 46260
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W0000	<p>This visit was for the annual fundamental recertification and state licensure survey.</p> <p>This visit was conducted in conjunction with the PCR (Post Certification Revisit) to the investigation of complaint #IN00109399 completed on 7/9/12.</p> <p>Dates of Survey: 9/18/12, 9/19/12, 9/20/12, 9/21/12, 9/24/12, 9/26/12 and 9/28/12.</p> <p>Facility Number: 000952 Provider Number: 15G438 AIMS Number: 100244640</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/9/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 1 of 3 sampled clients (#2), the governing body failed to exercise operating direction over the facility to ensure client #2's finances were not in excess of predetermined maximum amounts allowed by Medicaid.</p> <p>Findings include:</p> <p>Client #2's financial record was reviewed on 9/20/12 at 10:00 AM. Client #2's facility based Cluster account ledger dated 6/1/12 through 9/18/12 indicated the following:</p> <p>-6/1/12, SSD (Social Security Deposit), \$1,064.00 with an ending balance in the amount of \$8,485.00</p> <p>-6/14/12, RBW (Room and Board Withdrawal), \$1,012.00 with an ending balance in the amount of \$7,473.00</p> <p>-7/3/12, SSD, \$1,064.00 with an ending balance in the amount of \$8,537.00</p> <p>-7/17/12, RBW, \$1,012.00 with an ending balance in the amount of \$7,525.00</p>	W0104	<p>The Home Manager and Program Director will complete an audit of all consumers finances, including Client #2, to determine if anyone's account balance is in excess of the allowable amount. If any consumers account balances are in excess of the allowable amount the Home Manager and Program Director will work with the Social Worker and Client Finance Specialist to spend the money in an appropriate manner to get the balance below the allowable amount.</p> <p>The Home Manager and Program Director will receive retraining on consumers finances including ensuring that all consumers accounts are below the allowable amount.</p> <p>Ongoing the Client Finance Specialist will provide a record monthly to the Area Director of all consumers that have an account balance in excess of the allowable amount. The Area Director will ensure that the Program Director and Home Manager are notified so the can work with the Social Worker and Client Finance Specialist to spend the money in an appropriate manner to get the balance below</p>	10/28/2012			

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	<p>-8/3/12, SSD, \$1,064.00 with an ending balance in the amount of \$8,589.00</p> <p>-8/20/12, RBW, \$1,012.00 with an ending balance in the amount of \$7,577.00</p> <p>-8/31/12, SSD, \$1,064.00 with an ending balance in the amount of \$8,641.00</p> <p>-9/11/12, RBW, \$1,012.00 with an ending balance in the amount of \$7,629.00</p> <p>-9/18/12, Personal Needs withdrawal, \$150.00 with an ending balance in the amount of \$7,479</p> <p>Interview with AS (Administrative Staff) #1 on 9/20/12 at 11:30 AM indicated the maximum allowable amount should be \$1,500.00. AS #1 indicated client #2's account balance was in excess of the allowable amount.</p> <p>9-3-1(a)</p>		<p>the allowable amount.</p> <p>Responsible Party: Home Manager, Program Director, Area Director, Client Finance Specialist</p>		

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W0120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client. Based on observation, record review and interview for 1 of 3 sampled clients (client #2), the facility failed to ensure the outside day services met the needs of the client.</p> <p>Findings include:</p> <p>Observations were conducted at client #2's outside day service placement on 9/19/12 from 11:53 AM through 12:53 PM. Client #2 was observed throughout the observation period. Client #2 was seated in a wheelchair with a gait belt wrapped around the wheelchair seat and tied around client #2's waist.</p> <p>DSS (Day Service Staff) #1 was interviewed on 9/19/12 at 11:55 AM. DSS #1 indicated client #2 had a gait belt tied around his waist and the wheelchair. DSS #1 indicated client #2's wheelchair did not have a seatbelt and the gait belt was being used as a seatbelt.</p> <p>Client #2's record was reviewed on 9/18/12 at 3:15 PM. Client #2's record did not indicate client #2 should be secured to his wheelchair using a gait belt.</p>	W0120	<p>The Direct Support staff, Home Manager and Day Service Staff will receive retraining on not using restrictive measures for clients that have not been approved by guardians and Human Rights Committee, including not using a gait belt as a means for securing client #2 to his wheelchair. The Program Nurse will follow up with the doctor to clarify if client #2 needs to be secured to his wheelchair. If so, the Program Nurse will work with the Home Manager and Program Director to evaluate if Client #2 needs evaluation for a new wheelchair or if a seatbelt can be added to his current wheelchair. If it is determined that Client #2 needs to be secured to his wheelchair, the Program Director will obtain guardian and HRC approval as necessary for the restrictive measure. Ongoing, the Home Manager, Program Nurse and Program Director will ensure that any restrictive measures need for clients are approved by the guardian and Human Rights Committee prior to their implementation. The Program Director will ensure that Day Services Staff are trained on any restrictive measures so that they can be implemented properly as directed. For 4 weeks, the HM</p>	10/28/2012	

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	<p>Interview with AS #1 on 9/21/12 at 10:20 AM indicated staff should not use a gait belt to secure client #2 to his wheelchair. AS #1 indicated client #2's BDP and ISP did not include the use of a gait belt to secure client #2 to his wheelchair. When asked if the use of a gait belt to secure client #2 was considered a restrictive practice, AS #1 stated, "Yes."</p> <p>9-3-1(a)</p>		<p>and/or PD will complete observations at the day program once per week to ensure they are not using a gait belt as a means for securing client #2 to his wheelchair. Ongoing the HM and/or PD will complete observations at the day program at least once every 2 months to ensure Day Service staff are not using restrictive measures on clients that have not been approved.</p> <p>Responsible Party: Home Manager, Program Director, Program Nurse, Day Services Staff</p>		

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W0125	<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 record review and interview for 1 of 4 sampled clients (#2), the facility failed to secure a surrogate to assist client #2 with making informed choices and decisions.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 9/18/12 at 3:15 PM. The review indicated the client's diagnoses included, but were not limited to, profound mental retardation, cerebral palsy and autonomic storms. The record review indicated a Behavior Development Program (BDP) dated 7/30/12 which indicated the client received medication for behavior management: clonazepam (anti anxiety) 0.5 milligrams daily and trazodone (depression) 100 milligrams daily. Client #2's ISP (Individual Support Plan) dated 6/25/12 indicated, "[Client #2] has not demonstrated an understanding of the concepts nor that he can make choices that reflect a judgement process." Client #2's ISP indicated, "[Client #2] has demonstrated an understanding of the</p>	W0125	<p>Interdisciplinary team will convene to determine the need for a Health Care Representative or State Appointed Guardian for Client #2. The Program Director will assess the need of guardianship for all clients in the Home.</p> <p>Program Director and Home Manager will have mandatory paperwork completed to obtain a Health Care Representative or State appointed guardianship as needed.</p> <p>Responsible Parties: Home Manager, Program Director</p>	10/28/2012			

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	<p>concepts of privacy or choice...." Client #2's ISP indicated the client had been assessed as being able to provide informed consent in, "No areas." The record review did not indicate a surrogate had been appointed to assist client #2 make informed decisions.</p> <p>Interview with AS (Administrative Staff) #1 on 9/20/12 at 11:30 AM indicated client #2 was not assessed as being able to give informed consent. AS #1 indicated client #2 did not have a surrogate appointed to assist him make informed decisions. AS #1 indicated client #2 should have a surrogate to assist him make informed decisions.</p> <p>9-3-2(a)</p>				

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 4 sampled clients (#2) plus one additional client (#6), the facility failed to implement its policy and procedure to complete an investigation in regards to client #6's bruises of unknown origin. The facility failed to implement its policy and procedure to complete an investigation in regards to client #2's bruise of unknown origin within 5 business days.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 9/18/12 at 11:40 AM. The review indicated the following:</p> <p>-BDDS report dated 7/8/12 indicated, "On 7/7/12, staff was assisting [client #2] with his evening bathing and noticed a small bruise about the size of a quarter on his left buttock. They were unable to determine where or when this bruise may have occurred. Staff will monitor [client #2] for his health and safety. The nurse was paged but did not return page."</p> <p>-Investigation dated 7/17/12 regarding the</p>	W0149	<p>The Program Director will receive retraining on investigations including ensuring that all reports of injuries of unknown origin for consumes are investigated, investigations are completed thoroughly and accurately and all investigations are reported to the administrator or designee the results within 5 work days.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Quality Assurance Specialist. If the investigations are not thorough enough the Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Program Director, Quality Assurance Specialist, Area Director.</p>	10/28/2012	

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	<p>7/8/12 BDDS indicated the investigation had been initiated on 7/8/12 to determine the origin of client #2's bruise.</p> <p>-BDDS report dated 9/1/12 indicated on 8/31/12, "[HM (Home Manager) #1] noticed a small bruise on [client #6's] left arm. [HM #1] reported that the bruise looked like it was a few days old, it is approximately 1 inch long and half inch wide. One staff said the bruise had been there for some time."</p> <p>The review did not indicate an investigation regarding the origin of client #6's bruise.</p> <p>Interview with AS (Administrative Staff) #1 on 9/20/12 at 11:30 AM indicated the 8/31/12 injury of unknown origin for client #6 should have been investigated as an injury of unknown origin. AS #1 indicated investigations for injuries of unknown origin should be completed within 5 business days. AS #1 indicated the 7/17/12 Investigation regarding the 7/7/12 injury of unknown origin for client #2 was not completed within 5 business days.</p> <p>The facility's policy and procedures were reviewed on 9/26/12 at 4:03 PM. The facility's 4/11 policy and procedure entitled Quality Risk Management indicated "Indiana Mentor is committed to completing a thorough investigation for any event</p>			

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	<p>out of the ordinary which jeopardizes the health and safety of any individual served or other employee." The Quality Risk Management policy dated 4/11 indicated, "Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident."</p> <p>9-3-2(a)</p>			

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W0154	<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 record review and interview for 1 of 5 incidents of abuse, neglect or injuries of unknown origin reviewed for 1 additional client (#6), the facility failed to complete an investigation in regards to client #6's bruise of unknown origin.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 9/18/12 at 11:40 AM. The review indicated the following:</p> <p>-BDDS report dated 9/1/12 indicated on 8/31/12, "[HM (Home Manager) #1] noticed a small bruise on [client #6's] left arm. [HM #1] reported that the bruise looked like it was a few days old, it is approximately 1 inch long and half inch wide. One staff said the bruise had been there for some time."</p> <p>The review did not indicate an investigation regarding the origin of client #6's bruise.</p> <p>Interview with AS (Administrative Staff) #1 on 9/20/12 at 11:30 AM indicated the</p>	W0154	<p>The Program Director will receive retraining on investigations including ensuring that all reports of injuries of unknown origin for consumes are investigated, investigations are completed thoroughly and accurately and all investigations are reported to the administrator or designee the results within 5 work days.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Quality Assurance Specialist. If the investigations are not thorough enough the Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Program Director, Quality Assurance Specialist, Area Director.</p>	10/28/2012	

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	8/31/12 injury of unknown origin for client #6 should have been investigated as an injury of unknown origin. 9-3-2(a)			

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W0156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 5 incidents of abuse, neglect or injuries of unknown origin reviewed for 1 of 3 sampled clients (#2), the facility failed to report the results of the investigation of client #2's bruise of unknown origin within 5 business days.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 9/18/12 at 11:40 AM. The review indicated the following:</p> <p>-BDDS report dated 7/8/12 indicated, "On 7/7/12, staff was assisting [client #2] with his evening bathing and noticed a small bruise about the size of a quarter on his left buttock. They were unable to determine where or when this bruise may have occurred. Staff will monitor [client #2] for his health and safety. The nurse was paged but did not return page."</p> <p>-Investigation dated 7/17/12 regarding the 7/8/12 BDDS indicated the investigation</p>	W0156	<p>The Program Director will receive retraining on investigations including ensuring that all reports of injuries of unknown origin for consumes are investigated, investigations are completed thoroughly and accurately and all investigations are reported to the administrator or designee the results within 5 work days.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Quality Assurance Specialist. If the investigations are not thorough enough the Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Program Director, Quality Assurance Specialist, Area Director.</p>	10/28/2012			

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	<p>had been initiated on 7/8/12 to determine the origin of client #2's bruise.</p> <p>Interview with AS (Administrative Staff) #1 on 9/20/12 at 11:30 AM indicated investigations for injuries of unknown origin should be completed within 5 business days. AS #1 indicated the 7/17/12 Investigation regarding the 7/7/12 injury of unknown origin for client #2 was not completed within 5 business days.</p> <p>9-3-2(a)</p>				

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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (#2), the facility's ISP (Individual Support Plan) failed to included the needed supports and/or services regarding how staff was to assist client #2 to ambulate.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/18/12 from 4:03 PM through 4:50 PM, 9/19/12 from 6:06 AM through 8:00 AM and on 9/19/12 from 11:53 AM through 12:53 PM. Client #2 was observed throughout the observation periods. Client #2 utilized a wheelchair throughout the observation periods.</p> <p>Client #2's record was reviewed on 9/18/12 at 3:15 PM. Client #2's physical therapy record of visit form dated 10/1/08 indicated, "Recommend use of gait belt with transfers in the home and wheelchair in the community. Recommend continue to ambulate [client #2] multiple times/day. Encourage crawling or any active movement of all extremities." Client #2's ISP dated 6/25/12 indicated, "[Client #2] is unable to stand alone, but has been known to use items in his</p>	W0240	<p>The Program Director will work with the Program Nurse to evaluate Client #2 recommendations from OT/PT evaluations and primary care physician to determine what supports are recommended to assist Client #2 with ambulation. The Program nurse will clarify with the Primary Care Physician recommendations/directions for use of a gait belt and wheelchair. Once clarified, the Program Nurse and Program Director will develop goals/objectives for assisting and supporting client #2 with ambulation. Program Director will update Client #2 ISP to include new goals and objectives for assisting with ambulation. Staff will receive training on goals/objectives to assist Client #2 with ambulation.</p> <p>The Program Director will receive retraining to ensure that all consumers ISPs identify specific needs and supports to assist the consumers with working towards independence in identified areas as determined by the Interdisciplinary Team.</p> <p>Ongoing, the Program Director will ensure that any needed supports to assist consumers toward independence that are</p>	10/28/2012

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	<p>environment to stand. [Client #2] must have something to hold onto in order to provide balance. In the community, [client #2] uses a wheelchair. [Client #2] also has a backwards walker in the home that he does not use. At home, if staff supports [client #2] by standing in front of him and holding both his hands to balance and guide him, [client #2] can ambulate in the home." The ISP indicated, "In the past, [client #2] has had a formal goal to walk with staff holding his hands for support, up to 17 steps. [Client #2] has been successful at meeting this goal." Client #2's ISP did not indicate informal or formal training/supports regarding client #2's in home ambulation.</p> <p>Interview with AS (Administrative Staff) #1 on 9/21/12 at 10:20 AM indicated client #2 should be using the wheelchair for during transportation and while in the community. AS #1 indicated client #2 needed supports to ambulate in the home.</p> <p>9-3-4(a)</p>		<p>identified by the IDT are included in consumers ISPs. For the next 3 months the Area Director will review all ISPs submitted by the Program Director to ensure that goals for all needed supports recommended by the IDT are included in the ISP.</p> <p>Responsible Party: Program Nurse, Program Director, Area Director</p>		

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W0259	<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. Based on record review and interview for 1 of 3 sampled clients (#2), the facility failed to ensure client #2 had a current CFA (Comprehensive Functional Assessment) completed annually.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 9/18/12 at 3:15 PM. Client #2's record did not indicate client #2's CFA had been updated since 7/17/11.</p> <p>Interview with AS (Administrative Staff) #1 on 9/20/12 at 11:30 AM indicated client #2's CFA should be reviewed annually.</p> <p>9-3-4(a)</p>	W0259	<p>Comprehensive Functional Assessments for all consumers, including Client #2 will be completed and placed in the consumers file.</p> <p>The Program Director will receive retraining on ensuring that all consumers have Comprehensive Functional Assessments completed annually in accordance with the annual Individual Support plan.</p> <p>For the next 3 months, the Area Director will review all ISPs written by this Program Director to ensure that Comprehensive Functional Assessments are being completed and the data collected is being utilized in the development of training goals and objectives.</p> <p>Responsible Party: Program Director, Area Director.</p>	10/28/2012	

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W0263	<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 sampled clients (#1 and #2) with psychotropic behavior control medications, the facility's human rights committee (HRC) failed to ensure the facility obtained written informed consent from the client or the client's legal representative prior to the restrictive program.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 9/20/12 at 10:11 AM. Client #1's ISP (Individual Support Plan) dated 6/27/12 indicated client #1 had a guardian. Client #1's BDP (Behavior Development Program) dated 7/28/11 indicated client #1 received fluoxetine (depression) 20 milligrams daily, divalproex (depression) 1000 milligrams daily and trazodone (depression) 50 milligrams daily. The plan indicated the facility's HRC had reviewed/approved the BDP on 7/11/12. There was no documentation client #1's guardian had given written approval.</p> <p>2. Client #2's record was reviewed on</p>	W0263	<p>The Program Director will receive retraining on ensuring that any psychotropic medications that consumers are receiving for behavior management are included in the consumers Behavior Support Plans and Guardian or consumer consent if they are emancipated; approvals are obtained prior to getting HRC approval.</p> <p>Ongoing, the Program Director will ensure that any additions or changes to psychotropic medications are included in the Behavior Support Plan and guardian or consumer approval if they are emancipated; is obtained prior to presenting to the Human Rights Committee for approval. Program Director will ensure that documentation of guardian or client approval is available for review. Prior to any future Human Rights Committee meetings, the HRC will be reminded that they should not approve any changes to medications or Behavior Support Plans without ensuring that guardian or client, if emancipated, approvals have been obtained.</p> <p>Responsible Party: Program</p>	10/28/2012	

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	<p>9/18/12 at 3:15 PM. Client #2's BDP dated 7/30/12 indicated, "[Client #2] currently receives a total daily dosage of clonazepam (anxiety) 0.5 milligram and trazodone (depression) 100 milligram for sleep disturbance. [Client #2] also receives triazolam (insomnia) 0.25 milligram prior to medical/dental appointments." Client #2's ISP (Individual Support Plan) dated 6/25/12 indicated client #2 was an emancipated adult. There was no documentation client #2 had given written approval.</p> <p>Interview with AS (Administrative Staff) #1 on 9/20/12 at 11:30 AM indicated BDPs that include the use of psychotropic medication should have written approval from the guardian or the client if emancipated.</p> <p>9-3-4(a)</p>		Director, Human Rights Committee		

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W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 1 of 2 clients with adaptive equipment (#2), the facility failed to ensure client #2 had a sippy cup while at day services.</p> <p>Findings include:</p> <p>Observations were conducted at client #2's day service site on 9/19/12 from 11:53 AM through 12:53 PM. Client #2 was observed throughout the observation period. At 12:16 PM DSS (Day Service Staff) #1 poured client #2's serving of milk into an open mouth cup during the day service meal. DSS #1 lifted the cup of milk to client #2's mouth and held the cup for client #2 while he drank the milk. DSS #1 continued to hold client #2's cup of milk to his mouth for drinks of milk throughout the meal. Client #2 did not use a sippy cup during his meal while at day services.</p> <p>Client #2's record was reviewed on 9/18/12 at 3:15 PM. Client #2's ISP (Individual Support Plan) dated 6/25/12</p>	W0436	<p>The Home Manager and Program Director will provide the Day Services with sippy cups to use as identified in the ISP. The Home Manager and/or Program Director will train the Day Services staff on the need for Client #2 to use a sippy cup as outlined in Client #2 ISP.</p> <p>The Home Manager and Program Director will receive retraining to include ensuring that all adaptive equipment identified in the ISP is provided to the group home staff and day services staff and all staff are trained on the use of adaptive equipment.</p> <p>Ongoing, the Home Manager and/or Program Director will complete observations at the Day Services program at least 2 times per month to ensure that Day Services are using the adaptive equipment for Client #2 as indicated by the ISP.</p> <p>Responsible Party: Home Manager, Program Director, Day Services</p>	10/28/2012			

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	<p>indicated, "Dining equipment used: [client #2] uses a regular teaspoon and a sippy cup."</p> <p>Interview with HM (Home Manager) #1 on 9/21/12 at 10:15 AM indicated client #2 should be using a sippy cup for drinking during meals.</p> <p>Interview with AS (Administrative Staff) #1 on 9/21/12 at 10:20 AM indicated client #2 should be using a sippy cup for drinking during meals.</p> <p>9-3-7(a)</p>			
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W9999	<p>STATE FINDINGS:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>(1) 460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin (TB) test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview for 1 of 3 sampled staff (staff #1) personnel records reviewed, the facility failed to obtain yearly PPD's and/or a chest x-ray and/or PPD screening checklist for employed staff.</p> <p>Findings include:</p> <p>Staff #1's personnel record was reviewed on</p>	W9999	<p>Program Director and Area Director will review Mantoux records for all staff. Program Director and Area Director will notify any staff if their Mantoux is outdated and provided them with the list of next clinic dates and deadline for completion.</p> <p>Program Director and Area Director will monitor expiration dates for Mantoux for all staff no less than monthly and notify staff as needed of completion.</p> <p>Responsible Party: Program Director, Area Director</p>	10/28/2012			

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	<p>9/18/12 at 1:04 PM. Staff #1's personnel record did not include a Mantoux test, chest x-ray or TB (Tuberculosis) checklist/screening to indicate the staff person was free of TB symptoms.</p> <p>Interview with AS (Administrative Staff) #1 on 9/20/12 at 1:07 PM indicated there were no additional Mantoux test, chest x-ray or TB (Tuberculosis) checklist/screening documents available for review. AS #1 indicated staff #1's personnel record should contain evidence of completion of an annual Mantoux test, chest x-ray or TB (Tuberculosis) checklist/screening to indicate the staff person was free of TB symptoms.</p> <p>9-3-3(e)</p>			