

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G407	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2015
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2113 E KESSLER BLVD INDIANAPOLIS, IN 46220
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W 000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: March 31, April 1 and 17, 2015.</p> <p>Facility Number: 000921 AIM Number: 100249310 Provider Number: 15G407</p> <p>These federal deficiencies reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 104 Bldg. 00	<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 4 of 4 sampled clients (#1, #2, #3 and #4), and 4 additional client (#5, #6, #7 and #8), the facility's governing body neglected to ensure clients' living spaces were kept in a sanitary condition.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 3/31/15 from 6:00</p>	W 104	<p>Client #7's room will be deep cleaned. A cleaning checklist specific for Client #7's bedroom will be put into place. This cleaning checklist will be used formally, and informally as needed. All Direct Support Professionals will be trained on the new cleaning checklist for Client #7's bedroom. An IDT was conducted on 5-1-2015 regarding Client 7 and his urination concerns. The team decided to order</p>	05/17/2015

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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W 149 Bldg. 00	<p>A.M. until 7:40 A.M.. Upon entering the group home there was a strong odor.</p> <p>An evening observation was conducted at the group home on 3/31/15 from 3:10 P.M. until 5:10 P.M.. Upon entering the group home there was a strong odor.</p> <p>An interview with DSP #1 was conducted on 3/31/15 at 6:15 A.M.. DSP #1 indicated client #7 urinates in his bed every night and further indicated staff at the group home have tried getting the urine smell out of client #7's bedroom, but have had no success at doing so.</p> <p>An interview with the Area Director (AD) was conducted on 4/1/15 at 4:00 P.M.. The AD indicated the group home should not smell of urine.</p> <p>9-3-1(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 3 of 4 sampled clients (#1, #2 and #3), and 1 additional client (#6), the facility</p>	W 149	<p>a new monitor that can be placed on the bed to detect any wetness. This will assist staff with getting any urination messes cleaned up quicker.</p> <p>The team also decided that Client #7 will be placed on a toileting schedule for in the middle of the night to assist with the amount of urination in his Depends. The client will continue to utilize the Depends and the bed mats to assist with the ongoing urination and smell.</p> <p>Ongoing, the Home Manager will check the client's bedroom each morning, upon arrival to the house, to ensure that no urine smell is detected and the cleaning checklist has been completed.</p> <p>Ongoing, the Program Director/QIDP (QIDP) will complete a monthly walk thru of the home to ensure that the staff are appropriately cleaning the house.</p> <p>Responsible Party: Home Manager and Program Director/QIDP</p> <p>The Direct Support Professionals will be retrained on reporting all incidents to the Home Manager. This training will include Indiana</p>	05/17/2015	

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	<p>neglected to implement written policy and procedures to prevent abuse/neglect of clients in regard to preventing client to client aggression and documenting/reporting Injuries of Unknown Origin (IUO).</p> <p>Findings include:</p> <p>A review of the group home staff communication record was conducted on 3/31/15 at 6:30 A.M.. Review of the record indicated:</p> <p>-Entry dated 1/4/15 involving client #6: "[Client #6] from home (visit) her left eye has a red or blood spot on it."</p> <p>-Entry dated 2/21/15 involving client #3 indicated: "[Client #3] has 7 scratches on her right arm. She and [client #1] are saying [client #1] scratched her yesterday. I (staff) cleansed area and applied Bacitracin (antibiotic ointment)."</p> <p>-Entry dated 3/6/15 involving client #1 indicated: "[Client #1's] right eye is swollen. It may just be because he slept on that side. He is saying [client #3] slapped him yesterday, but his glasses are okay, so I don't know."</p> <p>A review of client #1's record was conducted on 4/1/15 at 11:30 A.M..</p>		<p>MENTOR's policy and procedures on incident reporting.</p> <p>The Home Manager will be retrained on reporting all incidents to the Program Director/QIDP and/or administrator for further review, per the Indiana MENTOR policy and procedures.</p> <p>The Direct Support Professionals will be retrained on the difference between recording and reporting. This retraining will include who to report to, and what to document the reporting on. It will also include that Direct Support Professionals should document in the staff reporting log what incidents were reported, to who, when the report was made, and what follow up the staff completed as a result.</p> <p>The Home Manager will also be retrained on reviewing the documents, including but not limited to the staff communication log, for any unreported incidents.</p> <p>The Home Manager will complete the documentation review form and ensure that all staff are made aware of the missing documentation or reports. The Home Manager will initial on each report so that it is noted that he was made aware. The Program Director/QIDP will review these on a monthly basis to ensure that no incident goes unreported by the Home Manager.</p> <p>Ongoing, all Direct Support Professionals will report the incidents to their Home Manager for further review.</p>	

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	<p>Review of client #1's Behavior Program Reports (BPRs)-Narrative Notes indicated:</p> <p>-BPR dated 10/7/14 involving client #1 and client #2 indicated: "On the van...On the way home from bible study...[Client #1] spit on [client #2] for no reason."</p> <p>-BPR dated 11/3/14 involving client #1 and another client (unidentified in record) indicated: "[Client #1] scratching another resident...Another resident told [client #1] to stop singing. [Client #1] went over to other resident and scratched his neck and nose."</p> <p>-BPR dated 12/5/14 involving client #1 and client #3 indicated: "[Client #3] sat on couch in the living room and [client #1] was yelling no work. [Client #3] said to him to keep quiet, shut your mouth up then [client #1] move (sic) to her and scratched her on her nose and neck."</p> <p>-BPR dated 1/13/15 involving client #1 and another resident (unidentified in record) indicated: "[Client #1] was in the med room refused to come out for other peers to come in. After a peer came in [client #1] grabbed her and started hitting her."</p> <p>-BPR dated 1/13/15 involving client #1</p>		<p>Ongoing, the Home Manager will report all incidents to the Program Director/QIDP so that the appropriate forms can be completed per the Indiana MENTOR policy and procedures.</p> <p>Responsible Party: Home Manager and Program Director/QIDP</p>	

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	<p>and another peer (unidentified in record) indicated: "Within 10 minutes [client #1] spit on peer 2 times and then through (sic) his yo yo across the room trying to hit another peer."</p> <p>A review of the facility's records was conducted at the facility's administrative office on 3/31/15 at 11:45 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IRs) and investigation records failed to indicate the above mentioned incidents were documented and reported to the administrator.</p> <p>A review of the facility's policy dated April 2011 was conducted on 3/31/15 at 6:00 P.M.. Review of the policy entitled "Quality and Risk Management" 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. 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</p>			

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9-3-2(a)	<p>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.</p> <p>An interview with the Group Home Manager (GHM) was conducted on 3/31/15 at 3:32 P.M.. The GHM indicated the documented incidents were not documented on IRs or immediately reported to the administrator. The GHM indicated staff call him on the phone and make him aware of the incidents. No documentation was available for review to indicate the mentioned incidents were reported to the administrator, on an IR or BDDS.</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 4/1/15 at 2:45 P.M.. The PD/QIDP indicated all staff are trained on the facility's documentation and reporting/Abuse/Neglect policy upon hire, annually and as needed. The PD/QIDP indicated staff should have immediately documented an IR and reported the mentioned incidents of IUO and client to client aggression to the administrator.</p>			

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W 153 Bldg. 00	<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, the facility failed for 3 of 4 sampled clients (#1, #2, #3), and one additional client (#6), to report injuries of unknown origin immediately to the administrator.</p> <p>Findings include:</p> <p>A review of the group home staff communication record was conducted on 3/31/15 at 6:30 A.M.. Review of the record indicated:</p> <p>-Entry dated 1/4/15 involving client #6: "[Client #6] from home (visit) her left eye has a red or blood spot on it."</p> <p>-Entry dated 2/21/15 involving client #3 indicated: "[Client #3] has 7 scratches on her right arm. She and [client #1] are</p>	W 153	<p>The Direct Support Professionals will be retrained on reporting all incidents to the Home Manager. This training will include Indiana MENTOR's policy and procedures on incident reporting. The Home Manager will be retrained on reporting all incidents to the Program Director/QIDP and/or administrator for further review, per the Indiana MENTOR policy and procedures. The Direct Support Professionals will be retrained on the difference between recording and reporting. This retraining will include who to report to, and what to document the reporting on. It will also include that Direct Support Professionals should document in the staff reporting log what incidents were reported, to who, when the report was made, and what follow up the</p>	05/17/2015

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	<p>saying [client #1] scratched her yesterday. I (staff) cleansed area and applied Bacitracin."</p> <p>-Entry dated 3/6/15 involving client #1 indicated: "[Client #1's] right eye is swollen. It may just be because he slept on that side. He is saying [client #3] slapped him yesterday, but his glasses are okay, so I don't know."</p> <p>A review of client #1's record was conducted on 4/1/15 at 11:30 A.M.. Review of client #1's Behavior Program Reports (BPRs)-Narrative Notes indicated:</p> <p>-BPR dated 10/7/14 involving client #1 and client #2 indicated: "On the van...On the way home from bible study...[Client #1] spit on [client #2] for no reason."</p> <p>-BPR dated 11/3/14 involving client #1 and another client (unidentified in record) indicated: "[Client #1] scratching another resident...Another resident told [client #1] to stop singing. [Client #1] went over to other resident and scratched his neck and nose."</p> <p>-BPR dated 12/5/14 involving client #1 and client #3 indicated: "[Client #3] sat on couch in the living room and [client #1] was yelling no work. [Client #3] said</p>		<p>staff completed as a result.</p> <p>The Home Manager will also be retrained on reviewing the documents, including but not limited to the staff communication log, for any unreported incidents.</p> <p>The Home Manager will complete the documentation review form and ensure that all staff are made aware of the missing documentation or reports. The Home Manager will initial on each report so that it is noted that he was made aware. The Program Director/QIDP will review these on a monthly basis to ensure that no incident goes unreported by the Home Manager.</p> <p>Ongoing, all Direct Support Professionals will report the incidents to their Home Manager for further review.</p> <p>Ongoing, the Home Manager will report all incidents to the Program Director/QIDP so that the appropriate forms can be completed per the Indiana MENTOR policy and procedures.</p> <p>Responsible Party: Home Manager and Program Director/QIDP</p>	

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	<p>to him to keep quiet, shut your mouth up then [client #1] move (sic) to her and scratched her on her nose and neck."</p> <p>-BPR dated 1/13/15 involving client #1 and another resident (unidentified in record) indicated: "[Client #1] was in the med room refused to come out for other peers to come in. After a peer came in [client #1] grabbed her and started hitting her."</p> <p>-BPR dated 1/13/15 involving client #1 and another peer (unidentified in record) indicated: "Within 10 minutes [client #1] spit on peer 2 times and then through (sic) his yo yo across the room trying to hit another peer."</p> <p>A review of the facility's records was conducted at the facility's administrative office on 3/31/15 at 11:45 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IRs) and investigation records failed to indicate the above mentioned incidents were documented and reported to the administrator.</p> <p>An interview with the Group Home Manager (GHM) was conducted on 3/31/15 at 3:32 P.M.. The GHM indicated the documented incidents were not documented on IRs or immediately</p>			

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W 189 Bldg. 00	<p>reported to the administrator. The GHM indicated staff call him on the phone and make him aware of the incidents. No documentation was available for review to indicate the mentioned incidents were reported to the administrator or on an IR.</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 4/1/15 at 2:45 P.M.. PD/QIDP indicated staff should have immediately documented an IR and reported the mentioned incidents of IUO and client to client aggression to the administrator. The PD/QIDP further indicated there was no documentation to indicate the administrator and BDDS were notified of the injuries of unknown origin and client to client aggression.</p> <p>9-3-2(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p>			

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	<p>Based on record review and interview for 3 of 4 sampled clients (#1, #2, and #3), and 1 additional client (#6), the facility failed to ensure all staff who worked with the clients were sufficiently trained to assure competence in immediately reporting injuries of unknown origin and client to client aggression.</p> <p>Findings include:</p> <p>A review of the group home staff communication record was conducted on 3/31/15 at 6:30 A.M.. Review of the record indicated:</p> <p>-Entry dated 1/4/15 involving client #6: "[Client #6] from home (visit) her left eye has a red or blood spot on it."</p> <p>-Entry dated 2/21/15 involving client #3 indicated: "[Client #3] has 7 scratches on her right arm. She and [client #1] are saying [client #1] scratched her yesterday. I (staff) cleansed area and applied Bacitracin (antibiotic ointment)."</p> <p>-Entry dated 3/6/15 involving client #1 indicated: "[Client #1's] right eye is swollen. It may just be because he slept on that side. He is saying [client #3] slapped him yesterday, but his glasses are okay, so I don't know."</p>	W 189	<p>The Direct Support Professionals will be retrained on reporting all incidents to the Home Manager. This training will include Indiana MENTOR's policy and procedures on incident reporting.</p> <p>The Home Manager will be retrained on reporting all incidents to the Program Director/QIDP and/or administrator for further review, per the Indiana MENTOR policy and procedures.</p> <p>The Direct Support Professionals will be retrained on the difference between recording and reporting. This retraining will include who to report to, and what to document the reporting on. It will also include that Direct Support Professionals should document in the staff reporting log what incidents were reported, to who, when the report was made, and what follow up the staff completed as a result.</p> <p>The Home Manager will also be retrained on reviewing the documents, including but not limited to the staff communication log, for any unreported incidents.</p> <p>The Home Manager will complete the documentation review form and ensure that all staff are made aware of the missing documentation or reports. The Home Manager will initial on each report so that it is noted that he was made aware. The Program Director/QIDP will review these on a monthly basis to ensure that no incident goes unreported by the Home Manager.</p>	05/17/2015

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	<p>her."</p> <p>-BPR dated 1/13/15 involving client #1 and another peer (unidentified in record) indicated: "Within 10 minutes [client #1] spit on peer 2 times and then through (sic) his yo yo across the room trying to hit another peer."</p> <p>A review of the facility's records was conducted at the facility's administrative office on 3/31/15 at 11:45 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IRs) and investigation records failed to indicate the above mentioned incidents were documented and reported to the administrator.</p> <p>An interview with the Group Home Manager (GHM) was conducted on 3/31/15 at 3:32 P.M.. The GHM indicated the documented incidents were not documented on IRs or immediately reported to the administrator. The GHM indicated staff call him on the phone and make him aware of the incidents. No documentation was available for review to indicate the mentioned incidents were reported to the administrator or on an IR.</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was</p>			

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W 249 Bldg. 00	<p>conducted on 4/1/15 at 2:45 P.M.. The PD/QIDP indicated all staff are trained on the facility's documentation and reporting/Abuse/Neglect policy upon hire, annually and as needed. The PD/QIDP indicated staff should have immediately documented an IR and reported the mentioned incidents of IUO and client to client aggression to the administrator.</p> <p>9-3-3(a)</p> <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. Based on observation, record review, and interview, the facility failed to implement written objectives during times of opportunity for 2 of 2 clients (clients #6 and #7), observed during medication administration.</p> <p>Findings include:</p>	W 249	The Direct Support Professionals will be retrained on medication administration; specifically on including the medication goals each time that medication administration is completed with each client. After the retraining occurs, the Home Manager will complete two (2) weekly medication administration observations to ensure that the medication goals are	05/17/2015

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	<p>A morning observation was conducted at the group home on 3/31/15 from 6:00 A.M. until 7:40 A.M.. At 7:00 A.M. Direct Support Professional (DSP) #1 began administering client #7's prescribed oral medications. DSP #1 retrieved each of client 7's medication packets, popped each medication into a medication cup, handed the medication cup to client #7 and prompted him to take his medications. Client #7 did not identify any of his medications and there was no teaching or training during this medication administration.</p> <p>An evening observation was conducted at the group home on 3/31/15 from 3:10 P.M. until 5:10 P.M.. At 4:50 P.M., DSP #5 administered client #6's prescribed medications. DSP #5 retrieved client #6's medications, popped them out into a medication cup and handed the medications to client #6. Client #6 did not and was not prompted to name her medications and there was no teaching or training during this medication administration.</p> <p>A review of client #5's record was conducted on 4/1/15 at 2:55 P.M.. Client #5's "Monthly Summary" training objective record dated 3/15 indicated: "Will increase medication skills /daily. Will name her medications."</p>		<p>being completed with each client as specified for four (4) weeks. These will then be reviewed by the Program Director/QIDP ensuring that there are no further training needs.</p> <p>After the initial four (4) weeks, the Home Manager and/or Program Director/QIDP will complete weekly medication administration observations ongoing, and will ensure that all needed retrainings will be completed.</p> <p>Ongoing each DSP will work with each client during medication administration on their specific Individualized Support Plan that states each medication goal.</p> <p>Responsible Party: Home Manager and Program Director/QIDP</p>	

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W 369 Bldg. 00	<p>A review of client #7's record was conducted on 4/1/15 at 2:48 P.M.. Client #7's "Monthly Summary" training objective record dated 3/15 indicated: "Will increase medication skill. [Client #7] will identify his Luvox (obsessive compulsive disorder) medication by name."</p> <p>The Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was interviewed on 4/1/15 at 2:45 P.M.. The PD/QIDP stated client objectives should be implemented "at all times of opportunity."</p> <p>9-3-4(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview, the facility failed for 1 of 2</p>	W 369	The Direct Support Professionals will be retrained on medication administration. This training will	05/17/2015

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	<p>clients observed during the morning medication administration (client #7) to ensure staff administered 1 of 5 of the client's medications, as ordered without error.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 3/31/15 from 6:00 A.M. until 7:40 A.M.. At 7:00 A.M., Direct Support Professional (DSP) #1 began administering client #7's prescribed oral medications. DSP #1 retrieved a nasal spray out of client #7's medication bin and sprayed once in each of client #7's nostrils. At 7:05 A.M., DSP #1 retrieved client #7's prescribed eye drops and administered one drop into each of client #7's eyes. A review of the medication labels and Medication Administration Record (MAR) dated 3/1/15 to 3/31/15 was conducted on 3/31/15 at 7:10 A.M. and indicated "Flonase .05% Nasal Spray...2 sprays in each nostril for allergies...Artificial Tears...2 drops into each eye twice daily." DSP #1 did not spray two sprays into client #7's nostrils as ordered and did not administer 2 drops into each of client #7's eyes as ordered..</p> <p>An interview with the facility's Qualified Intellectual Disabilities Professional</p>		<p>include the specific doses for each medication, which must be according to what is listed on the Med Sheets.</p> <p>After the retraining occurs, the Home Manager will complete two (2) weekly medication administration observations to ensure that the administration is being completed according to Indiana MENTOR policy and procedures for four (4) weeks. These will then be reviewed by the Program Director ensuring that there are no further training needs. After the initial four (4) weeks, the Home Manager and/or Program Director will complete weekly medication administration observations ongoing, and will ensure that all needed future retrainings will be completed. Ongoing each DSP will complete Medication Administration as expected by Indiana MENTOR's policy and procedures.</p> <p>Responsible Party: Home Manager and Program Director/QIDP</p>	

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W 440 Bldg. 00	<p>(QIDP) was conducted on 4/1/15 at 2:45 P.M.. The QIDP indicated DSP #1 should have administered client #7's medications as ordered.</p> <p>9-3-6(a)</p> <p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills which affected 8 of 8 clients living in the facility (clients #1, #2, #3, #4, #5, #6, #7 and #8).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 3/31/15 at 6:10 A.M.. The review failed to indicate the facility held an evacuation drill for clients #1, #2, #3, #4, #5, #6, #7 and #8 during the morning staff shift (8:00 A.M. to 4:00 P.M.) for the third quarter (July 1st through September 30th) of 2014 and no drills were available for review to indicate the facility held evacuation drills during the morning staff shift (8:00 A.M. to 4:00 P.M.), evening shift (4:00 P.M. to 12:00 P.M.) and the</p>	W 440	<p>All Direct Support Professionals will receive a retraining every other month to ensure that they understand the importance of completing the monthly fire drills. The retraining will include reviewing a copy of the Fire Drill Schedule. Ongoing, the Direct Support Professionals will complete one fire drill per month (or more as needed) according to the schedule to ensure that the health and safety of the client's needs are met. Ongoing, all completed fire drill reports will be turned in to and reviewed by Quality Assurance for accuracy and thoroughness of each drill.</p> <p>Responsible Party: Home Manager and Program Director/QIDP</p>	05/17/2015

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W 455 Bldg. 00	<p>overnight shift (12:00 A.M. to 8:00 A.M.) for the first quarter (January 1 through March 31) of 2015.</p> <p>The Area Director (AD) was interviewed on 4/1/15 4:15 P.M.. The AD indicated evacuation drills are to be conducted during each quarter for each shift of personnel.</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview, the facility failed to maintain proper hygiene practices and prevent cross contamination, for 4 of 4 sampled clients and 4 additional clients (clients #1, #2, #3, #4, #5, #6, #7 and #8), observed during meal time.</p> <p>Findings include:</p> <p>A morning observation, including breakfast, was conducted at the group home on 3/31/15 from 6:00 A.M. until 7:40 A.M.. At 7:17 A.M., client #4, sneezed into his hand. Client #4 then</p>	W 455	All Direct Support Professionals will be retrained on Indiana MENTOR's policy and Procedure regarding Infection Control. The DSPs will be retrained on ensuring the clients wash their hands before and after they eat. The clients will be retrained on ensuring they wash their hands before and after they eat. The Program Director will complete 2 weekly active treatment observations for 4 weeks, and then 1 per week afterwards to ensure that the infection control policy is being instructed and utilized as expected. Ongoing, the Area Director will complete quarterly pop in visits to ensure	05/17/2015

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W 460 Bldg. 00	<p>stuck his hand into the box of cereal to unfold the plastid and began pouring cereal into his bowl. Client #4 then placed the box of cereal on the table for the other clients to use. Client #4 did not and was not prompted to wash his hands.</p> <p>An evening meal observation was conducted at the group home on 3/31/15 from 3:10 P.M. until 5:10 P.M.. At 4:10 P.M., Direct Support Professional (DSP) #4 prompted client #7 to set the dining table for dinner. Client #7 began setting clients #1, #2, #3, #4, #5, #6 and #7's place settings. While setting the table client #7 sneezed into his hand, wiped his nose and continued to set the table. Client #7 did not and was not prompted to wash his hands.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/1/15 at 2:45 P.M.. The QIDP indicated staff should have prompted clients #4 and #7 to wash their hands before handling the cereal, tableware, cups and bowls.</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and</p>		that all policies and procedures are being followed. Responsible Party: Home Manager and Program Director/QIDP		

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	<p>specially-prescribed diets.</p> <p>Based on observation, record review and interview, for 3 of 4 sampled clients (#1, #2, and #3), and 1 additional client (#5), the facility failed to assure menus were developed to assure the staff provided food in accordance with the clients' diagnoses of GERD (Gastroesophageal Reflux Disease) and failed to follow the physician's dietary order.</p> <p>Findings include:</p> <p>A morning observation was conducted on 3/31/15 from 6:00 A.M. until 7:40 A.M.. At 7:15 A.M., client #2 was observed eating breakfast which consisted of a bowl of cold cereal. Client #2 did not and was not prompted to drink 2-8 ounce glasses of water before eating his meal.</p> <p>An evening observation was conducted at the group home on 3/31/15 from 3:10 P.M. until 5:10 P.M.. At 5:00 P.M., clients #1, #2 and #3 were observed eating their dinner which consisted of bar-b-que beef brisket, mashed potatoes, green beans, salad, hamburger bun, apple sauce and kool aid. Client #2 did not and was not prompted to drink 2-8 ounce glasses of water before eating his meal.</p> <p>A review of the dinner menu for 3/31/15</p>	W 460	<p>All Direct Support Professionals will be retrained on the physician's orders for each client in the home. Ongoing, each staff will ensure that client #2 drinks 2 glasses of water before his meals as ordered. All Direct Support Professionals will be retrained on the GERD protocols for clients 1 and 3. The Home Manager and staff will be retrained on utilizing a menu made available for individuals with GERD. The Home Manager and/or Program Director will complete 2 weekly meal time observations for 4 weeks, and then 1 per week afterwards to ensure that the physician orders and diet restrictions are being followed. Ongoing, the Direct Support Professionals will follow all diet restrictions and protocols. Responsible Party: Home Manager and Program Director/QIDP</p>	05/17/2015

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	<p>was conducted on 3/31/15 at 4:30 P.M. and indicated: "Regular menu." There was no menu that addressed clients #1 and #3's diagnoses of GERD.</p> <p>A review of client #1's record was conducted on 4/1/15 at 11:30 A.M.. Review of client #1's record indicated a most current physicians order dated 3/1/15 to 3/31/15 which indicated client #1 was prescribed "Ranitidine 300 mg (milligrams) (GERD)...Take 1 tablet by mouth every morning...Omeprazole 20 mg capsule...1 capsule by mouth every morning." Further review of the record indicated client #1 had a "Gastroesophageal Reflux Disease Protocol" dated 3/9/15 which indicated: "GERD...avoid spicy foods, adequate fluids, administer routine medications...."</p> <p>A review of client #2's record was conducted on 4/1/15 at 12:30 P.M.. Review of client #2's record indicated a most current physicians order dated 3/1/15 to 3/31/15 which indicated: "Give (2) 8 oz (ounce) glasses of H2O (water) before meals to aid in satiety and help avoid."</p> <p>A review of client #3's record was conducted on 4/1/15 at 2:00 P.M.. Review of client #3's record indicated a most current physicians order dated</p>			

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	<p>3/1/15 to 3/31/15 which indicated client #3 was prescribed "Ranitidine 300 mg (milligrams) (GERD)...Take 1 tablet by mouth every morning...Omeprazole 20 mg capsule...1 capsule by mouth every morning." Further review of the record indicated client #3 had a "Gastroesophageal Reflux Disease Protocol" dated 3/9/15 which indicated: "GERD...avoid spicy foods, adequate fluids, administer routine medications...."</p> <p>A review of client #5's record was conducted on 4/1/15 at 2:30 P.M.. Review of client #5's record indicated a most current physicians order dated 3/1/15 to 3/31/15 which indicated client #5 was prescribed "Ranitidine 300 mg (milligrams) (GERD)...Take 1 tablet by mouth every morning." Further review of the record indicated client #5 had a "Gastroesophageal Reflux Disease Protocol" dated 3/9/15 which indicated: "GERD...avoid spicy foods, adequate fluids, administer routine medications...."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/1/15 at 2:45 P.M.. The QIDP indicated the facility's Dietician had not developed menus for clients #1, #2, #3's and #5's diagnoses of GERD. The QIDP further indicated staff should follow the clients' ordered diets</p>			

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	and should have prompted client #2 to drink two glasses of water before his meals as ordered by his physician. 9-3-8(a)				