

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G225	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/21/2014
NAME OF PROVIDER OR SUPPLIER  REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362		
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W000000	<p>This visit was for a pre-determined full annual recertification and state licensure survey.</p> <p>This visit resulted in an IMMEDIATE JEOPARDY.</p> <p>Dates of Survey: March 10, 11,12, 13, 17 and 21, 2014.</p> <p>Provider Number: 15G225 Facility Number: 000749 AIM Number: 100243360</p> <p>Surveyor: Kathy Wanner, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/26/14 by Ruth Shackelford, QIDP.</p>	W000000			

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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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review, observation and interview, the Condition of Participation: Governing Body and Management is not met for 2 of 4 additional clients (clients #5 and #7). The governing body failed to develop and implement a system to protect 2 of 4 additional clients who lived in the home (clients #5 and #7) from potential harm from high water temperatures in the home.</p> <p>Findings include:</p> <p>1. Please refer to W104. The governing body failed to exercise operating direction over the facility to develop and implement a system to regulate and monitor hot water temperatures in the home for 2 of 4 additional clients who lived in the home (clients #5 and #7) who were unable to independently mix hot and cold water.</p> <p>2. Please refer to W406. The Condition of Participation: Physical Environment was not met due to the facility failing to regulate and monitor the hot water temperature at the group home for 2 of 4 additional clients who lived in the home (clients #5 and #7) who were unable to</p>	W000102	<p><b>1. What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Maintenance has been contacted and installed an anti-scald device</li> <li>· Staff will be retrained on monitoring, documenting and reporting water temperatures.</li> <li>· Staff will do nightly water temperature checks.</li> <li>· Water assessments will be conducted on every client, yearly, to determine independence with mixing and self-regulating temperature.</li> <li>· Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards.</li> <li>· Home Manager will evaluate water temperatures, weekly, to ensure group home meets safety standards. Any issues will be reported to Program Director and Maintenance.</li> </ul> <p><b>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the same</li> </ul>	04/20/2014			

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	independently mix hot and cold water.  9-3-1(a)		<p>deficient practice.</p> <ul style="list-style-type: none"> <li>· Maintenance has been contacted and installed an anti-scald device</li> <li>· Staff will be retrained on monitoring, documenting and reporting water temperatures.</li> <li>· Staff will do nightly water temperature checks.</li> <li>· Water assessments will be conducted on every client, yearly, to determine independence with mixing and self-regulating temperature.</li> <li>· Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards.</li> <li>· Home Manager will evaluate water temperatures, weekly, to ensure group home meets safety standards. Any issues will be reported to Program Director and Maintenance.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Maintenance has been contacted and installed an anti-scald device</li> <li>· Staff will be retrained on monitoring, documenting and reporting water temperatures.</li> <li>· Staff will do nightly water temperature checks.</li> <li>· Water assessments will be conducted on every client, yearly, to</li> </ul>		

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			<p>determine independence with mixing and self-regulating temperature.</p> <ul style="list-style-type: none"> <li>Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards.</li> <li>Home Manager will evaluate water temperatures, weekly, to ensure group home meets safety standards. Any issues will be reported to Program Director and Maintenance.</li> </ul> <p><b>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards.</li> <li>Home Manager will evaluate water temperatures, weekly, to ensure group home meets safety standards. Any issues will be reported to Program Director and Maintenance.</li> </ul> <p><b>5. What is the date by which the systemic changes will be completed?</b></p> <p>4/20/14</p>		

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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, record review and interview for 2 of 4 additional clients (clients #5 and #7), the governing body failed to exercise operating direction over the facility to develop and implement a system to regulate and monitor hot water temperatures in the home.  Findings include:  Water temperatures were taken at the group home during the 3/10/14 observation period from 4:47 P. M until 6:53 P.M. At 6:24 P.M. the sink in the bathroom used by clients #1, #2, #3, #4, #5, #6, #7 and #8 was measured at 135.5 degrees Fahrenheit. At 6:22 P.M. the kitchen sink used by clients #1, #2, #3, #4, #5, #6, #7 and #8 was measured at 129.5 degrees Fahrenheit. At 6:28 P.M. the sink in the bathroom with the walk-in-shower used by clients #1, #2, #3, #4, #5, #6, #7 and #8 was at 133.3 degrees Fahrenheit and at 6:26 P.M. the shower was measured at 124.3 degrees Fahrenheit. Client #5 ambulated independently and rapidly in his wheelchair throughout the group home during the observation period. Staff were not with client #5 at all times when he</p>	W000104	<p><b>1. What corrective action will be accomplished?</b> · Maintenance has been contacted and installed an anti-scald device · Staff will be retrained on monitoring, documenting and reporting water temperatures. · Staff will do nightly water temperature checks. · Water assessments will be conducted on every client, yearly, to determine independence with mixing and self-regulating temperature. · Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards. · Home Manager will evaluate water temperatures, weekly, to ensure group home meets safety standards. Any issues will be reported to Program Director and Maintenance. <b>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> · All residents have the potential to be affected by the same deficient practice. · Maintenance has been contacted and installed an anti-scald device · Staff will be retrained on monitoring, documenting and reporting water temperatures. · Staff will do nightly water temperature checks. · Water</p>	04/20/2014			

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	<p>was in the areas of the hallway bathrooms. Client #7 ambulated independently in his electric wheelchair throughout the home. Staff were not with client #7 at all times.</p> <p>Client #1 was interviewed on 3/10/14 at 6:35 P.M. Client #1 stated, "Sometimes the tub is too cold. Then the shower scalds you." Client #1 indicated he knew how to adjust the water so it would not be too hot or cold.</p> <p>Client #6 was interviewed on 3/10/14 at 6:38 P.M. Client #6 stated, "It gets too hot."</p> <p>Direct Care Staff (DCS) #3 was interviewed on 3/10/14 at 6:48 P.M. When asked if the clients living in the home were able to regulate water temperature, he stated, "I think most of them can, maybe not [client #5] and [client #7], but we have to physically assist them with their showers anyway. We don't have them wash their hands by themselves. There have never been any problems with anyone getting hurt."</p> <p>DCS #1 was interviewed on 3/10/14 at 6:28 P.M. When asked if all the clients could adjust water temperatures safely, DCS #1 stated, "Yes, they can all mix water safely maybe not the two in</p>		<p>assessments will be conducted on every client, yearly, to determine independence with mixing and self-regulating temperature. · Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards. · Home Manager will evaluate water temperatures, weekly, to ensure group home meets safety standards. Any issues will be reported to Program Director and Maintenance. <b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> · Maintenance has been contacted and installed an anti-scald device · Staff will be retrained on monitoring, documenting and reporting water temperatures. · Staff will do nightly water temperature checks. · Water assessments will be conducted on every client, yearly, to determine independence with mixing and self-regulating temperature. · Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards. · Home Manager will evaluate water temperatures, weekly, to ensure group home meets safety standards. Any issues will be reported to Program Director and Maintenance. <b>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</b> · Quarterly</p>		

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	<p>wheelchairs (clients #5 and #7) but we help them bathe."</p> <p>Client #5's records were reviewed on 3/11/14 at 12:01 P.M. Client #5's Hot Water Adjustment Review/Assessment dated 1/8/14 indicated client #5 "Requires physical assistance to adjust water temperatures."</p> <p>Client #7's records were reviewed on 3/11/14 at 12:05 P.M. Client #7's Hot Water Adjustment Review/Assessment dated 1/8/14 indicated client #7 "Requires physical assistance to adjust water temperatures."</p> <p>A Water Temp Check dated 1/15/2014 at 10:48 A.M. was reviewed on 3/11/14 at 12:25 P.M. indicating the water temperature was 108 degrees Fahrenheit. There were no other Water Temp Check forms available for review.</p> <p>The Program Director (PD) was interviewed on 3/11/14 at 11:55 A.M. and stated, "He (client #5) can wash his hands by himself." The PD indicated client #7 required physical assistance from staff to wash his hands.</p> <p>The Residential Director (RD) was interviewed again on 3/11/14 at 1:45 P.M. and indicated he was part of the</p>		<p>Health and Safety Assessments will be conducted to ensure group home meets safety standards. · Home Manager will evaluate water temperatures, weekly, to ensure group home meets safety standards. Any issues will be reported to Program Director and Maintenance. <b>5. What is the date by which the systemic changes will be completed?</b> 4/20/14</p>				

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	governing body and was responsible to ensure water temperatures were regulated in the home. The RD stated, "Water check documentation was the responsibility of the PD and HM (home manager). Normally we do the checks three times a week and one time on the weekend, we used to do them monthly." The RD indicated he was aware there was only one documented water check available for review. He further indicated clients were supervised while bathing and showering.  9-3-1(a)			
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W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review, the facility failed to allow unrestricted access to bread for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients (#5, #6, #7 and #8).</p> <p>Findings include:</p> <p>Observations of the evening meal were conducted on 3/10/14 between 4:47 P. M. and 6:53 P.M. At 6:05 P.M. Direct Care Staff (DCS) #3 got a loaf of bread from a locked cabinet in the medication/laundry room, placed slices of bread onto a plate and set it on the table.</p> <p>Client #1 was interviewed on 3/11/14 at 7:30 A.M. He stated, "They keep the bread locked up so they don't steal it. It is in the med cabinet in the laundry room."</p> <p>Observations of the locked medication cabinets were conducted on 3/12/14 at 7:40 A.M. The locked medication cabinet contained loaves of bread, a jar of peanut butter, diet bars, bottles of orange juice</p>	W000125	<p><b>1. What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Bread and other food items will be accessible to clients at all times.</li> <li>· Staff will be retrained on clients' rights and food storage.</li> <li>· Home Manager will monitor the storage and accessibility of food. Any issues will be addressed with staff and reported to Program Director.</li> </ul> <p><b>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the same deficient practice.</li> <li>· Bread and other food items will be accessible to clients at all times.</li> <li>· Staff will be retrained on clients' rights and food storage.</li> <li>· Home Manager will monitor the storage and accessibility of food. Any issues will be addressed with</li> </ul>	04/20/2014			

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	<p>and bottles of protein drinks.</p> <p>DCS #4 was interviewed on 3/12/14 at 7:42 A.M. "Yeah, we keep [client #4's] diet bars locked up for him at his request. I heard the bread is locked up because the guys (clients #1, #2, #3, #4, #5, #6, #7 and #8) went through 9 loaves of bread in three days. There is a jar of peanut butter in the kitchen, this one is just an extra jar. The orange juice is for [client #3] to take with his medication."</p> <p>Client #1's record was reviewed on 3/12/14 at 11:36 A.M. Client #1's record did not include informed consent by client #1, his POA (power of attorney) or the Human Rights Committee (HRC) for locking up the bread in the home.</p> <p>Client #2's record was reviewed on 3/12/14 at 12:55 P.M. Client #2's record did not include informed consent by client #2 or the HRC for locking up the bread in the home.</p> <p>Client #3's record was reviewed on 3/12/14 at 1:09 P.M. Client #3's record did not include informed consent by client #3, his guardian or the HRC for locking up the bread in the home.</p> <p>Client #4's record was reviewed on 3/12/14 at 1:25 P.M. Client #4's record</p>		<p>staff and reported to Program Director.</p> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Bread and other food items will be accessible to clients at all times.</li> <li>· Staff will be retrained on clients' rights and food storage.</li> <li>· Home Manager will monitor the storage and accessibility of food. Any issues will be addressed with staff and reported to Program Director.</li> </ul> <p><b>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Home Manager will monitor the storage and accessibility of food. Any issues will be addressed with staff and reported to Program Director.</li> </ul> <p><b>5. What is the date by which the systemic changes will be completed?</b></p> <p>4/20/14</p>				

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	<p>did not include informed consent by client #4, his Health Care Representative (HCR) or the HRC for locking up the bread in the home.</p> <p>Client #5's record was reviewed on 3/12/14 at 1:28 P.M. Client #5's record did not include informed consent by client #5, his POA or the HRC for locking up the bread in the home.</p> <p>Client #6's record was reviewed on 3/12/14 at 1:30 P.M. Client #6's record did not include informed consent by client #6 or the HRC for locking up the bread in the home.</p> <p>Client #7's record was reviewed on 3/12/14 at 1:32 P.M. Client #7's record did not include informed consent by client #7, his guardian or the HRC for locking up the bread in the home.</p> <p>Client #8's record was reviewed on 3/12/14 at 1:35 P.M. Client #8's record did not include informed consent by client #8, his guardian or the HRC for locking up the bread in the home.</p> <p>The Program Director (PD) was interviewed on 3/13/14 at 3:35 P.M. The PD stated "The bread should not be locked up. I was not aware it was locked."</p>			
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	<p>The Residential Director (RD) was interviewed on 3/13/14 at 4:11 P.M. and indicated he was unaware food items were locked up. The RD indicated the food items should not be locked up.</p> <p>9-3-2(a)</p>			
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W000209	<p>483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.</p> <p>Based on record review and interview, the facility failed to insure participation by the client and/or their guardian or advocate in the Individual Program Plan/Behavior Support Plan process for 3 of 4 sampled clients (clients #1, #3 and #4).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 3/12/14 at 11:36 A.M. Client #1's Individual Support Plan (ISP) dated 5/14/13 indicated he had a POA (Power of Attorney) to assist him with decision making. Client #1's Behavior Support Plan (BSP) dated 5/20/13 indicated he was prescribed the following medications for behavior management, Abilify (anti psychotic) for schizophrenia, Lithium (antimanic) for schizophrenia, Trileptal (anticonvulsant) for schizophrenia, and Klonopin (anticonvulsant) for schizophrenia. There was no indication client #1 and/or his POA had participated in the ISP and BSP developmental process.</p> <p>Client #3's record was reviewed on</p>	W000209	<p>Participation by the client, his and her parent (if the client is the minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.</p> <p><b>1. What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Clients and/or POA will participate in annual ISP meetings and quarterly reviews, to ensure they are involved in the process.</li> <li>· Signature sheets will be used at these meetings and all attendees, including client and/or POA.</li> <li>· Staff will be retrained to ensure use of signature sheets/</li> <li>· Program Directors will inform POAs of meeting dates and obtain client/ POA signatures at yearly ISP and quarterly review meetings.</li> </ul> <p><b>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the same deficient practice.</li> <li>· Clients and/or POA will participate in annual ISP meetings and quarterly reviews, to ensure</li> </ul>	04/20/2014			

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	<p>3/12/14 at 1:09 P.M. Client #3's ISP dated 6/27/13 indicated he had a guardian to assist him with decision making. Client #3's Behavior Support Plan (BSP) dated 6/27/13 indicated he was prescribed the following medications for behavior management, Divalproex (mood stabilizer) for anxiety and Gabapentin (anticonvulsant) for psychosis. There was no indication client #3 and/or his guardian had participated in the ISP and BSP developmental process.</p> <p>Client #4's record was reviewed on 3/12/14 at 1:25 P.M. Client #4's ISP dated 4/3/13 indicated he had a HCR (health care representative) to assist him with decisions. Client #4's BSP dated 4/19/13 indicated he was prescribed Sertraline (anti-depressant) for depression. There was no indication client #4 and/or his HCR had participated in the ISP and BSP developmental process.</p> <p>An interview was conducted with the Residential Director (RD) on 3/13/14 at 4:35 P.M. When asked about client, guardian and advocate participation, the RD stated, "They should have signature pages with the plans, the signature pages for the plans must have been misplaced." The RD indicated clients and their guardians/advocates should be involved</p>		<p>they are involved in the process.</p> <ul style="list-style-type: none"> <li>· Signature sheets will be used at these meetings and all attendees, including client and/or POA.</li> <li>· Staff will be retrained to ensure use of signature sheets.</li> <li>· Program Directors will inform POAs of meeting dates and obtain client/ POA signatures at yearly ISP and quarterly review meetings.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Clients and/or POA will participate in annual ISP meetings and quarterly reviews, to ensure they are involved in the process.</li> <li>· Signature sheets will be used at these meetings and all attendees, including client and/or POA.</li> <li>· Staff will be retrained to ensure use of signature sheets.</li> <li>· Program Directors will inform POAs of meeting dates and obtain client/ POA signatures at yearly ISP and quarterly review meetings.</li> </ul> <p><b>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Program Directors will inform POAs of meeting dates and obtain client/ POA signatures at yearly ISP and quarterly review meetings.</li> </ul> <p><b>5. What is the date by which the systemic changes will be</b></p>				

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	in the ISP/BSP process.  9-3-4(a)		completed?  4/20/14	

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W000262	<p>483.440(f)(3)(i) PROGRAM MONITORING &amp; 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, the facility failed to insure the Human Rights Committee (HRC) reviewed, approved, and monitored the Behavior Support Plans which included the use of restrictive interventions (medications) for behavior management for 3 of 4 sampled clients (clients #1, #3 and #4).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 3/12/14 at 11:36 A.M. Client #1's Behavior Support Plan (BSP) dated 5/20/13 indicated he was prescribed the following medications for behavior management, Abilify (anti psychotic) for schizophrenia, Lithium (antimantic) for schizophrenia, Trileptal (anticonvulsant) for schizophrenia, and Klonopin (anticonvulsant) for schizophrenia. There was no indication the HRC had reviewed, approved, and monitored the BSP for client #1 prior to and while it was being implemented.</p> <p>Client #3's record was reviewed on</p>	W000262	<p><b>1. What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· All behavior support plans and/or changes to the BSP will be reviewed by the HRC.</li> <li>· HRC signatures will be obtained, on a signature page, in order to document completion of this process.</li> <li>· Staff will be retrained to ensure use of signature sheets.</li> <li>· Program Directors will monitor utilization of signature sheets.</li> </ul> <p><b>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All behavior support plans and/or changes to the BSP will be reviewed by the HRC.</li> <li>· HRC signatures will be obtained, on a signature page, in order to document completion of this process.</li> <li>· Staff will be retrained to ensure use of signature sheets.</li> <li>· Program Directors will monitor utilization of signature</li> </ul>	04/20/2014			

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	<p>3/12/14 at 1:09 P.M. Client #3's Behavior Support Plan (BSP) dated 6/27/13 indicated he was prescribed the following medications for behavior management, Divalproex (mood stabilizer) for anxiety and Gabapentin (anticonvulsant) for psychosis. There was no indication the HRC had reviewed, approved, and monitored the BSP for client #3 prior to and while it was being implemented.</p> <p>Client #4's record was reviewed on 3/12/14 at 1:25 P.M. Client #4's BSP dated 4/19/13 indicated he was prescribed Sertraline (anti-depressant) for depression. There was no indication the HRC had reviewed, approved, and monitored the BSP for client #4 prior to and while it was being implemented.</p> <p>An interview was conducted with the Residential Director (RD) on 3/13/14 at 4:35 P.M. When asked about HRC approval and monitoring, the RD stated, "They should have signature pages with the plans, the signature pages for the plans must have been misplaced." The RD indicated the HRC was to review and approve restrictive plans only after informed consent had been obtained from the client or their guardian.</p> <p>9-3-4(a)</p>		<p>sheets.</p> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· All behavior support plans and/or changes to the BSP will be reviewed by the HRC.</li> <li>· HRC signatures will be obtained, on a signature page, in order to document completion of this process.</li> <li>· Staff will be retrained to ensure use of signature sheets.</li> <li>· Program Directors will monitor utilization of signature sheets.</li> </ul> <p><b>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Program Directors will monitor utilization of signature sheets.</li> </ul> <p><b>5. What is the date by which the systemic changes will be completed?</b></p> <p>4/20/14</p>				

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W000312	<p>483.450(e)(2) DRUG USAGE</p> <p>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, the facility failed to include specific criteria as part of a plan of reduction for each medication used for the management or elimination of behaviors and/or symptoms of diagnoses as indicated in 2 of 3 sampled clients (clients #1 and #3) who were prescribed medications for management of behaviors.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 3/12/14 at 11:36 A.M. Client #1's Physician's Orders (PO) dated for February 2014 indicated he was prescribed Abilify (anti psychotic) for schizophrenia, Lithium (antimanic) for schizophrenia, Trileptal (anticonvulsant) for schizophrenia, and Klonopin (anticonvulsant) for schizophrenia. Client #1's Behavior Support Plan (BSP) dated 5/20/13 indicated he had the targeted behaviors of, symptoms of schizophrenia, agitation, physical aggression, inappropriate sexual behavior and psychosis. Client #1's BSP indicated</p>	W000312	<p>1. <b>What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Plans of reduction have been developed and will be implemented with all clients.</li> <li>· Staff will be trained on reporting and documenting target behaviors.</li> <li>· Program Directors will review and evaluate quarterly and at yearly ISP meetings and discuss any need for reduction with Psychiatrist/Physician at quarterly appointments.</li> </ul> <p>2. <b>How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the same deficient practice.</li> <li>· Plans of reduction have been developed and will be implemented with all clients.</li> <li>· Staff will be trained on reporting and documenting target behaviors.</li> <li>· Program Directors will review and evaluate quarterly and at yearly ISP meetings and discuss any need</li> </ul>	04/20/2014
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	<p>"When data reflects a decrease in symptoms (0 incidents of psychosis, 0 incidents of agitation, 0 incidents of sexual aggression) for the 4 consecutive months immediately preceding annual review the IDT (interdisciplinary team) will refer to consulting psychiatrist for consideration of a decrease/alternative medication." Client #1's BSP did not indicate what specific behaviors Abilify, Lithium, Trileptal and Klonopin were prescribed to address. Client #1's BSP did not indicate what specific criteria needed to be achieved for Abilify, Lithium, Trileptal and Klonopin to be considered for possible reductions. Client #1's BSP did not indicate a specific medication for reduction.</p> <p>Client #3's record was reviewed on 3/12/14 at 1:09 P.M. Client #3's Physician's Orders (PO) dated for February 2014 indicated he was prescribed Divalproex (mood stabilizer) for anxiety and Gabapentin (anticonvulsant) for psychosis. Client #3's Behavior Support Plan (BSP) dated 6/27/13 indicated he had the targeted behaviors of, agitation, physical aggression, and property destruction. Client #3's BSP indicated "When the data reflects stabilization of symptoms (0 incidents of agitation, physical aggression or property misuse/destruction) for the 3</p>		<p>for reduction with Psychiatrist/Physician at quarterly appointments.</p> <p>3. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Plans of reduction have been developed and will be implemented with all clients.</li> <li>· Staff will be trained on reporting and documenting target behaviors.</li> <li>· Program Directors will review and evaluate quarterly and at yearly ISP meetings and discuss any need for reduction with Psychiatrist/Physician at quarterly appointments.</li> </ul> <p>4. <b>How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Program Directors will review and evaluate quarterly and at yearly ISP meetings and discuss any need for reduction with Psychiatrist/Physician at quarterly appointments.</li> </ul> <p>5. <b>What is the date by which the systemic changes will be completed?</b> 4/20/14</p>				

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	<p>consecutive months immediately prior to psychiatric review the IDT (interdisciplinary team) will consider a decrease/alternative medication." Client #3's BSP did not indicate what specific behaviors Divalproex and Gabapentin were prescribed to address. Client #3's BSP did not indicate what specific criteria needed to be achieved for Divalproex and Gabapentin to be considered for possible reductions. Client #3's BSP did not indicate a specific medication for reduction.</p> <p>An interview was conducted with the Residential Director on 3/13/14 at 4:35 P.M. When asked about a plan of reduction for behavior medication, the RD indicated he could see where if there are different types of medications prescribed it would be difficult to determine which was being effective. The RD stated, "We are looking at this and changing the behavior plan process." 9-3-5(a)</p>				

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W000406	<p>483.470 PHYSICAL ENVIRONMENT The facility must ensure that specific physical environment requirements are met. Based on observation, interview and record review, the Condition of Participation: Physical Environment is not met for 2 of 4 additional clients (clients #5 and #7). The facility failed to regulate and monitor the hot water temperature at the group home for 2 of 4 additional clients who lived in the group home (clients #5 and #7) who were assessed as unable to independently mix hot and cold water.</p> <p>An IMMEDIATE JEOPARDY began on 3/10/14 and was identified on 3/11/14 at 1:25 P.M. The Residential Director #1 and Program Director #1 were notified of the Immediate Jeopardy on 3/11/14 at 1:55 P.M.</p> <p>A plan of action from the facility to remove the immediate jeopardy, dated 3/11/14 was received on 3/12/14 at 12:20 P.M. The plan indicated the following steps would be immediately implemented:</p> <p>"1. Formal training has been put into place on 3/11/14 for all eight clients to address water temperature regulation. This will be ran (sic) daily by staff. Staff were also trained and acknowledged the</p>	W000406	<p><b>1. What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Maintenance has been contacted and installed an anti-scald device</li> <li>· Staff will be retrained on monitoring, documenting and reporting water temperatures.</li> <li>· Staff will do nightly water temperature checks.</li> <li>· Water assessments will be conducted on every client, yearly, to determine independence with mixing and self-regulating temperature.</li> <li>· Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards.</li> <li>· Home Manager will evaluate water temperatures, weekly, to ensure group home meets safety standards. Any issues will be reported to Program Director and Maintenance.</li> </ul> <p><b>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the same deficient practice.</li> </ul>	04/20/2014			

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	<p>new programming on 3/11 and 3/12.</p> <p>2. Indiana Mentor's maintenance coordinator trained staff on 3/11/14 on how to lower the water temperature for the water heater.</p> <p>3. Daily water temperature checks are being conducted daily by staff and being documented on a log. The house manager (HM), program director (PD), and area director (AD) are reviewing the documenting daily to ensure that the temperatures do not exceed 110 degrees. The house manager is also doing daily checks with a new thermometer to ensure accuracy. The Program Director (PD) will be following up daily and signing off to ensure compliance.</p> <p>4. Indiana Mentor contracted a plumber to install an anti-scald device that will regulate the temperature of the water in the house. The device will allow for the temperature to only reach 110 degrees. The work was completed on 3/12/14 by [name of Plumbing Company].</p> <p>5. There will be a weekly meeting at the end of each week with the PD, AD and HM where they will review all documentation for all consumers and evaluate any changes/interventions needed at that time. At this meeting, the team will also review the temperature logs to evaluate any changes needed at that time."</p>		<ul style="list-style-type: none"> <li>· Maintenance has been contacted and installed an anti-scald device</li> <li>· Staff will be retrained on monitoring, documenting and reporting water temperatures.</li> <li>· Staff will do nightly water temperature checks.</li> <li>· Water assessments will be conducted on every client, yearly, to determine independence with mixing and self-regulating temperature.</li> <li>· Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards.</li> <li>· Home Manager will evaluate water temperatures, weekly, to ensure group home meets safety standards. Any issues will be reported to Program Director and Maintenance.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Maintenance has been contacted and installed an anti-scald device</li> <li>· Staff will be retrained on monitoring, documenting and reporting water temperatures.</li> <li>· Staff will do nightly water temperature checks.</li> <li>· Water assessments will be conducted on every client, yearly, to determine independence with</li> </ul>	

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	<p>The IMMEDIATE JEOPARDY was removed on 3/13/14 at 2:05 P.M. based upon observation of the plan's implementation in the group home. On 3/12/14 at 6:50 P.M. the water temperature at the anti-scald device read 104.5 degrees Fahrenheit, and 103.4 degrees Fahrenheit at the sink in the laundry room. On 3/13/14 at 1:00 P.M. the water temperature at the bathroom sink was 108.8 degrees Fahrenheit. Review of facility tracking of the water temperatures between 3/11/14 at 1:25 P.M. and 3/13/14 at 10:45 A.M. indicated the water temperatures in the home had not exceeded 108.8 degrees Fahrenheit since the anti-scald device was installed. The condition remains out of compliance to ensure the monitoring system remains effective over a period of time.</p> <p>Findings include:</p> <p>Please refer to W426. The facility failed to maintain water temperature at below 110 degrees Fahrenheit for 2 of 4 additional clients who lived in the group home (clients #5 and #7) who were assessed as being unable to regulate hot water controls.</p> <p>9-3-7(a)</p>		<p>mixing and self-regulating temperature.</p> <ul style="list-style-type: none"> <li>· Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards.</li> <li>· Home Manager will evaluate water temperatures, weekly, to ensure group home meets safety standards. Any issues will be reported to Program Director and Maintenance.</li> </ul> <p><b>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards.</li> <li>· Home Manager will evaluate water temperatures, weekly, to ensure group home meets safety standards. Any issues will be reported to Program Director and Maintenance.</li> </ul> <p><b>5. What is the date by which the systemic changes will be completed?</b></p> <p>4/20/14</p>				

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W000426	<p>483.470(d)(3) CLIENT BATHROOMS</p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>Based on observation, interview and record review, the facility failed to maintain the temperature at below 110 degrees Fahrenheit for 2 of 4 additional clients who lived in the group home (clients #5 and #7) who were assessed as unable to independently regulate water temperature.</p> <p>Findings include:</p> <p>Water temperatures were taken at the group home during the 3/10/14 observation period from 4:47 P. M until 6:53 P.M. At 6:24 P.M. the sink in the bathroom used by clients #1, #2, #3, #4, #5, #6, #7 and #8 was measured at 135.5 degrees Fahrenheit. At 6:22 P.M. the kitchen sink used by clients #1, #2, #3, #4, #5, #6, #7 and #8 was measured at 129.5 degrees Fahrenheit. At 6:28 P.M. the sink in the bathroom with the walk-in-shower used by clients #1, #2, #3, #4, #5, #6, #7 and #8 was at 133.3 degrees Fahrenheit and at 6:26 P.M. the shower was measured at 124.3 degrees Fahrenheit. Client #5 ambulated</p>	W000426	<p><b>1. What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Maintenance has been contacted and installed an anti-scald device</li> <li>· Staff will be retrained on monitoring, documenting and reporting water temperatures.</li> <li>· Staff will do nightly water temperature checks.</li> <li>· Water assessments will be conducted on every client, yearly, to determine independence with mixing and self-regulating temperature.</li> <li>· Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards.</li> <li>· Home Manager will evaluate water temperatures, weekly, to ensure group home meets safety standards. Any issues will be reported to Program Director and Maintenance.</li> </ul> <p><b>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p>	04/20/2014			

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	<p>independently and rapidly in his wheelchair through out the group home during the observation period. Staff were not with client #5 at all times when he was in the areas of the hallway bathrooms. Client #7 ambulated independently in his electric wheelchair through out the home. Staff were not with client #7 at all times.</p> <p>Client #1 was interviewed on 3/10/14 at 6:35 P.M. Client #1 stated, "Sometimes the tub is too cold. Then the shower scalds you." Client #1 indicated he knew how to adjust the water so it would not be too hot or cold.</p> <p>Client #6 was interviewed on 3/10/14 at 6:38 P.M. Client #6 stated, "It gets too hot."</p> <p>Direct Care Staff (DCS) #3 was interviewed on 3/10/14 at 6:48 P.M. When asked if the clients living in the home were able to regulate water temperature, he stated, "I think most of them can, maybe not [client #5] and [client #7], but we have to physically assist them with their showers anyway. We don't have them wash their hands by themselves. There have never been any problems with anyone getting hurt."</p> <p>DCS #1 was interviewed on 3/10/14 at</p>		<ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the same deficient practice.</li> <li>· Maintenance has been contacted and installed an anti-scald device</li> <li>· Staff will be retrained on monitoring, documenting and reporting water temperatures.</li> <li>· Staff will do nightly water temperature checks.</li> <li>· Water assessments will be conducted on every client, yearly, to determine independence with mixing and self-regulating temperature.</li> <li>· Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards.</li> <li>· Home Manager will evaluate water temperatures, weekly, to ensure group home meets safety standards. Any issues will be reported to Program Director and Maintenance.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Maintenance has been contacted and installed an anti-scald device</li> <li>· Staff will be retrained on monitoring, documenting and reporting water temperatures.</li> <li>· Staff will do nightly water</li> </ul>	
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	<p>6:28 P.M. When asked if all the clients could adjust water temperatures safely, DCS #1 stated, "Yes, they can all mix water safely maybe not the two in wheelchairs (clients #5 and #7) but we help them bathe."</p> <p>Client #5's records were reviewed on 3/11/14 at 12:01 P.M. Client #5's Hot Water Adjustment Review/Assessment dated 1/8/14 indicated client #5 "Requires physical assistance to adjust water temperatures."</p> <p>Client #7's records were reviewed on 3/11/14 at 12:05 P.M. Client #7's Hot Water Adjustment Review/Assessment dated 1/8/14 indicated client #7 "Requires physical assistance to adjust water temperatures."</p> <p>A Water Temp Check dated 1/15/2014 at 10:48 A.M. was reviewed on 3/11/14 at 12:25 P.M. indicating the water temperature was 108 degrees Fahrenheit. There were no other Water Temp Check forms available for review.</p> <p>The Program Director (PD) was interviewed on 3/11/14 at 11:55 A.M. and stated, "He (client #5) can wash his hands by himself." The PD indicated client #7 required physical assistance from staff to wash his hands.</p>		<p>temperature checks.</p> <ul style="list-style-type: none"> <li>· Water assessments will be conducted on every client, yearly, to determine independence with mixing and self-regulating temperature.</li> <li>· Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards.</li> <li>· Home Manager will evaluate water temperatures, weekly, to ensure group home meets safety standards. Any issues will be reported to Program Director and Maintenance.</li> </ul> <p><b>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards.</li> <li>· Home Manager will evaluate water temperatures, weekly, to ensure group home meets safety standards. Any issues will be reported to Program Director and Maintenance.</li> </ul> <p><b>5. What is the date by which the systemic changes will be completed?</b></p> <p>4/20/14</p>		

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	<p>The Residential Director (RD) was interviewed again on 3/11/14 at 1:45 P.M. and indicated he was part of the governing body and was responsible to ensure water temperatures were regulated in the home. The RD stated, "Water check documentation was the responsibility of the PD and HM (home manager). Normally we do the checks three times a week and one time on the weekend, we used to do them monthly." The RD indicated he was aware there was only one documented water check available for review. He further indicated clients were supervised while bathing and showering.</p> <p>9-3-7(a)</p>			
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W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to hold evacuation drills at least quarterly for each shift at the group home where 4 of 4 sampled clients lived (clients #1, #2, #3 and #4) and 4 of 4 additional clients lived (clients (#5, #6, #7 and #8)).</p> <p>Findings include:</p> <p>Evacuation drills for the time period between 3/10/13 and 3/10/14 were reviewed on 3/13/14 at 5:40 P.M. for clients #1, #2, #3, #4, #5, #6, #7, and #8. There were three evacuation drills available for review dated/timed as follows: 7/9/13 at 3:32 P.M., 8/13/13 at 4:30 P.M., and 1/17/14 at 7:30 P.M.</p> <p>The Program Director (PD) was interviewed on 3/13/14 at 4:44 P.M. and stated, "We had a previous Home Manager who did not track and run drills as required."</p> <p>The Residential Director (RD) was interviewed on 3/13/14 at 4:45 P.M. and stated, "We have a new schedule we run fire drills monthly, tornado drills one time each year in February, and Severe Weather drills one time each year in</p>	W000440	<p>1. <b>What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Fire Drills will be scheduled and executed, successfully, by Home managers and staff on a monthly basis.</li> <li>· Staff will be retrained on execution, frequency and documentation of drills .</li> <li>· Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards.</li> <li>· Home Manager will ensure group home meets safety standards. Any issues will be reported to Program Director.</li> </ul> <p>2. <b>How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the same deficient practice.</li> <li>· Fire Drills will be scheduled and executed, successfully, by Home managers and staff on a monthly basis.</li> <li>· Staff will be retrained on execution, frequency and documentation of drills.</li> <li>· Quarterly Health and Safety</li> </ul>	04/20/2014			

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	March. We realize it was not met and we will fix it." 9-3-7(a)		<p>Assessments will be conducted to ensure group home meets safety standards.</p> <ul style="list-style-type: none"> <li>Home Manager will ensure group home meets safety standards. Any issues will be reported to Program Director.</li> </ul> <p>3. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>Fire Drills will be scheduled and executed, successfully, by Home managers and staff on a monthly basis.</li> <li>Staff will be retrained on execution, frequency and documentation of drills .</li> <li>Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards.</li> <li>Home Manager will ensure group home meets safety standards. Any issues will be reported to Program Director.</li> </ul> <p>4. <b>How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards.</li> <li>Home Manager will ensure group home meets safety standards.</li> </ul>		

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			<p>Any issues will be reported to Program Director.</p> <p>5. <b>What is the date by which the systemic changes will be completed?</b></p> <p>4/20/14</p>		

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W000460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview, the facility failed to follow the menu/diets for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients (#5, #6, #7 and #8)).</p> <p>Findings include:</p> <p>Observations of the morning meal were conducted on 3/12/14 between 6:39 A.M. and 7:58 A.M. The clients were offered choice of three cold cereals, 1% milk, sugar free orange drink, sugar free strawberry drink, water and artificial sweetener which was on the table. Whole wheat bread (1/2 loaf) and butter spread were placed on the back kitchen counter next to the toaster. Clients #1 and #6 each made themselves two pieces of toast with butter spread after eating their cereal. At 7:05 A.M. Client #4 drank some of his orange drink and stated, "This tastes awful, I think they must have put too much water in it or something."</p> <p>The menus posted on the wall were reviewed on 3/12/14 at 7:03 A.M. The menu dated 10/7/09 Fall/Winter week #1 indicated for an 1800 Kcal Diet each</p>	W000460	<p><b>1. What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Food substitution lists and diet plans will be readily available in every home.</li> <li>· Staff will be retrained on diets and food substitution list and responsible for implementing them.</li> <li>· Home managers will monitor that the diets and substitution lists are being used and followed by staff. Any issues will be reported to Program Director.</li> </ul> <p><b>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the same deficient practice.</li> <li>· Food substitution lists and diet plans will be readily available in every home.</li> <li>· Staff will be retrained on diets and food substitution list and responsible for implementing them.</li> <li>· Home managers will monitor that the diets and substitution lists are being used and followed by staff. Any issues will be reported to Program Director.</li> </ul>	04/20/2014			

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	<p>individual was to have received 1/2 cup apple juice, 1/2 cup scrambled eggs, 2 slices whole wheat toast, 1 tsp. margarine, 1 tsp. low sugar jelly, 1 cup water, coffee/tea if desired, 1 cup skim or 1% milk. The menu dated 12/19/07 Fall/Winter week #1 for an 1800 Calorie Diabetic Diet each individual was to have received 1/2 cup apple juice, 3/4 cup dry cereal, 1/2 English muffin, 2 tsp. diet jelly/jam, 1 tsp. margarine, 2 eggs, 1 cup water, coffee/tea if desired, 1 cup skim or 1% milk. There were no menus posted for a regular diet or Renal diet.</p> <p>There were no eggs served to clients #1, #2, #3, #4, #5, #6, #7 and #8 and no protein substitution made for the eggs at the meal. Observations of the refrigerator indicated there were protein substitutions available (sausage, cheese, cream cheese, peanut butter).</p> <p>Direct Care Staff (DCS) #1 was interviewed on 3/12/14 at 7:20 A.M. "We only had seven eggs that is why they have the cereal, they like cereal." When asked about a substitution list being in the home, DCS indicated she did not know of one, but would ask the House Manager.</p> <p>DCS #4 was interviewed on 3/12/14 at 7:42 A.M. When asked if cereal was an appropriate substitution for eggs, DCS #4</p>		<p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Food substitution lists and diet plans will be readily available in every home.</li> <li>· Staff will be retrained on diets and food substitution list and responsible for implementing them.</li> <li>· Home managers will monitor that the diets and substitution lists are being used and followed by staff. Any issues will be reported to Program Director.</li> </ul> <p><b>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Home managers will monitor that the diets and substitution lists are being used and followed by staff. Any issues will be reported to Program Director.</li> </ul> <p><b>5. What is the date by which the systemic changes will be completed?</b> 4/20/14</p>				

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	<p>stated, "Well no, not if you are a diabetic, you would need to use another form of protein." DCS #4 indicated there were several of the clients in the home who were diabetic and on insulin. DCS #4 indicated the guys knew where the peanut butter and cheese were, and could have gotten some for themselves if they had wanted it.</p> <p>Client #4 was again interviewed on 3/12/14 at 7:10 A.M. and was asked if he knew he could have made himself some toast with peanut butter or cheese. "Yeah, I guess I could, but we don't have much in there. She needs to go to the grocery store, I don't think there is even anything in there for supper."</p> <p>Client #1 was interviewed on 3/11/14 at 7:30 A.M. He stated, "They keep the bread locked up so they don't steal it. It is in the med cabinet in the laundry room."</p> <p>Client #1's record was reviewed on 3/12/14 at 11:36 A.M. Client #1's Physician's Order (PO) dated for March 2014 indicated he had a diagnosis of Diabetes Mellitus Type II and was prescribed medications for his diagnosis of Diabetes. Client #1's PO indicated he was on an 1800 ADA diet, caffeine free.</p> <p>Client #2's record was reviewed on</p>						

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NAME OF PROVIDER OR SUPPLIER  REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362
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	<p>3/12/14 at 12:55 P.M. Client #2's PO dated for March 2014 indicated he was on a regular diet, low fat, no concentrated sweets.</p> <p>Client #3's record was reviewed on 3/12/14 at 1:09 P.M. Client #3's PO dated for March 2014 indicated he was on an 1800 regular diet, low fat, no concentrated sweets.</p> <p>Client #4's record was reviewed on 3/12/14 at 1:25 P.M. Client 4's PO dated for March 2014 indicated he had diagnoses of, but not limited to Diabetes Mellitus Type II - uncontrolled and obesity and was prescribed medications for his diagnosis of Diabetes. Client #4's PO indicated he was on an 1800 ADA diet.</p> <p>Client #5's record was reviewed on 3/12/14 at 1:28 P.M. Client #5's PO dated for March 2014 indicated he was on an 1800 regular diet, low fat, no concentrated sweets, monitor protein, low cholesterol.</p> <p>Client #6's record was reviewed on 3/12/14 at 1:30 P.M. Client #6's PO dated for March 2014 indicated he had a diagnosis of Diabetes Mellitus Type I/insulin dependent and was prescribed medications for his diagnosis of Diabetes.</p>			

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	<p>Client #6's PO indicated he was on an 1800 calorie Renal diet, seconds limited to non-starchy vegetables and protein sources, watch fluid intake, low salt.</p> <p>Client #7's record was reviewed on 3/12/14 at 1:32 P.M. Client #7's PO dated for March 2014 indicated he was on an 1800 regular diet.</p> <p>Client #8's record was reviewed on 3/12/14 at 1:35 P.M. Client #8's PO dated for March 2014 indicated he was on an 1800 regular diet, low fat, no concentrated sweets, single servings.</p> <p>An interview was conducted with the Program Director (PD) on 3/11/14 at 12:10 P.M. When asked if cereal was an appropriate substitution for scrambled eggs, the PD stated, "Not for a Diabetic. They (staff) should ask them or offer a choice of something more nutritional." The PD indicated there should be a food substitution list in the home.</p> <p>9-3-8(a)</p>			

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W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview, the facility failed to promote independent dining for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 of 4 additional clients (clients (#5, #6, #7 and #8).</p> <p>Findings include:</p> <p>Observations of the evening meal were conducted on 3/10/14 between 4:47 P. M. and 6:53 P.M. Direct Care Staff (DCS) #1 placed three glasses, napkins and silverware at each of the eight place settings on the table. Clients #1 and #8 were in the kitchen at the time and not asked to help. At 5:07 P.M. client #8 independently made himself a glass of tea with ice. Client #8 then placed a plate at each place setting. At 5:21 P.M. client #6 rinsed dishes from meal preparation and lunches, loaded the dishwasher and attempted to start the dishwasher DCS #1 assisted client #6 with the buttons on the dishwasher. DCS #1 asked client #5 to assist with stirring the carrots cooking on the stove. At 5:25 P.M. client #3 came to the kitchen and walked around, but was not encouraged to assist with the meal preparations. At 5:58 P.M. DCS #1, #2 and #3 put the serving dishes onto the</p>	W000488	<p>The facility must assure that each client eat in a manner consistent with his or her developmental level.</p> <p><b>1. What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>· Clients who are developmentally and physically capable of assisting with meal and dining preparation will be asked to participate.</li> <li>· Staff will be retrained on engaging clients in meal time activities, to encourage independence.</li> <li>· Home managers will monitor client engagement at meal time. Any issues will be reported to Program Director.</li> </ul> <p><b>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All residents have the potential to be affected by the same deficient practice.</li> <li>· Clients who are developmentally and physically capable of assisting with meal and dining preparation will be asked to participate.</li> </ul>	04/20/2014			

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	<p>table. DCS #1 poured milk into a glass at each client's (clients #1, #2, #3, #4, #5, #6 #7 and #8) place setting. DCS #3 walked around the table with the serving bowl of chicken and mushroom soup and placed portions of chicken on each plate for clients #1, #2, #3, #4, #5, #6, #7 and #8. Client #1 was the only client seated at the table at the time. Client #2 walked into the kitchen and got a different knife and spoon for himself from the drawer. At 6:05 P.M. DCS #3 got a loaf of bread from a locked cabinet in the medication/laundry room, placed slices of bread onto a plate and set it on the table. At 6:09 P.M. the clients began to eat.</p> <p>Observations of the morning meal were conducted on 3/12/14 between 6:39 A.M. and 7:58 A.M. At 6:47 A.M. DCS #1 put three glasses on the table at each of the eight place settings. At 7:01 A.M. after medication pass the table was completely set with all tableware and food items. DCS #1 was in the kitchen. No clients were in the kitchen at this time.</p> <p>An interview was conducted with the Program Director (PD) on 3/13/14 at 3:35 P.M. When asked about client independence with meals, the PD stated, "They need to be as independent as possible if they (clients) can do it they</p>		<ul style="list-style-type: none"> <li>· Staff will be retrained on engaging clients in meal time activities, to encourage independence.</li> <li>· Home managers will monitor client engagement at meal time. Any issues will be reported to Program Director.</li> </ul> <p><b>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Clients who are developmentally and physically capable of assisting with meal and dining preparation will be asked to participate.</li> <li>· Staff will be retrained on engaging clients in meal time activities, to encourage independence.</li> <li>· Home managers will monitor client engagement at meal time. Any issues will be reported to Program Director.</li> </ul> <p><b>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Home managers will monitor client engagement at meal time. Any issues will be reported to Program Director</li> </ul> <p><b>5. What is the date by which the systemic changes will be completed?</b> 4/20/14</p>				

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	<p>should do it." The PD indicated the clients could have been encouraged to be more independent at their meals.</p> <p>9-3-8(a)</p>			