

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G712		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/04/2013	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8337 N COLLEGE AVE INDIANAPOLIS, IN 46240			
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W000000	<p>This visit was for an extended recertification and state licensure survey.</p> <p>Dates of survey: October 21, 24, 29, 30, 31 and November 4, 2013.</p> <p>Facility Number: 001089 Provider Number: 15G712 AIMS Number: 100239940</p> <p>Surveyor: Claudia Ramirez, RN</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed November 7, 2013 by Dotty Walton, 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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W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p> <p>Based on record review and interview, for 2 of 4 sample clients (clients #1 and #2) and 1 additional client (client #7), the facility failed to maintain an accurate accounting system for each client's personal funds account.</p> <p>Findings include:</p> <p>On 10/21/13 at 2:00 PM and on 10/23/13 at 3:15 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports and internal incident/accident reports was completed and included the following:</p> <p>07/18/13: A BDDS report indicated, "During a routine audit of [client #1's] finances, it was found that there is \$224.25 that there are no receipts to account for. [Client #1] will be reimbursed \$224.25. Program Director and Home Manager will receive retraining on ensuring that all consumers (sic) finances are completed accurately and thoroughly and ensuring that receipts are obtained for all money spent."</p> <p>07/18/13: A BDDS report indicated, "During a routine audit of [client #2's] finances, it was found that there is \$109.58 that there are no receipts to account for. [Client #2] will be reimbursed \$109.58. Program Director and Home Manager will receive retraining on ensuring that all consumers (sic) finances are completed accurately and thoroughly and ensuring that receipts are obtained for all money spent."</p>	W000140	<p>The Program Director and Home Manager will receive retraining on client finances to ensure that they are completing a full and complete accounting of clients financial transactions including collecting and documenting receipts to show how consumers money is spent and ensuring that client check register records and cash on hand ledgers are balanced and reconciled weekly by the HM and monthly by the Program Director and copies of records are provided monthly to the Client Finance Specialist.</p> <p>Ongoing, the Home Manger will record and balance all client transactions a minimum of weekly and note this in the clients finance records. Ongoing the Program Director will review and reconcile client finances a minimum of monthly and note this in the client finance records. The Program Director will provide copies of the clients' financial transactions to the Client Finance Specialist a minimum of monthly. Monthly, the Client Finance Specialist will provide the Area Director a list of what client finances have not been turned in by the scheduled deadlines and any corrections that need to be made so the Area Director can follow up with HM</p>	12/04/2013
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	<p>07/18/13: A BDDS report indicated, "During a routine audit of [client #7's] finances, it was found that there is \$88.40 that there are no receipts to account for. [Client #7] will be reimbursed \$88.40. Program Director and Home Manager will receive retraining on ensuring that all consumers (sic) finances are completed accurately and thoroughly and ensuring that receipts are obtained for all money spent."</p> <p>Client #1's records were reviewed on 10/29/13 at 11:40 AM. Client #1's ISP (Individual Support Plan) dated 05/30/13 indicated client #1 was not able to independently handle his money and required assistance.</p> <p>Client #2's records were reviewed on 10/29/13 at 12:40 PM. Client #2's ISP dated 11/05/12 indicated client #2 was not able to independently handle her money and required assistance.</p> <p>Client #7's records were reviewed on 10/29/13 at 2:40 PM. Client #7's ISP dated 11/09/12 indicated client #7 was not able to independently handle his money and required assistance.</p> <p>An interview was conducted on 10/31/13 at 11:45 AM, with the Area Director (AD). The AD indicated clients #1, #2 and #7 were not independent in handling their money and required total assistance from the agency/staff. The AD indicated all of the money should be accounted for with receipts.</p> <p>9-3-2(a)</p>		and/or PD to ensure these requirements are being met. Responsible Party: Home Manager, Program Director, Client Finance Specialist, Area Director				

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on observation, record review and interview, the QIDP (Qualified Intellectual Disabilities Professional) failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 3 additional clients (clients #5, #6 and #7) to ensure: client funds were monitored, client assessments were completed, diets were followed, training programs were implemented, guardians approved restrictive programs, fire evacuation drills were completed and clients' behavior plans included drug withdrawal criteria.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Please refer to W140. The QIDP failed for 2 of 4 sample clients (clients #1 and #2) and 1 additional client (client #7), to maintain an accurate accounting system for each client's personal funds account. 2. Please refer to W210. The QIDP failed for 1 of 1 new client admitted to the home, (client #3), to ensure assessments were completed within 30 days after admission. 3. Please refer to W249. The QIDP failed for 3 of 4 sampled clients (clients #1, #2 and 4), to implement the clients' Individual Support Plans (ISP) as written. 4. Please refer to W259. The QIDP failed for 1 of 4 sampled clients (client #2), the facility failed to ensure the comprehensive functional assessment (CFA) was reviewed and updated annually. 	W000159	Please refer to W140Please refer to W210Please refer to W249Please refer to W259Please refer to W263Please refer to W312Please refer to W440Please refer to W 460	12/04/2013	

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	<p>5. Please refer to W263. The QIDP failed for 3 of 3 sampled clients (clients #1, #2 and #4) with restrictive programs, to obtain the health care representative (HCR) or guardian's (GU) approval before implementation of a Behavioral Support Plan.</p> <p>6. Please refer to W312. The QIDP failed for 3 of 3 sampled clients (clients #1, #2 and #4) who were on medications related to behaviors, by not ensuring the clients' Behavior Support Plan (BSP) included the medication or a titration plan for the medications in the plan.</p> <p>7. Please refer to W440. The QIDP failed for 7 of 7 clients (clients #1, #2, #3, #4, #5, #6 and #7) who resided in the home, by not ensuring an evacuation drill was conducted at least every 90 days on the night shift.</p> <p>8. Please refer to W460. The QIDP failed for 1 of 4 sample clients (client #1) who was on a modified diet to ensure diet orders were followed.</p> <p>On 10/31/13 at 11:35 AM an interview was conducted with the AD (Area Director). The AD indicated the QIDP failed in the following areas: to maintain accurate accounting systems for client personal funds; to ensure assessments were completed on new admissions within 30 days after admission; to implement the clients' ISPs as written; to ensure the CFAs were reviewed and updated annually; to obtain the HCR or GU's approval before implementation of a BSP; to ensure the BSPs contained titration plans; to ensure evacuations drills were conducted on the night shift and to ensure modified diet orders were followed.</p> <p>9-3-3(a)</p>			

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview, the facility failed for 1 of 1 new client admitted to the home, (client #3), to ensure assessments were completed within 30 days after admission.</p> <p>Findings include:</p> <p>Client #3's records were reviewed on 10/29/13 at 1:25 PM. Client #3's ISP (Individual Support Plan) dated 09/17/13 indicated he was admitted to the group home on 09/04/13. Client #3's record did not contain a hearing examination. The physical dated 08/30/13 indicated client #3 was to have a sleep study test. The record did not indicate the sleep study test had been completed. Client #3's record did not contain a CFA (Comprehensive Functional Assessment). Client #3's record did not contain any goals to indicate goals were being implemented.</p> <p>On 10/31/13 at 11:35 AM an interview was conducted with the Area Director (AD). The AD indicated a CFA should have been completed within 30 days of admission and the goals should have been put into place once the ISP had been completed on 09/17/13. She indicated she had spoken to the HM (House Manager) who indicated she had not implemented the goals yet and was planning on implementing them on 11/01/13.</p> <p>On 10/31/13 at 12:35 PM an interview with the RN (Registered Nurse) was conducted. The RN indicated the hearing examination and sleep study</p>	W000210	<p>A Comprehensive Functional assessment will be completed for Client #3. A hearing examination and sleep study test have been scheduled for Client #3. Goal tracking sheets have been developed for Client #3 based on his ISP. Staff have been trained and goals have been implemented for Client #3. Program Director will receive retraining on ensuring that all assessments, including a Comprehensive Functional assessment are completed for each consumer within 30 days of admission and reviewed and updated a minimum of annually on an ongoing basis. Program Director and Program Nurse will receive retraining on ensuring that all assessments including hearing assessments are completed within 30 days following admission. In addition, the Program Nurse will receive retraining to include ensuring that all recommendations obtained from medical appointments are followed up on as needed. Program Director will receive retraining on ensuring that goals are developed, staff are trained and goals are implemented once the ISP is completed 30 days</p>	12/04/2013

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	test had not yet been completed. 9-3-4(a)		after admission. Ongoing, the Program Director will ensure that Comprehensive Functional assessments are completed for each consumer within 30 days of admission and a minimum of annually on an ongoing basis. Ongoing the Program Director and Program Nurse will ensure that all initial medical assessments are completed within 30 days after admission. The Area Director will communicate with the Program Director and Program Nurse at the 30 day post-admission time to ensure that all assessments, medical appointments and goals have been completed as needed. Responsible Party: Program Director, Program Nurse, Area Director		

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, the facility failed for 3 of 4 sampled clients (clients #1, #2 and 4), to implement the clients' Individual Support Plans(ISP) as written.</p> <p>Findings include:</p> <p>1. Observations were conducted in the group home on 10/24/13 from 4:12 PM until 5:45 PM and staff #1, #2, #3 and #4 were on duty. The observation included a medication administration. At 4:44 PM client #1 came to the medication administration area. Staff #1 poured a clear liquid from a pitcher and handed it to client #1 to take with his medications. Staff #4 was interviewed at 4:45 PM on 10/24/13 and she indicated the clear liquid was tap water.</p> <p>Client #1's records were reviewed on 10/29/13 at 11:40 AM. Client #1's ISP dated 05/30/13 included the following goal: "Daily, at AM and PM med pass, [client #1] will pour his water to take his</p>	W000249	<p>All staff will receive retraining on all consumers' goals and objectives including Client #1 medication goal, Client #2 communication goal and Client #4 medication goal. For the next four weeks, the Home Manager and/or Program Director will complete Medication Administration and Active Treatment observations a minimum of twice weekly to ensure that all staff are completing all consumers' goals including Medication Administration and communication goals as written. Ongoing, the Home Manager and/or Program Director will complete Medication Administration and Active Treatment observations a minimum of once weekly to ensure that all staff are completing all consumers' goals including Medication Administration and communication goals as written. Responsible Staff: Home Manager, Program Director</p>	12/04/2013

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	<p>medication." Client #1 did not pour his water.</p> <p>On 10/31/13 at 11:35 AM an interview with the Area Director (AD) was conducted. The AD indicated staff #1 should have implemented client #1's goal as written.</p> <p>2. Observations were conducted in the group home on 10/24/13 from 4:12 PM until 5:45 PM and staff #1, #2, #3 and #4 were on duty. Observations were also conducted on 10/30/13 from 7:00 AM until 8:00 AM and staff #5, #6, #7 and #8 were on duty. During both observation times client #2 walked about the home independently and touched staff #1, #2, #3, #4, #5, #6, #7 and #8's arms at times to get their attention as she make sounds. During both observation times staff #1, #2, #3, #4, #5, #6, #7 and #8 asked client #2 what she wanted. During the observation times client #2 was not seen using a communication book and staff #1, #2, #3, #4, #5, #6, #7 and #8 did not prompt client #2 to go get her communication book or get it for her to use.</p> <p>Client #2's records were reviewed on 10/29/13 at 12:40 PM. Client #2's ISP dated 11/05/12 included the following goal: "Daily, [client #2] will point to</p>				

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	<p>pictures in a communication book to inform staff what she is needing." Client #2 was observed not to use a communication book.</p> <p>On 10/31/13 at 11:35 AM an interview with the Area Director (AD) was conducted. The AD indicated client #2 should have used her communication book during the observations.</p> <p>3. Observations were conducted in the group home on 10/24/13 from 4:12 PM until 5:45 PM and staff #1, #2, #3 and #4 were on duty. The observation included a medication administration. At 4:54 PM client #4 came to the medication administration area. Staff #1 poured a clear liquid from a pitcher and handed it to client #4 to take with two medications, one of which was Metformin (for diabetes), staff #1 had placed in a medication cup. Staff #1 did not ask client #4 any questions about the medications he was taking.</p> <p>Client #4's records were reviewed on 10/29/13 at 1:45 PM. Client #4's ISP dated 06/14/13 included the following goal: "Daily, [client #4] will identify the reason that he takes _____." The goal sheet indicated his response was to be "states diabetes or sugar." Client #4 was not asked about his diabetes</p>			

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	<p>medication by staff #1.</p> <p>On 10/31/13 at 11:35 AM an interview with the Area Director (AD) was conducted. The AD indicated staff #1 should have implemented client #4's goal as written.</p> <p>9-3-4(a)</p>				

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W000259	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on interview and record review for 1 of 4 sampled clients (client #2), the facility failed to ensure the comprehensive functional assessment (CFA) was reviewed and updated annually.</p> <p>Findings include:</p> <p>Client #2's records were reviewed on 10/29/13 at 12:40 PM. The CFA was dated 01/03/12.</p> <p>On 10/31/13 at 11:35 AM an interview with the Area Director (AD) was conducted. The AD indicated the CFAs were to be updated annually and this was not completed in the annual time frame.</p> <p>9-3-4(a)</p>	W000259	<p>The Program Director and Home Manager will work to complete CFAs for all Clients including Client #2. The Program Director and Home Manager will be retrained on completing CFAs for all clients. This training will include the importance of these CFA's, the reason for them, how to complete them, and when to complete them. Ongoing, the Area Director will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter. Responsible Party: Home Manager, Program Director, Area Director</p>	12/04/2013	

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W000263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview, the facility failed to obtain the health care representative (HCR) or guardian's (GU) approval before implementation of a Behavioral Support Plan for 3 of 3 sampled clients (clients #1, #2 and #4) with restrictive programs.</p> <p>Findings include:</p> <p>1. Client #1's records were reviewed on 10/29/13 at 11:40 AM. Client #1's BSP dated 11/16/12 indicated client #1's behaviors included repetitive verbalizations, inappropriate space (invading another's personal space), physical aggression and anxiety with medical/dental appointments. The BSP indicated client #1 was on the following medications for the behaviors: Buspirone (anxiety), Citalopram (depression) and Divalproex (mood). The BSP did not indicate written informed consent was obtained from client #1's HCR for the BSP.</p> <p>On 10/31/13 at 11:35 AM an interview was conducted with the Area Director</p>	W000263	<p>The Program Director will receive retraining on ensuring that any updates or changes to consumers' Behavior Support Plans are reviewed and written consent is obtained by the consumers Guardian or Health Care Representative or the consumer if they are emancipated prior to getting HRC approval. Ongoing the Program Director will ensure any updates or changes to consumers' Behavior Support Plans are reviewed and written consent is obtained by the consumers Guardian or Health Care Representative or the consumer if they are emancipated prior to getting HRC approval. Program Director will ensure that documentation of guardian or client approval is available for review. Prior to any future Human Rights Committee meetings, the HRC will be reminded that they should not approve any changes to Behavior Support Plans without ensuring that guardian or client, if emancipated, approvals have been obtained. Responsible Party: Program Director, Human Rights Committee</p>	12/04/2013	

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	<p>(AD). The AD indicated client #1's BSP was not signed by the HCR.</p> <p>2. Client #2's records were reviewed on 10/29/13 at 12:40 PM. Client #2's BSP dated 08/30/12 indicated client #2's behaviors included property destruction, physical assault, taking non-menu items, vacating, inappropriate nudity, self-injurious behavior, inappropriate sexual behavior, incontinence, extreme irritability, temper outbursts and crying. The BSP indicated client #2 was on the following medications for the behaviors: Olanzapine (anti-psychotic), Clonazepam (anxiety), Amphetamine (hyperactivity), Perphenazine (anti-psychotic), Amitriptyline (depression) and Valproic Acid (mood disorder). The BSP did not indicate written informed consent was obtained from client #2's GU for the BSP.</p> <p>On 10/31/13 at 11:35 AM an interview was conducted with the Area Director (AD). The AD indicated client #2's BSP was not signed by the GU.</p> <p>3. Client #4's records were reviewed on 10/29/13 at 1:45 PM. Client #4's BSP dated 08/29/12 indicated client #4's behaviors included temper outbursts and verbal abuse. The BSP indicated client #4 was on the following medications for</p>						

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	<p>the behaviors: Mirtazapine Soltab (depression) and Citalopram (depression) for mood stabilization. The BSP did not indicate written informed consent was obtained from client #4's GU for the BSP.</p> <p>On 10/31/13 at 11:35 AM an interview was conducted with the Area Director (AD). The AD indicated client #4's BSP was not signed by the GU.</p> <p>9-3-4(a)</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 for 3 of 3 sampled clients (clients #1, #2 and #4) who were on medications related to behaviors, to ensure the clients' Behavior Support Plans (BSPs) included the medications or a titration plan for the medications in the plans.</p> <p>Findings include:</p> <p>1. Client #1's records were reviewed on 10/29/13 at 11:40 AM. Client #1's BSP dated 11/16/12 indicated client #1's behaviors included repetitive verbalizations, inappropriate space (invading another's personal space), physical aggression and anxiety with medical/dental appointments. The BSP indicated client #1 was on the following medications for the behaviors: Buspirone (anxiety), Citalopram (depression) and Divalproex (mood). The BSP contained a "current baseline/date" for each of the behaviors. The plan's current baseline did not include any data of the behavior after September 2012. The BSP's "Titration</p>	W000312	<p>The QIDP will convene the IDT for client #1, #2 and #4. The IDT will assess the behaviors for which clients#1, #2 and #4 are prescribed medication and develop appropriate and attainable titration plans. The Behavior Consultant will be retrained on the requirement to include an appropriate plan to address medication withdrawal based on behaviors and ensure that the titration plan is measurable and attainable. . The Behavior Consultant will revise the Behavior Plans to include the titration plan developed by the IDT. The QIDP will obtain required approvals as soon as the plans are available. The QIDP will also ensure the staff is trained on the implementation of the plans. The QIDP will review each client's files to ensure each client that receives medication to manage behavior has an appropriate titration plan. Responsible Staff: Program Director, Area Director, Behavior Consultant</p>	12/04/2013	

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	<p>Criteria" indicated, "Recommendations for medication review will be based upon data collected through program data forms. Recommendations will be based on data indicating significant, sustained reduction in behavior (e.g.) (example): at least 75% improvement in rate, duration or intensity of behaviors to increase lasting no less than 6 consecutive months...." The BSP did not contain a measurable component to determine what the rate was in order to calculate a, "75% improvement in rate." The BSP did not contain a measurable titration plan.</p> <p>On 10/31/13 at 11:35 AM an interview was conducted with the Area Director (AD). The AD indicated client #1's BSP should contain a measurable titration plan.</p> <p>2. Client #2's records were reviewed on 10/29/13 at 12:40 PM. Client #2's BSP dated 08/30/12 indicated client #2's behaviors included property destruction, physical assault, taking non-menu items, vacating, inappropriate nudity, self-injurious behavior, inappropriate sexual behavior, incontinence, extreme irritability, temper outbursts and crying. The BSP indicated client #2 was on the following medications for the behaviors: Olanzapine (anti-psychotic), Clonazepam (anxiety), Amphetamine (hyperactivity),</p>				

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	<p>Perphenazine (anti-psychotic), Amitriptyline (depression) and Valproic Acid (mood disorder). The BSPs medication reduction plan indicated client #2 needed to reduce the behaviors to zero over a 90 day period before the medication would be considered for a decrease. The BSP did not contain an attainable titration plan.</p> <p>On 10/31/13 at 11:35 AM an interview was conducted with the Area Director (PD). The AD indicated client #2's BSP should contain a titration plan that was attainable.</p> <p>3. Client #4's records were reviewed on 10/29/13 at 1:45 PM. Client #4's BSP dated 08/29/12 indicated client #4's behaviors included temper outbursts and verbal abuse. The BSP indicated client #4 was on the following medications for the behaviors: Mirtazapine Soltab (depression) and Citalopram (depression) for mood stabilization. The BSPs medication reduction plan indicated client #4 needed to reduce the behaviors to zero over a 90 day period before the medication would be considered for a decrease. The BSP did not contain an attainable titration plan.</p> <p>On 10/31/13 at 11:35 AM an interview was conducted with the Area Director</p>			

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	(AD). The AD indicated client #4's BSP should contain a titration plan that was attainable. 9-3-5(a)			

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W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, record review and interview, the Condition of Participation: Health Care Services was not met for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 1 additional client (client #5). The facility's Health Care Services failed to ensure clients received health care services for their medical needs by failing to: obtain an annual physical for client #1; ensure client #1 had a risk protocol for choking/aspiration; ensure the MAR (Medication Administration Record) contained specific administration instructions for client #1's thick it; ensure client #2's dental health recommendations were addressed to brush teeth twice daily; update client #2's seizure protocol annually; obtain assessments for client #3 which included a hearing evaluation and the ordered sleep study test in 30 days; obtain admission medications for client #3; obtain a medical evaluation by a licensed professional for client #4 after missing 22 days of his blood pressure medication; update medical protocols for client #1 annually, follow diet orders and by failing to ensure medications were given as prescribed by the physician for clients #2, #3, #4 and #5.</p> <p>Findings include:</p>	W000318	Please refer to W322Please refer to W331Please refer to W368Please refer to W460	12/04/2013			

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	<p>1. Please refer to W322. The facility's nursing services failed for 1 of 4 sampled clients (client #1) to ensure an annual physical examination was completed.</p> <p>2. Please refer to W331. The facility nursing services failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 1 additional client (client #5), to ensure clients received nursing services according to their medical needs: by failing to obtain an annual physical for client #1; by failing to ensure client #1 had a risk protocol for choking/aspiration; by failing to ensure the MAR (Medication Administration Record) contained specific administration instructions for client #1's thick it; by failing to ensure client #2's dental health recommendations were addressed to brush teeth twice daily; by failing to update client #2's seizure protocol annually; by failing to obtain assessments for client #3 which included a hearing evaluation and the ordered sleep study test in 30 days; by failing to obtain admission medications for client #3; by failing to obtain a medical evaluation by a licensed professional for client #4 after missing 22 days of his blood pressure medication; by failing to update medical protocols for client #1 annually and by failing to ensure medications were given as prescribed by the physician for clients</p>			

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	<p>#2, #3, #4 and #5.</p> <p>3. Please refer to W368. The facility's nursing services failed for 3 of 4 sampled clients (clients #2, #3 and #4) and 1 additional client (client #5), who take medications prescribed by the physician, to administer medications as ordered.</p> <p>4. Please refer to W460. The facility's nursing services failed for 1 of 4 sample clients (client #1) who was on a modified diet, to follow diet orders.</p> <p>9-3-6(a)</p>			

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W000322	<p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #1) to have an annual physical examination.</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 10/29/13 at 11:40 AM. Client #1's record did not contain a physical examination after 10/29/12.</p> <p>On 10/31/13 at 11:35 AM an interview was conducted with the AD (Area Director). The AD indicated client #1 had not had a physical examination since 10/29/12 and there was not one scheduled.</p> <p>9-3-6(a)</p>	W000322	<p>A physical examination has been scheduled for Client #1. Home Manager, Program Director and Program Nurse will receive retraining to include ensuring that all consumers have physical examinations completed annually. Ongoing, the Area Director will track all consumers' annual physical examination dates and review the list a minimum of monthly. The Area Director will work with the Program Director to monitor which consumers physical examination dates are coming up in the upcoming months so examinations can be scheduled. Responsible Party: Home Manager, Program Director, Area Director, Program Nurse</p>	12/04/2013	

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 1 additional client (client #5), to ensure clients received nursing services according to their medical needs: by failing to obtain an annual physical for client #1; by failing to ensure client #1 had a risk protocol for choking/aspiration; by failing to ensure the MAR (Medication Administration Record) contained specific administration instructions for client #1's thick it; by failing to ensure client #2's dental health recommendations were addressed to brush teeth twice daily; by failing to update client #2's seizure protocol annually; by failing to obtain assessments for client #3 which included a hearing evaluation and the ordered sleep study test in 30 days; by failing to obtain admission medications for client #3; by failing to obtain a medical evaluation by a licensed professional for client #4 after missing 22 days of his blood pressure medication; by failing to update medical protocols for client #1 annually and by failing to ensure medications were given as prescribed by the physician for clients #2, #3, #4 and #5.</p> <p>Findings include:</p>	W000331	<p>1. A choking/aspiration protocol has been developed for Client #1. A physical examination has been scheduled for Client #1. Directions for Client #1 diet order for Nectar Thick Liquids has been clarified on the MAR. Program Nurse will receive retraining to include ensuring that all consumers that have identified risks such as choking/aspiration have appropriate protocols developed so staff are aware on how to monitor and prevent the risks. In addition, the retraining will include ensuring all consumers have physical examinations completed a minimum of annually and all diet modifications specifically outlined on the MAR for staff to implement them. Ongoing the Program Nurse will review and update as needed, a minimum of quarterly, all consumer protocols to ensure most accurate information is available to staff. Program Nurse will also ensure staff are trained as needed for any updates.2. Client #2 seizure protocol has been updated and reviewed by the Program Nurse. A dental hygiene goal for Client #2 has been developed based on the dental examination recommendations. Program Nurse will receive retraining to include ensuring that all</p>	12/04/2013			

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	<p>1. Client #1's records were reviewed on 10/29/13 at 11:40 AM. Client #1's Individual Support Plan (ISP) was dated 05/30/12 and indicated he was a choking and aspiration risk. His record did not contain a risk plan or protocol for the choking/aspiration. Client #1's record contained an annual physical dated 10/29/12. His record did not contain a physical after that date. Client #1's October 2013 MAR indicated an order for "Thick-It" "use as directed." The MAR did not contain the directions for the Thick-It. Client #1's Nutritional Assessment dated 05/20/13 indicated client #1's diet included NTL (Nectar Thick Liquids). The MAR did not contain the directions for the Nectar Thick Liquids.</p> <p>On 10/31/13 at 11:35 AM an interview with the AD (Area Director) was conducted. The AD indicated client #1 did not have an annual examination after 10/29/12 and none was scheduled currently. She indicated he was a choking/aspiration risk and should have a protocol. The AD indicated the MAR should contain the specific directions for the Thick-It to ensure client #1's liquids were prepared at a nectar thick consistency. She indicated all of these were responsibilities of the nurse.</p>		<p>consumers protocols are reviewed and updated as needed a minimum of quarterly. Retraining will also include ensuring that all medical/dental exam recommendations are relayed to the Program Director and Home Manager so that appropriate goals/objectives can be implemented. Ongoing the Program Nurse will review and update as needed, a minimum of quarterly, all consumer protocols to ensure most accurate information is available to staff. Program Nurse will also ensure staff are trained as needed for any updates. In addition the Program Nurse will review the results and recommendations of any medical/dental appointments after they occur and ensure the Program Director and Home Manager are notified of any recommendations so that they can be followed up on and any new goals/objectives can be developed as needed. 3. A hearing examination has been scheduled for Client #3. A sleep study test has also been scheduled for Client #3. Program Director and Program Nurse will receive retraining on ensuring that all assessments including hearing assessments are completed within 30 days following admission. In addition, the Program Nurse will receive retraining to include ensuring that all recommendations obtained from medical appointments are</p>		

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	<p>2. Client #2's records were reviewed on 10/29/13 at 12:40 PM. Client #2's ISP dated 11/05/12 indicated her diagnosis included, but was not limited to, seizures. Client #2's record contained a seizure protocol/plan dated 04/11/12. The record did not contain an updated plan or any indication the nurse had reviewed the plan after 04/11/12. Client #2's dental examination dated 06/17/13 indicated for her dental health she was to brush her teeth twice daily. Client #2's record did not contain any documentation to indicate this health recommendation was being addressed or monitored.</p> <p>On 10/31/13 at 11:35 AM an interview with the AD (Area Director) was conducted. The AD indicated client #2's diagnosis included seizures, she should have a seizure plan and it should be reviewed no less than yearly. The AD indicated the record did not contain any documentation to indicate client #2's dental health recommendations were being carried out. The AD indicated all of these were the responsibility of the nurse.</p> <p>3. Client #3's records were reviewed on 10/29/13 at 1:25 PM. Client #3's ISP (Individual Support Plan) dated 09/17/13 indicated he was admitted to the group</p>		<p>followed up on as needed. Ongoing the Program Director and Program Nurse will ensure that all initial medical assessments are completed within 30 days after admission. The Area Director will communicate with the Program Director and Program Nurse at the 30 day post-admission time to ensure that all assessments, medical appointments and goals have been completed as needed.</p> <p>4. All staff have received retraining and corrective action for failing to notify the Home Manager, Program Director and/or Program Nurse that Client #4 was missing his medication for several days. Home Manager and Program Nurse will receive retraining and corrective action for not reviewing the MAR within the 10/1-10/23 timeframe. Program Nurse will receive retraining to include ensuring that any consumers that have a serious medical condition or incident occur are formally assessed by a licensed medical professional as soon as possible after the incident occurs to monitor their condition. The retraining will also include ensuring that documentation is present for review of any medical assessment following a serious medical incident. Program Nurse will receive retraining to include ensuring that all consumers protocols are reviewed and updated as needed a minimum of</p>		

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	<p>home on 09/04/13. Client #3's record did not contain a hearing examination. The physical dated 08/30/13 indicated client #3 was to have a sleep study test. The record did not indicate the sleep study test had been completed. Client #3's September 2013 MAR indicated client #3 was ordered 81 mg (milligram) of Aspirin daily. The September MAR did not record the medication as given until 09/11/13.</p> <p>On 10/31/13 at 11:35 AM an interview with the AD (Area Director) was conducted. The AD indicated client #3 had not had a hearing evaluation within his 30 days of admission and the sleep study test had not been completed. The AD indicated client #3's MAR indicated he did not receive 6 doses of the Aspirin after he moved in. The AD indicated all of these were the responsibility of the nurse. The AD indicated the nurse was responsible to ensure new admissions have their ordered medications when they move into the home.</p> <p>4. Client #4's records were reviewed on 10/29/13 at 1:45 PM. Client #4's ISP dated 06/14/13 indicated client #4's diagnosis included, but was not limited to, high blood pressure. His ISP indicated he took medication to control the blood pressure. Client</p>		<p>quarterly. Ongoing, the Home Manager and Program Nurse will review the MAR a minimum of weekly to ensure any issues with consumers medications are brought to the attention of the Program Nurse and Program Director as immediately as possible. Ongoing the Program Nurse will ensure that after a serious medical condition occurs the consumer is seen by a licensed professional as soon as possible after the incident and documentation of this assessment is present for review. The Area Director will work with the Program Nurse to ensure that medical assessments are completed following a serious medical incident. 5. All staff have received retraining on Medication administration to include ensuring all consumers are receiving medications as prescribed by the physician. For 4 weeks, the Home Manager and/or Program Director will complete Medication Administration observations a minimum of twice weekly to ensure all consumers' are getting their medications as prescribed. After the 4 weeks, on an ongoing basis the Program Director and/or Home Manager will complete Medication Administration observations a minimum of weekly to ensure that all consumers are getting their medications as prescribed by the physician. Ongoing, the Home Manager and Program Nurse will</p>				

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	<p>#4's record contained a BDDS (Bureau of Developmental Disabilities Services) report dated 10/23/13 which indicated, "During a review it was discovered that [client #4] had missed his Lisinopril, blood pressure medication from 10/01-10/23/13...Nurse was notified. HM (House Manager) ordered the medication. Staff were circling and initialing but failed to notify supervisor medication was missing. Staff were reminded and retrained on medication administration and notifying appropriate supervisor. HM was reminded to thoroughly check med (medication) book weekly." Client #4's record did not contain documentation to indicate he was seen for a medical evaluation by a licensed professional after missing 22 days of his blood pressure medication. Client #4's record contained health care protocols, which included, but were not limited to: High Blood Pressure, Diabetes, High cholesterol and Reflux. The protocols were all dated 06/20/12.</p> <p>On 10/31/13 at 11:35 AM an interview with the House Manager (HM) was conducted. The HM indicated when the error was found the nurse was called and she advised the staff to take client #4's blood pressure. The HM indicated client #4 was not seen by a health care individual on 10/23/13 after the error was discovered. The HM indicated she did</p>		<p>review the MAR a minimum of weekly to ensure any issues with consumers medications are brought to the attention of the Program Nurse and Program Director as immediately as possible. Addendum: The Home Manager, Program Nurse, and/or Program Director will review the medication administration records (MARs) no less than every Monday, Wednesday, and Friday for the first 4 weeks. After the 4 initial weeks and ongoing, the Home Manager, Program Nurse, and/or Program Director will review the MARs randomly, no less than 2 times per week, per Indiana MENTOR policy and procedure for documentation review. In addition to the book audits that will be completed by the Clinical Supervisor and/or the Area Director, the Program Nurse will implement the Weekly/Monthly Nursing Progress Report. This report was designed to assist nursing staff with ensuring that all weekly, bi-weekly, and monthly duties are completed and on time. For the first 4weeks, the Area Director and/or Clinical Supervisor will meet with the Program Nurse once a week during a scheduled meeting to review the 'Weekly/Monthly Nursing Progress Report' that is in progress. This will be a designated meeting to discuss what the nurse has accomplished, what is still left to</p>				

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	<p>not contact the doctor until 10/28/13; 5 days after the error was discovered.</p> <p>On 10/31/13 at 12:40 PM an interview was conducted with the RN (Registered Nurse). She indicated she told the HM to take client #4's blood pressure on 10/23/13 and she indicated client #4 was not examined on 10/23/13. The RN indicated she saw client #4 on 10/24/13. There was no documentation to indicate the RN examined client #4 on 10/24/13. The RN indicated she spoke with the doctor on 10/25/13. There was no documentation to indicate the RN spoke with the doctor on 10/25/13.</p> <p>On 10/31/13 at 1:15 PM an interview with the AD (Area Director) was conducted. The AD indicated there was no documentation to indicated client #4 was seen by a health care professional after missing 22 doses of his blood pressure medication. The AD indicated he should have been evaluated. The AD indicated all health risk protocols were to be reviewed at least annually. The AD indicated these were the responsibility of the nurse.</p> <p>5. Client #5's records were reviewed on 10/29/13 at 3:45 PM. Client #4's record contained a BDDS (Bureau of Developmental Disabilities Services)</p>		<p>do, and to assist in creating a work plan to get all left over items accomplished. After the first initial 4 weeks, the Area Director and/or clinical supervisor will meet with the Program Nurse once every 2 weeks to continue to review the 'Weekly/Monthly Nursing Progress Report' that is in progress at the time. This will continue for 4 additional weeks. Following the follow up 4 weeks, the Area Director and/or Clinical Supervisor will continue to meet with the Program Nurse no less than once a month. This meeting will consist of continuing to review the ongoing 'Weekly/Monthly Nursing Progress Report' that is in progress at the time. Ongoing, the Program Nurse will continue to utilize the 'Weekly/Monthly Nursing Progress Report', and turn it in at the beginning of the following month to be reviewed by the Area Director and/or Clinical Supervisor for any further follow up that may need to be completed or discussed. Responsible Party: Program Director, Home Manager, Program Nurse, Area Director</p>		

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	<p>report dated 12/29/12 which indicated, "[Client #5] was not given his Levetiraceta (sic) (seizures). Nurse was notified..." Client #5's October 2013 Physician Orders indicated client #5's diagnosis included, but was not limited to, seizures.</p> <p>On 10/31/13 at 11:35 AM an interview with the House Manager (HM) was conducted. The HM indicated medicines were to be given as prescribed by the physician and client #5 was at risk of seizures if he did not get his seizure medication.</p> <p>9-3-6(a)</p>			

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed for 3 of 4 sampled clients (clients #2, #3 and #4) and 1 additional client (client #5), who take medications prescribed by the physician, to administer medications as ordered.</p> <p>Findings include:</p> <p>On 10/21/13 at 2:00 PM and on 10/23/13 at 3:15 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports and internal incident/accident reports was completed and included the following medication errors:</p> <p>12/29/12: "[Client #5] was not given his Levetiraceta (sic) (seizures). Nurse was notified...."</p> <p>07/03/13: "[Client #2] did not receive her Adderall (behaviors) on 07/01/13 and 07/02/13...HM (House Manager) said [client #2] had some minor negative behaviors due to missing the medication but no major issues...."</p> <p>10/04/13: "From 09/04/13 - 09/11/13 there was no bubble pack from the</p>	W000368	<p>All staff have received retraining on Medication administration to include ensuring all consumers are receiving medications as prescribed by the physician. For 4 weeks, the Home Manager and/or Program Director will complete Medication Administration observations a minimum of twice weekly to ensure all consumers' are getting their medications as prescribed. After the 4 weeks, on an ongoing basis the Program Director and/or Home Manager will complete Medication Administration observations a minimum of weekly to ensure that all consumers are getting their medications as prescribed by the physician. Ongoing, the Home Manager and Program Nurse will review the MAR a minimum of weekly to ensure any issues with consumers medications are brought to the attention of the Program Nurse and Program Director as immediately as possible. Addendum: The Home Manager, Program Nurse, and/or Program Director will review the medication administration records (MARs) no less than every Monday, Wednesday, and Friday for the first 4 weeks. After the 4 initial weeks and ongoing, the Home Manager, Program Nurse,</p>	12/04/2013			

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	<p>pharmacy for [client #3's] aspirin (health)...The MARS (Medication Administration Records) was incorrect...."</p> <p>10/23/13: "During a review it was discovered that [client #4] had missed his Lisinopril, blood pressure medication from 10/01-10/23/13...Nurse was notified. HM ordered the medication. Staff were circling and initialing but failed to notify supervisor medication was missing. Staff were reminded and retrained on medication administration and notifying appropriate supervisor. HM was reminded to thoroughly check med (medication) book weekly."</p> <p>On 10/31/13 at 11:35 AM an interview was conducted with the AD (Area Director). The AD indicated medications that were not given as prescribed were considered medication errors as staff were not following the physician's orders.</p> <p>9-3-6(a)</p>		<p>and/or Program Director will review the MARs randomly, no less than 2 times per week, per Indiana MENTOR policy and procedure for documentation review. Responsible Party: Program Director, Home Manager, Program Nurse, Area Director</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 for 7 of 7 clients (clients #1, #2, #3, #4, #5, #6 and #7) who resided in the home, to ensure an evacuation drill was conducted at least every quarter on the night shift.</p> <p>Findings include:</p> <p>On 10/21/13 at 2:30 PM, record reviews were completed of the facility's evacuation drills for the period of 10/01/12 through 10/20/13. The review of the evacuation drill records included evacuation drills which were conducted for personnel and clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>There were no recorded night shift drills conducted in 2012. The first night shift drill was on 03/19/13 at 1:30 AM.</p> <p>On 10/24/13 at 12:00 PM an interview with the Area Director (AD) was conducted. The AD indicated the drills were to be conducted every quarter and there were no additional evacuation drills for review.</p> <p>9-3-7(a)</p>	W000440	The Home Manager will be retrained on the policy and procedures for the completion of evacuation drills. The Home Manager will be responsible for submitting a copy of the fire drill to the Program Director and Quality Assurance Specialist before the last day of each month. The Quality Assurance Specialist will review the report and request any necessary follow-up. The Program Director will be responsible for ensuring the needed follow-up is completed. Responsible Staff: Program Director, Home Manager, Quality Assurance Specialist	12/04/2013			

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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.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 4 sample clients (client #1) who was on a modified diet to follow diet orders.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 10/24/13 from 4:12 PM until 5:45 PM and staff #1, #2, #3 and #4 were on duty. The observation included a medication administration. At 4:44 PM client #1 came to the medication administration area. Staff #1 poured a clear liquid from a pitcher, handed it to client #1 and he drank the liquid with his medications. Staff #1 was interviewed at 4:45 PM on 10/24/13 and she indicated the clear liquid was tap water.</p> <p>Client #1's records were reviewed on 10/29/13 at 11:30 AM. Client #1's record contained a dietary Nutritional Assessment dated 05/30/13. The assessment indicated client #1 was to have nectar thick liquids due to a choking risk.</p> <p>On 10/31/13 at 11:35 AM an interview with the Area Director (AD) was</p>	W000460	All staff will receive retraining to include ensuring that all consumers diet modification orders are followed as directed, including at medication administration times. For 4 weeks, the Home Manager and/or Program Director will complete Mealtime and Medication Administration observations a minimum of twice weekly to ensure all consumers' diet orders are being followed as prescribed. After the 4 weeks, on an ongoing basis the Program Director and/or Home Manager will complete Mealtime and Medication Administration observations a minimum of weekly to ensure that all consumers diet orders are being followed as prescribed by the physician. Responsible Party: Program Director, Home Manager, Program Nurse, Area Director	12/04/2013	

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	<p>conducted. The AD indicated staff #1 should have followed the dietary guidelines and client #1's liquids should have been thickened to a nectar consistency.</p> <p>9-3-8(a)</p>			