

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/25/2014
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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
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W000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint #IN00156482.</p> <p>Complaint #IN00156482: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W149, W154 and W252.</p> <p>Survey dates: September 22, 23, 24 and 25, 2014.</p> <p>Facility Number: 001082 Provider Number: 15G568 AIMS Number: 100245520</p> <p>Surveyors: Paula Eastmond, QIDP-TC Glenn David, RN</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed October 6, 2014 by Dotty Walton, QIDP.</p>	W000000		
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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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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 1 of 4 sampled clients (B), the facility failed to implement its written policy and procedures to prevent neglect of the client in regard to elopement from the group home.</p> <p>Findings include:</p> <p>During the 9/22/14 observation period between 4:00 PM and 6:30 PM, at the group home, the group home was located on a two lane busy street. The street did not have any side walks and no street lights were located near the group home. The street had 2 street lights located about a block away from the group home on each side of the street. During the 9/22/14 observation period, client B was not in line of staff's sight. Client B walked out of his bedroom into the dining room and/or kitchen area without being in line of sight of staff.</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 9/23/14 at 2:40 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p>	W000149	<p>1. The Program Director will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>1. All staff will receive retraining to include ensuring that Client B 15 minute check forms are being completed daily as directed and when completed are completed accurately and thoroughly. Home Manager and Program Director will retrain staff to clarify exactly how the 15 minute check forms</p>	10/25/2014

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	<p>-5/27/14 "[Client B] became upset from a phone call with his mother and stated he wanted to sign out of group home services. [Client B] decided to walk off from group home without informing staff. Staff searched nearby areas and could not locate [client B]. Staff was instructed by PD (Program Director) to call the police for assistance. Police came out but would not fill out a missing person report because [client B] is an emancipated adult that wanted to leave. Home Manager and PD went to look for [client B] and he was located with a family's friend. IDT (interdisciplinary team) will meet to discuss [client B's] behaviors, concerns, and staff will be trained accordingly to any changes. Staff will continue to monitor [client B's] health and safety." The reportable incident report indicated the incident occurred at 6:00 PM on 5/27/14.</p> <p>The facility's 6/13/14 follow-up report for the 5/2714 incident indicated "IDT met with [client B] and counselled (sic) him on telling staff when he is leaving. [Client B] appears to have understanding of procedures on leaving group home. [Client B] has been assessed for pedestrian safety skill and [client B] knows how to safely maneuver in the community...." The 5/27/14 reportable</p>		<p>are to be completed including actually initialing and dating each line instead of drawing a line down through several spaces at a time.</p> <p>Home Manager and/or Program Director will review Client B 15 minute check forms a minimum of 3 times per week for 4 weeks to ensure staff are completing 15 minute check forms daily and completing them accurately and thoroughly.</p> <p>Ongoing Home Manager and/or Program Director will review Client B 15 minute check forms a minimum of weekly to ensure staff are completing 15 minute check forms daily and completing them accurately and thoroughly</p> <p>1.Program Director will receive retraining to include ensuring that IDT meetings are held with all parties involved as soon as possible after high risk incidents to determine if further protective measures need to be put into place or if any changes to consumers BSP need to be implemented. Training will also include ensuring that any protocols that are developed or recommended for implementation are put into place as soon as possible after the incident to ensure protective measures are being followed so that prevention of future incidents can occur. Training will also include ensuring</p>	

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	<p>incident report and/or 6/13/14 follow up report indicated the facility failed to conduct an investigation in regard to client B's elopement incident which included staff and client interviews, how the client eloped, how many staff were working, when the client left the group home, and any corrective actions to prevent reoccurrence.</p> <p>-6/12/14 "[Client B] decided to walk off from the group home without informing staff. Staff [staff #4] informed HM (home manager) [staff #1] and PD that [client B] eloped from group home. Staff notified police and police came out but did not take report because [client B] is emancipated adult and was not gone for 24 hours. [Client B] walked to his father's house and his father returned him back to the group home. IDT met with [client B] when he returned back to the group home. [Client B] stated he left because he felt down/depressed about things taking place in his life. HM and PD are looking into getting [client B] some additional supports to help deal with his anxiety. [Client B] was placed on Staff's Line of Sight Protocol until the next IDT meeting. Next IDT meeting will take place after [client B's] doctor appointments. Staff will closely monitor [client B's] health and safety." The 6/12/14 reportable incident report</p>		<p>that notes from any IDT meetings are available to review as needed.</p> <p>Ongoing, the Program Director will ensure that IDT meetings are held as soon as possible after high risk incidents so that protective measures can be implemented as soon as possible and that documentation of IDT meetings is readily available for review.</p> <p>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</p>		

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	<p>indicated client B was discovered missing at 1:00 AM. The facility's 6/12/14 reportable incident report indicated the facility failed to conduct an investigation in regard to client B's elopement incident.</p> <p>-7/29/14 "Overnight staff [staff #4] went to do routine checks on the group home clients at 12:00 am. When staff went to [client B's] room, she (staff #4) noticed he was not in bed. Staff did an immediate search, in and around the group home. Staff could not locate [client B] on the group home grounds. Staff called Home Manager [staff #1] and reported [client B] had eloped from the premises. [Staff #1] instructed staff to search the grounds again for [client B] and to call the police for assistance if not found. Police came out and searched for [client B] and they couldn't locate him. Staff called one of [client B's] friends by phone and [client B] was present at friend's home. Staff went to pick up [client B] and he appeared to be intoxicated and acting weird. Program Director [name of PD] instructed staff to take [client B] to ER (emergency room) for further evaluations (sic). Staff transported [client B] to [name of hospital] for further evaluations (sic). [Client B] was evaluated by Hospital staff and discharged with no follow up</p>			

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	<p>instructions. IDT met on 7/29 to discuss [client B's] elopement. IDT decided that [client B's] supervision level needs to increase to Line of Sight protocol during awaken (sic) hours and 15 minute checks at bedtime until [client B's] next court date October 7th. Staff will encourage [client B] to communicate when he wants to leave and go over friend (sic) house. Staff will continue to monitor [client B] for his health and safety." The 7/29/14 reportable incident report indicated client B was discovered missing at 12:20 AM. The 7/29/14 reportable incident report indicated the facility failed to conduct an investigation in regard to the 7/29/14 elopement incident (when he left, how long gone, where staff was, why staff did not know he was gone, and how he left, etc.).</p> <p>-8/25/14 "[Staff #3] went to do routine checks on the group home clients at 12:00 AM. When staff went to [client B's] room, he (staff #3) noticed [client B] had eloped out of his bedroom window. Staff called Home Manager [staff #1] and reported [client B] had eloped. [Staff #1] instructed staff to search the grounds again for [client B] and to call the police for assistance. Police called group home and informed staff [client B] was located. [Client B] was returned to the group home. IDT met 1/25 (sic) and [client B]</p>			

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	<p>was placed on 1 to 1 staffing (one staff to one client) during overnight shift. IDT met with [client B] and explained outing procedures. Staff will continues (sic) to encourage [client B] to follow outing procedures...IDT will meet in 2 weeks to revise supervision levels." The facility's reportable incident report indicated client B was discovered missing at 12:15 AM.</p> <p>The facility's 8/26/14 investigation indicated client B and staff #3 were interviewed. The facility's investigation indicated client B eloped because he wanted to go get a beer and meet some friends. The facility's 8/26/14 investigation indicated the facility failed to conduct a thorough investigation in regard to the 8/25/14 elopement incident as no other staff and/or clients were interviewed. The facility's investigation failed to indicate how and when client B left the group home and/or address the staffing level at the time the elopement occurred.</p> <p>Client B's record was reviewed on 9/24/14 at 11:40 AM. Client B's Behavior Progress Reports (BPR) -Narrative Notes indicated the following (not all inclusive):</p> <p>-7/28/14 "[Client B] was in his bed. Staff came in &amp; (and) [client B] was not</p>			

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	<p>in the house or around the house. Police were called. Staff searched in &amp; around house."</p> <p>-8/24/14 "[Client B] was faking like he was sleep (sic). When staff went to do 15 min. (minute) checks he noticed that [client B] had went out of the window...."</p> <p>Client B's Visual Monitoring Sheets indicated the following "Directions: Staff will have a visual contact with [client B] every 15 minutes. The staff making the visual contact will initial the appropriate time box. [Client B] is in line of sight and staff must make visual contact with [client B] every 15 minutes. Staff sign and initial name on appropriate shift." Client B's 6/12/14 Visual Monitoring Sheet indicated the 15 minutes checks started on 6/12/14. Client B's 15 minute checklists indicated the facility conducted 15 minute checks from 6/12/14 until 6/25/14 and then stopped. Client B's Visual Monitoring Sheets indicated the 15 minute checks resumed on 7/28/14 after the 7/28/14 incident occurred. Client B's Visual Monitoring Sheets indicated client B was on 15 minute checks when he eloped from the group home on 8/25/14.</p> <p>Client B's Visual Monitoring Sheets indicated the following (not all</p>			

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	<p>inclusive):</p> <p>-7/28/14 Fifteen minutes checks were started on 7/28/14 at 11:00 AM. Fifteen minute checks were not done from 1:00 PM to 4:30 PM on 7/28/14.</p> <p>-8/9/14 Fifteen minute checks were not done from 6:00 AM to 6:00 PM and from 12:00 AM to 6:00 AM on 8/10/14.</p> <p>-8/14/14 Fifteen minute checks were not done from 4:15 PM to 11:45 PM.</p> <p>-8/24/14 The 15 minute check sheet indicated staff initialed each 15 minute intervals from 6:00 AM until 12:30 AM. The 8/24/14 sheet indicated staff #4 initialed the 12:15 AM-12:30 AM space and drew a line through each time slot/space thereafter. Staff #4 resumed initialing each 15 minute time slot from 4:15 AM to 6:00 AM.</p> <p>-8/25/14 Facility staff did not initial each 15 minute time slot from 6:15 AM to 9:15 AM, 12:15 AM to 3:30 AM and from 4:15 AM to 5:45 AM as a line was drawn through/down each space.</p> <p>-9/3/14 The 15 minute checklist indicated no 15 minute checks were completed from 4:00 PM to 5:00 PM and facility staff did not initial each 15</p>			

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	<p>minute time slot from 5:15 PM to 9:00 PM and from 9:15 PM to 10:00 PM.</p> <p>-9/4/14 Facility staff did not initial each fifteen minute slot from 10:00 PM to 12:00 AM, 12:30 AM to 1:00 AM and 1:30 AM to 3:15 AM as a line was drawn through/down each space.</p> <p>-9/13/14 Facility staff did not initial each 15 minute slot from 12:30 AM until 3:15 AM as a line was drawn through/down each space.</p> <p>-9/16/14 Facility staff did not initial each 15 minute slot from 12:30 AM to 3:45 AM as a line was drawn through/down each space.</p> <p>-9/17/14 The 15 minute checklist indicated no 15 minute checks were completed from 12:00 AM to 6:00 AM.</p> <p>-9/18/14 The 15 minute checklist indicated no 15 minute checks were completed from 12:00 AM to 6:00 AM.</p> <p>-9/21/14 Facility staff did not initial each 15 minute slot from 2:30 AM to 3:30 AM and from 4:30 AM to 5:45 AM as a line was drawn through/down each space.</p> <p>-9/22/14 Facility staff did not initial each 15 minute time slot from 12:45 AM to</p>			

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	<p>3:45 AM and from 5:15 AM to 5:45 AM as a line was drawn through/down each space.</p> <p>Client B's 6/12/14 Supervision Protocol for [Client B] indicated the following:</p> <p>"-This protocol will be effective 6/12/2014 and remain in place until changed by his Interdisciplinary Team.</p> <p>-Staff will be scheduled during waking hours to ensure that a staff can provide line of sight supervision.</p> <p>-Line of sight supervision will begin when [client B] wakes up in the morning and remain in effect until he retires for the evening.</p> <p>-Line of sight supervision will be defined as staff being in the same room with [client B] or in staff's eye sight. Staff may be engaged in other activities such as documentation, playing a game, washing dishes, etc. as long as they see [client B] and what he is doing. When [client B] wants/needs to move from one place to another, staff must keep him in line of sight.</p> <p>-When [client B] is using the toilet or the shower, staff will remain in proximity (outside the bathroom door or hallway)</p>			

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	<p>until he is finished...."</p> <p>Client B's IDT Meeting Notes indicated the following (not all inclusive):</p> <p>6/2/14 "[Client B] has made some bad decisions in regards overnight visits and walking off situations from the Group Home. [Client B] is bored and finding a job has been difficult. [Client B] will notify staff when he wants to stay (sic) overnight or wants to go out into the community...."</p> <p>-6/19/14 "Continue 15 min (minute) check (sic) that started 6/12/14 til (sic) start work at [name of workshop] 6/25/14...."</p> <p>-8/25/14 "Wants to sign himself out/vacated last night. Feels the group home is not the best fit for him. Plans to move w(with)/friend if he allows (sic)...Understands the dangers of walking the streets &amp; (and) [client B] understands drinking, w/taking meds. Dr. recommends [client B] not to drink because of medications [client B] is taking. If [client B] signs himself out he has no where to go. HM, PD, AD (Area Director) reassured [client B] when he wants to go to inform staff he is leaving instead of vacating w/out staff knowledge...." Client B's 8/25/14 IDT</p>			

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	<p>did not indicate the facility placed client B on one to one staffing as indicated by the 8/25/14 reportable incident report. Client B's above mentioned IDT notes did not indicate client B's 6/12/14 supervision protocol had been discontinued as the facility's 7/29/14 reportable incident report indicated the protocol would be continued until client B's October 2014 court date. Client B's record and/or IDT notes did not indicate the client's IDT met after client B's 7/28/14 elopement incident.</p> <p>Interview with staff #4 on 9/23/14 at 7:35 AM indicated client B had eloped 2 to 3 times since he moved into the group home. Staff #4 indicated client B eloped on the evening shift as she had found client B missing when she went to check on the client when she arrived to work on the midnight shift. Staff #4 stated one time "[Client B] was gone for my entire shift (12 midnight to 10 AM)." Staff #4 indicated the police were called each time. When asked how client B was supervised to prevent eloping from the group home, staff #4 indicated client B was on 15 minute checks. Staff #4 indicated client B had been on one to one staffing for a month after the incident occurred.</p> <p>Interview with administrative staff #1 on</p>			

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	<p>9/24/14 at 1:50 PM indicated client B should still be on 15 minute checks at night and in line of sight when client B was awake. Administrative staff #1 indicated client B's record and/or IDT did not document client B's being placed on one on one staffing on 8/25/14. Administrative staff #1 indicated she thought the supervision protocol had been updated. Administrative staff #1 indicated client B's IDT also did not specifically document when client B's line of sight was to be discontinued. Administrative staff indicated client B had pedestrian safety skills. Administrative staff #1 indicated the facility did not conduct an investigation in regard to client B's elopement incidents. Administrative staff #1 indicated the investigation completed in regard to the 8/25/14 incident was not thorough.</p> <p>Interview with staff #1 on 9/24/14 at 2:49 PM indicated client B demonstrated the behavior of elopement. Staff #1 indicated client B was placed on 15 minute checks on 6/12/14 after client B eloped from the group home. Staff #1 indicated the IDT stopped the 15 minute checks on 6/25/14 once client B started working at the workshop. Staff #1 stated the IDT "thought [client B] was frustrated on starting work." Staff #1 indicated the</p>			

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	<p>15 minute checks were started again (7/28/14) after client B eloped on 7/26/14. Staff #1 indicated 15 minute checks were put in place and were to continue until client B returned, for a court date, in October 2014 for a client to client aggression incident at the group home. Staff #1 indicated client B did not have to be in line of sight of staff. Staff #1 indicated client B's line of sight supervision had been discontinued. Staff #1 indicated client B's one on one staffing was discontinued on 9/12/14. Staff #1 indicated there was no documentation done in regard to the IDT's decision to discontinue the line of sight protocol and/or client B's one on one staffing due to the client's elopement. Staff #1 indicated facility staff were not documenting the 15 minute checks correctly. Staff #1 indicated facility staff should not draw a line through/down the spaces on the 15 minute checklist. Staff #1 indicated facility staff were to initial each space after the 15 minute check was completed. The facility's policy and procedures were reviewed on 9/23/14 at 2:30 PM. The April 2011 facility's policy entitled QUALITY AND RISK MANAGERMENTS indicated "Indiana MENTOR promotes a high quality of service and seeks to protect individuals receiving Indiana MENTOR services through oversight of management</p>			

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W000154	<p>procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The policy indicated "...Indiana MENTOR is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee...."</p> <p>This federal tag relates to complaint #IN00156482.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on observation, record review and interview for 4 of 13 allegations of neglect and/or abuse reviewed, the facility failed to conduct investigations and/or thorough investigations in regard to client B's elopement incidents.</p> <p>Findings include:</p> <p>During the 9/22/14 observation period between 4:00 PM and 6:30 PM, at the</p>	W000154	<p>The Program Director will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an</p>	10/25/2014

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	<p>group home, the group home was located on a two lane busy street. The street did not have any side walks and no street lights were located near the group home. The street had 2 street lights located about a block away from the group home on each side of the street.</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 9/23/14 at 2:40 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-5/27/14 "[Client B] became upset from a phone call with his mother and stated he wanted to sign out of group home services. [Client B] decided to walk off from group home without informing staff. Staff searched nearby areas and could not locate [client B]. Staff was instructed by PD (Program Director) to call the police for assistance. Police came out but would not fill out a missing person report because [client B] is an emancipated adult that wanted to leave. Home Manager and PD went to look for [client B] and he was located with a family's friend. IDT (interdisciplinary team) will meet to discuss [client B's] behaviors, concerns, and staff will be trained accordingly to any changes. Staff will continue to monitor [client B's]</p>		<p>investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</p>		

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	<p>health and safety." The reportable incident report indicated the incident occurred at 6:00 PM on 5/27/14.</p> <p>The facility's 6/13/14 follow-up report for the 5/27/14 incident indicated "IDT met with [client B] and counselled (sic) him on telling staff when he is leaving. [Client B] appears to have understanding of procedures on leaving group home. [Client B] has been assessed for pedestrian safety skill and [client B] knows how to safely maneuver in the community...." The 5/27/14 reportable incident report and/or 6/13/14 follow up report indicated the facility failed to conduct an investigation in regard to client B's elopement incident which included staff and client interviews, how the client eloped, how many staff were working, when the client left the group home, and any corrective actions to prevent reoccurrence.</p> <p>-6/12/14 "[Client B] decided to walk off from the group home without informing staff. Staff [staff #4] informed HM (home manager) [staff #1] and PD that [client B] eloped from group home. Staff notified police and police came out but did not take a report because [client B] is emancipated adult and was not gone for 24 hours. [Client B] walked to his father's house and his father returned him</p>			

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	<p>back to the group home. IDT met with [client B] when he returned back to the group home. [Client B] stated he left because he felt down/depressed about things taking place in his life. HM and PD are looking into getting [client B] some additional supports to help deal with his anxiety. [Client B] was placed on Staff's Line of Sight Protocol until the next IDT meeting. Next IDT meeting will take place after [client B's] doctor appointments. Staff will closely monitor [client B's] health and safety." The 6/12/14 reportable incident report indicated client B was discovered missing at 1:00 AM. The facility's 6/12/14 reportable incident report indicated the facility failed to conduct an investigation in regard to client B's elopement incident.</p> <p>-7/29/14 "Overnight staff [staff #4] went to do routine checks on the group home clients at 12:00 am. When staff went to [client B's] room, she (staff #4) noticed he was not in bed. Staff did an immediate search, in and around the group home. Staff could not locate [client B] on the group home grounds. Staff called Home Manager [staff #1] and reported [client B] had eloped from the premises. [Staff #1] instructed staff to search the grounds again for [client B] and to call the police for assistance if not</p>			

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	<p>found. Police came out and searched for [client B] and they couldn't locate him. Staff called one of [client B's] friends by phone and [client B] was present at friend's home. Staff went to pick up [client B] and he appeared to be intoxicated and acting weird. Program Director [name of PD] instructed staff to take [client B] to ER (emergency room) for further evaluations (sic). Staff transported [client B] to [name of hospital] for further evaluations (sic). [Client B] was evaluated by Hospital staff and discharged with no follow up instructions. IDT met on 7/29 to discuss [client B's] elopement. IDT decided that [client B's] supervision level needs to increase to Line of Sight protocol during awaken (sic) hours and 15 minute checks at bedtime until [client B's] next court date October 7th. Staff will encourage [client B] to communicate when he wants to leave and go over friend (sic) house. Staff will continue to monitor [client B] for his health and safety." The 7/29/14 reportable incident report indicated client B was discovered missing at 12:20 AM. The 7/29/14 reportable incident report indicated the facility failed to conduct an investigation in regard to the 7/29/14 elopement incident (when he left, how long gone, where staff was, why staff did not know he was gone, and how he left, etc.).</p>			
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	<p>-8/25/14 "[Staff #3] went to do routine checks on the group home clients at 12:00 AM. When staff went to [client B's] room, he (staff #3) noticed [client B] had eloped out of his bedroom window. Staff called Home Manager [staff #1] and reported [client B] had eloped. [Staff #1] instructed staff to search the grounds again for [client B] and to call the police for assistance. Police called (sic) group home and informed staff [client B] was located. [Client B] was returned to the group home. IDT met 1/25 (sic) and [client B] was placed on 1 to 1 staffing (one staff to one client) during overnight shift. IDT met with [client B] and explained outing procedures. Staff will continues (sic) to encourage [client B] to follow outing procedures...IDT will meet in 2 weeks to revise supervision levels." The facility's reportable incident report indicated client B was discovered missing at 12:15 AM.</p> <p>The facility's 8/26/14 investigation indicated client B and staff #3 were interviewed. The facility's investigation indicated client B eloped because he wanted to go get a beer and meet some friends. The facility's 8/26/14 investigation indicated the facility failed to conduct a thorough investigation in regard to the 8/25/14 elopement incident</p>			

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W000240	<p>as no other staff and/or clients were interviewed. The facility's investigation failed to indicate how and when client B left the group home and/or address the staffing level at the time the elopement occurred.</p> <p>Interview with administrative staff #1 on 9/24/14 at 1:50 PM indicated the facility did not conduct an investigation in regard to client B's elopement incidents. Administrative staff #1 indicated the investigation completed in regard to the 8/25/14 incident was not thorough.</p> <p>This federal tag relates to complaint #IN00156482.</p> <p>9-3-2(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on interview and record review for 2 of 4 sampled clients (B and D) and 1 additional client (E), the clients' Individual Support Plan (ISP) failed to specifically indicate how facility staff were to handle/address the client D's Psychosis (delusions and hallucinations) when they occurred, and failed to indicate how facility staff were to monitor clients</p>	W000240	<p>1. The Program Director will work with the Behavior Specialist to evaluate and identify ways for staff to handle/address Client D Psychosis (delusions/hallucinations) when they occur. Once clarified, the Behavior Specialist and Program Director will update Client D ISP and BSP to include ways for staff</p>	10/25/2014

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	<p>B and E due to a significant client to client altercation.</p> <p>Findings include:</p> <p>1. Interview with client D on 9/22/14 at 4:20 PM indicated client D was concerned about gunshots being fired at the group home. Client D indicated client B and staff would shoot guns outside the group home. Client D stated he had been in the military and may be having "flashbacks."</p> <p>Interview with staff #3 on 9/22/14 at 4:30 PM indicated there had been no gunshots fired at the group home. Staff #3 indicated client D thought he had been in the military. Staff #3 stated client D would watch war movies on television and would indicate the client thought he was having "flashbacks." Staff #3 indicated client D thought gunshots were being fired on the Fourth of July when they were actually firecrackers. Staff #3 stated client D was "Not stable." Staff #3 indicated he had called the home manager in the past when client D demonstrated delusions and hallucinations.</p> <p>Client D's record was reviewed on 9/24/14 at 10:24 AM. Client D's 7/1/14 physician's order indicated client D's</p>		<p>to address Client D Psychosis when it occurs. Staff will receive training on the ISP and BSP in regard to how staff can assist Client D when Psychosis occurs.</p> <p>2. The Program Director will work with the Behavior Specialist to evaluate and identify ways for staff to monitor Client B's interactions with Client E to prevent continued altercations/aggression toward each other. . Once clarified, the Behavior Specialist and Program Director will update Client B ISP and BSP to include ways for staff to monitor Client B and Client E ongoing interactions to prevent further altercations/aggression toward each other. Staff will receive training on the ISP and BSP in regard to how staff can monitor Client B interactions with Client E to prevent further aggression/altercations from occurring.</p> <p>The Program Director will receive retraining to ensure that all consumers ISPs and BSPs identify specific needs and supports to assist the consumers with working towards independence in identified areas as determined by the Interdisciplinary Team.</p> <p>Ongoing, the Program Director will ensure that any needed supports to assist consumers</p>	

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	<p>diagnosis included, but was not limited to, Psychosis.</p> <p>Client D's March 2014 Behavioral Support Plan (BSP) indicated client D's diagnosis included, but was not limited to, Schizoaffective Disorder. Client D's March 2014 BSP and/or 5/20/14 ISP did not specifically indicate how facility staff were to deal with/address client D's delusions/hallucinations when they occurred.</p> <p>Interview with staff #1 in 9/24/14 at 2:49 PM indicated client D had a diagnosis of Psychosis. Staff #1 indicated client D's Psychosis included demonstrating delusions and hallucinations. Staff #1 indicated client D had been in and out of hospitals due to his Psychosis. Staff #1 stated when client D demonstrated delusions and/or hallucinations, staff were to "Bring [client D] back. Ask him questions like when it happened." Staff #1 indicated client D's ISP and/or BSP did not include any guidelines/protocols which addressed how facility staff were to handle/address the client's delusions/hallucinations when they occurred.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 9/23/14 at 2:40 PM. The</p>		<p>toward independence that are identified by the IDT are included in consumers ISPs and BSPs. For the next 3 months the Area Director will review all ISPs and BSPs submitted by the Program Director to ensure that goals for all needed supports recommended by the IDT are included in the ISP.</p> <p>Responsible Party: Behavior Specialist, Program Director, Area Director</p>	

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	<p>facility's 6/4/14 reportable incident report indicated "[Client E] and [client B] were preparing to leave out for an outing, when [client E] said something sarcastic, and postured [client B], with his fist clinched. [Client B] reacted and hit [client E] in the face. [Client E] and [client B] exchanged punches and staff separated the two. [Client E] suffered a cut under the eye and he called the police. Police came out and decided to detain [client B] for the injury to [client E's] eye. Police transported [client B] to [name of county jail] and Staff transported [client E] to [name of hospital] and he received 3 stitches under his left eye. [Client E] has a follow up in 7 days to remove stitches. IDT (interdisciplinary team) will meet to discuss [client B] and [client E's] behaviors and staff will be trained accordingly to any plan changes. [Client B] has court on June 6, 2014 and consequences will be determined at that time."</p> <p>Client B's record was reviewed on 9/24/14 at 11:40 AM. Client B's 8/5/14 BPR (Behavior Progress Record) -Narrative Notes indicated "Staff and another client (client E) was (sic) talking outside in private and [client B] walked out being aggressive in tone and verbally aggressive. [Client B] confronted housemate (client E) cursing, yelling and</p>			

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	<p>being a little threatening to housemate. [Client B] told housemate he hated him, couldn't stand him, called housemate a spoil brat b...."</p> <p>Client B's 6/12/14 "Supervision Protocol for [Client B]" indicated "...Staff will continue to document on 15 minute checks that [client B] is being safe and his location is known. [Client B] needs five feet of space between House Mate [client E] until changed by Interdisciplinary Team."</p> <p>Client B's 6/25/14 Mentor Meeting Note indicated "...[Client B] &amp; (and) housemate (client E) cannot be less than 5 ft (feet) apart per judge." Client B's IDT note and/or record did not indicate the ordered restriction had been discontinued.</p> <p>Client B's September 2014 Behavioral Support Plan (BSP) and/or 3/5/14 ISP did not specifically indicate how facility staff were to monitor clients B and E to prevent further aggression/altercations between the two.</p> <p>Interview with administrative staff #1 on 9/24/14 at 1:50 PM indicated client B and E's aggressive incident led to the police being called and client E receiving stitches. Administrative staff #1</p>			

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W000252	<p>indicated client B was arrested and had been going to court due to the incident. Administrative staff #1 indicated client B and E no longer had to be more than 5 feet apart. Administrative staff #1 indicated the judge removed the restriction as it was not able to be followed as both clients lived in the group home. Administrative staff #1 indicated client B's ISP and/or BSP did not indicate how facility staff were to monitor the clients to prevent altercations/aggression since the 5 foot restriction was not being followed.</p> <p>Interview with staff #1 on 9/24/14 at 2:49 PM stated "They (clients B and E) clicked" when client B first moved into the group home. Staff #1 stated "Then they started bumping heads." Staff #1 stated client B was "sarcastic." Staff #1 stated "[Client E] may not know how to take it."</p> <p>9-3-4(a)</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on interview and record review for</p>	W000252	All staff will receive retraining to include ensuring that Client B 15	10/25/2014			

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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250		
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	<p>1 of 4 sampled clients (B), the facility failed to ensure facility staff documented 15 minute checks as indicated by the client's Individual Support Plan/Interdisciplinary Team (IDT) note.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 9/23/14 at 2:40 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-5/27/14 "[Client B] became upset from a phone call with his mother and stated he wanted to sign out of group home services. [Client B] decided to walk off from group home without informing staff. Staff searched nearby areas and could not locate [client B]. Staff was instructed by PD (Program Director) to call the police for assistance. Police came out but would not fill out a missing person report because [client B] is an emancipated adult that wanted to leave. Home Manager and PD went to look for [client B] and he was located with a family's friend. IDT (interdisciplinary team) will meet to discuss [client B's] behaviors, concerns, and staff will be trained accordingly to any changes. Staff will continue to monitor [client B's]</p>		<p>minute check forms are being completed daily as directed and when completed are completed accurately and thoroughly. Home Manager and Program Director will retrain staff to clarify exactly how the 15 minute check forms are to be completed including actually initialing and dating each line instead of drawing a line down through several spaces at a time.</p> <p>Home Manager and/or Program Director will review Client B 15 minute check forms a minimum of 3 times per week for 4 weeks to ensure staff are completing 15 minute check forms daily and completing them accurately and thoroughly.</p> <p>Ongoing Home Manager and/or Program Director will review Client B 15 minute check forms a minimum of weekly to ensure staff are completing 15 minute check forms daily and completing them accurately and thoroughly.</p> <p>Responsible Party: Home Manager, Program Director, Area Director</p>		

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	<p>health and safety." The reportable incident report indicated the incident occurred at 6:00 PM.</p> <p>-6/12/14 "[Client B] decided to walk off from the group home without informing staff. Staff [staff #4] informed HM (home manager) [staff #1] and PD that [client B] eloped from group home. Staff notified police and police came out but did not take report because [client B] is emancipated adult and was not gone for 24 hours. [Client B] walked to his father's house and his father returned him back to the group home...."</p> <p>-7/29/14 "Overnight staff [staff #4] went to do routine checks on the group home clients at 12:00 am. When staff went to [client B's] room, she (staff #4) noticed he was not in bed. Staff did an immediate search, in and around the group home. Staff could not locate [client B] on the group home grounds. Staff called Home Manager [staff #1] and reported [client B] had eloped from the premises. [Staff #1] instructed staff to search the grounds again for [client B] and to call the police for assistance if not found (sic). Police came out and searched for [client B] and they couldn't locate him. Staff called one of [client B's] friends by phone and [client B] was present at friend's home. Staff went to</p>			
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	<p>pick up [client B] and he appeared to be intoxicated and acting weird...IDT met on 7/29 to discuss [client B's] elopement. IDT decided that [client B's] supervision level needs to increase to Line of Sight protocol during awaken (sic) hours and 15 minute checks at bedtime until [client B's] next court date October 7th..."</p> <p>-8/25/14 "[Staff #3] went to do routine checks on the group home clients at 12:00 AM. When staff went to [client B's] room, he (staff #3) noticed [client B] had eloped out of his bedroom window. Staff called Home Manager [staff #1] and reported [client B] had eloped. [Staff #1] instructed staff to search the grounds again for [client B] and to call the police for assistance. Police called group home and informed staff [client B] was located. [Client B] was returned to the group home...."</p> <p>Client B's record was reviewed on 9/24/14 at 11:40 AM. Client B's Visual Monitoring Sheets indicated the following "Directions: Staff will have a visual contact with [client B] every 15 minutes. The staff making the visual contact will initial the appropriate time box. [Client B] is in line of sight and staff must make visual contact with [client B] every 15 minutes. Staff sign and initial name on appropriate shift."</p>			

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	<p>Client B's 6/12/14 Visual Monitoring Sheet indicated the 15 minutes checks started on 6/12/14. Client B's 15 minute checklists indicated the facility conducted 15 minute checks from 6/12/14 until 6/25/14 and then stopped. Client B's Visual Monitoring Sheets indicated the 15 minute checks resumed on 7/28/14 after the 7/28/14 incident occurred. Client B's Visual Monitoring Sheets indicated client B was on 15 minute checks when he eloped from the group home on 8/25/14.</p> <p>Client B's Visual Monitoring Sheets indicated the following (not all inclusive):</p> <ul style="list-style-type: none"> <li>-7/28/14 Fifteen minutes checks were started on 7/28/14 at 11:00 AM. Fifteen minute checks were not done from 1:00 PM to 4:30 PM on 7/28/14.</li> <li>-8/9/14 Fifteen minute checks were not done from 6:00 AM to 6:00 PM and from 12:00 AM to 6:00 AM on 8/10/14.</li> <li>-8/14/14 Fifteen minute checks were not done from 4:15 PM to 11:45 PM.</li> <li>-8/24/14 The 15 minute check sheet indicated staff initialed each 15 minute intervals from 6:00 AM until 12:30 AM. The 8/24/14 sheet indicated staff #4</li> </ul>			

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	<p>initialed the 12:15 AM-12:30 AM space and drew a line through each time slot/space thereafter. Staff #4 resumed initialing each 15 minute time slot from 4:15 AM to 6:00 AM.</p> <p>-8/25/14 Facility staff did not initial each 15 minute time slot from 6:15 AM to 9:15 AM, 12:15 AM to 3:30 AM and from 4:15 AM to 5:45 AM as a line was drawn through/down each space.</p> <p>-9/3/14 The 15 minute checklist indicated no 15 minute checks were completed from 4:00 PM to 5:00 PM and facility staff did not initial each 15 minute time slot from 5:15 PM to 9:00 PM and from 9:15 PM to 10:00 PM.</p> <p>-9/4/14 Facility staff did not initial each fifteen minute slot from 10:00 PM to 12:00 AM, 12:30 AM to 1:00 AM and 1:30 AM to 3:15 AM as a line was drawn through/down each space.</p> <p>-9/13/14 Facility staff did not initial each 15 minute slot from 12:30 AM until 3:15 AM as a line was drawn through/down each space.</p> <p>-9/16/14 Facility staff did not initial each 15 minute slot from 12:30 AM to 3:45 AM as a line was drawn through/down each space.</p>			

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	<p>-9/17/14 The 15 minute checklist indicated no 15 minute checks were completed from 12:00 AM to 6:00 AM.</p> <p>-9/18/14 The 15 minute checklist indicated no 15 minute checks were completed from 12:00 AM to 6:00 AM.</p> <p>-9/21/14 Facility staff did not initial each 15 minute slot from 2:30 AM to 3:30 AM and from 4:30 AM to 5:45 AM as a line was drawn through/down each space.</p> <p>-9/22/14 Facility staff did not initial each 15 minute time slot from 12:45 AM to 3:45 AM and from 5:15 AM to 5:45 AM as a line was drawn through/down each space.</p> <p>Client B's 6/19/14 IDT Meeting Note indicated "Continue 15 min (minute) check that started 6/12/14 til (sic) start work at [name of workshop] 6/25/14...."</p> <p>Interview with staff #4 on 9/23/14 at 7:35 AM indicated client B had eloped 2 to 3 times since he moved into the group home. Staff #4 indicated client B eloped on the evening shift as she had found client B missing when she went to check on the client when she arrived to work on the midnight shift. When asked how client B was supervised to prevent</p>			

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	<p>eloping from the group home, staff #4 indicated client B was on 15 minute checks.</p> <p>Interview with administrative staff #1 on 9/24/14 at 1:50 PM indicated client B should still be on 15 minute checks at night and in line of sight when client B was awake.</p> <p>Interview with staff #1 on 9/24/14 at 2:49 PM indicated client B demonstrated the behavior of elopement. Staff #1 indicated client B was placed on 15 minute checks on 6/12/14 after client B eloped from the group home. Staff #1 indicated the IDT stopped the 15 minute checks on 6/25/14 once client B started working at the workshop. Staff #1 indicated the 15 minute checks were started again after client B eloped on 7/26/14 on 7/28/14. Staff #1 indicated 15 minute checks were put in place and were to continue until client B returned, for a court date, in October 2014 for a client to client aggression incident at the group home. Staff #1 indicated facility staff were not documenting the 15 minute checks correctly. Staff #1 indicated facility staff should not draw a line through/down the spaces on the 15 minute checklist. Staff #1 indicated facility staff were to initial each space after the 15 minute check was completed.</p>			

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W000255	<p>This federal tag relates to complaint #IN00156482.</p> <p>9-3-4(a)</p> <p>483.440(f)(1)(i) PROGRAM MONITORING &amp; CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. Based on observation, interview and record review for 2 of 4 sampled clients (B and C), the Qualified Intellectual Disabilities Professional (QIDP) failed to revise the clients' Individual Support Plan objectives when the clients achieved their objectives.</p> <p>Findings include:</p> <p>1. Client B's record was reviewed on 9/24/14 at 11:40 AM. Client B's 3/5/14 ISP indicated the client had the following objectives:</p> <p>-To write components of a check 85% of the time with 1 one verbal prompt for 3 consecutive months.</p>	W000255	<p>An audit will be completed on all consumers' goals and objectives to assess level of completion. All goals and objectives that the consumer has successfully completed will be revised as needed to allow for further progress.</p> <p>The Program Director will receive retraining to include ensuring that all consumers goals and objectives are reviewed a minimum of monthly and assessed a minimum of quarterly to review level of completion. If consumers are successfully completing objectives, they will be revised as needed to allow for further progress.</p> <p>The Program Director will receive retraining to ensure that monthly progress reviews of all</p>	10/25/2014

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	<p>-To shave his face without having to be prompted by staff 85% of the time for 3 consecutive months.</p> <p>-To complete a chore from the chore list every evening 80% of the time for 3 consecutive months.</p> <p>-To state 2 side effects of his Adderall (Attention Deficit Hyperactivity Disorder) medication 85 % of the time with 1 verbal prompt for 3 consecutive months.</p> <p>-To interact "appropriately" with peers without having to be redirected by staff 85% of the time for 3 consecutive months.</p> <p>Client B's record and/or ISP indicated client B's above mentioned objectives were last reviewed in May 2014 as the last monthly review, present in the client's record, was dated May 2014.</p> <p>Interview with administrative staff #1 on 9/24/14 at 1:50 PM indicated client B's QIDP was on vacation. Administrative staff #1 indicated she could not locate any additional monthly reviews for client B's ISP objectives. Administrative staff #1 indicated she did not know if client B had achieved his ISP objectives.2. During the 9/24/14 observation period at</p>		<p>consumers goals and objectives are completed and available for review.</p> <p>The Area Director will review the next 3 ISPs completed by this Program Director to review if consumers goals and objectives are being reviewed and revised as needed when consumers are achieving objectives as identified in the individual program plans. Area Director will track progress reviews a minimum of monthly to ensure they are being completed in a timely manner and are available for review as needed.</p> <p>Responsible Party: Program Director, Area Director</p>	

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W000256	<p>6:40 AM, when asked by staff, client C was able to verify the correct insulin (Humulin) dosage (8 units) and verbalize it was used for treatment of diabetes.</p> <p>Client C's record was reviewed on 9/24/14 at 10:50 PM. Client C's ISP, dated November 2013 indicated the client "will independently state how many units of insulin he takes and the reason he takes it in the AM and PM 70% of trials for 3 consecutive reviews."</p> <p>Client C's Goal Tracking Sheet indicated he attained a 100% satisfaction rate for this goal for 9 months beginning in January 2014 through and including September 2014.</p> <p>Interview with AS (Administrative staff) #1 on 9/24/14 at 11:00 AM indicated the QIDP was on vacation. AS #1 indicated client C's Goal Tracking Sheet and ISP had not been reviewed or revised in regards to the client having successfully completed the goal of knowing how many units of Humulin Insulin he takes and the related diagnosis (diabetes).</p> <p>9-3-4(a)</p> <p>483.440(f)(1)(ii) PROGRAM MONITORING &amp; CHANGE</p>						

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	<p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is regressing or losing skills already gained.</p> <p>Based on interview and record review for 1 of 4 sampled client (B), the Qualified Intellectual Disabilities Professional (QIDP) failed to revise the client's Individual Support Plan/ISP objectives when the client lost and/or regressed in skills.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Client B's record was reviewed on 9/24/14 at 11:40 AM. Client B's 3/5/14 ISP indicated the client had the following objectives: <ul style="list-style-type: none"> <li>-To write components of a check 85% of the time with 1 one verbal prompt for 3 consecutive months.</li> <li>-To shave his face without having to be prompted by staff 85% of the time for 3 consecutive months.</li> <li>-To complete a chore from the chore list every evening 80% of the time for 3 consecutive months.</li> <li>-To state 2 side effects of his Adderall (Attention Deficit Hyperactivity</li> </ul> </li> </ol>	W000256	<p>An audit will be completed on all consumers' goals and objectives to assess level of completion. All goals and objectives that the consumer has successfully completed will be revised as needed to allow for further progress.</p> <p>The Program Director will receive retraining to include ensuring that all consumers goals and objectives are reviewed a minimum of monthly and assessed a minimum of quarterly to review level of completion. If consumers are successfully completing objectives, they will be revised as needed to allow for further progress.</p> <p>The Program Director will receive retraining to ensure that monthly progress reviews of all consumers goals and objectives are completed and available for review.</p> <p>The Area Director will review the next 3 ISPs completed by this Program Director to review if consumers goals and objectives are being reviewed and revised as needed when consumers are achieving objectives as identified in the individual program plans.</p>	10/25/2014

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W000257	<p>Disorder) medication 85 % of the time with 1 verbal prompt for 3 consecutive months.</p> <p>-To interact "appropriately" with peers without having to be redirected by staff 85% of the time for 3 consecutive months.</p> <p>Client B's record and/or ISP indicated client B's above mentioned objectives were last reviewed in May 2014 as the last monthly review, present in the client's record, was dated May 2014.</p> <p>Interview with administrative staff #1 on 9/24/14 at 1:50 PM indicated client B's QIDP was on vacation. Administrative staff #1 indicated she could not locate any additional monthly reviews for client B's ISP objectives. Administrative staff #1 indicated she did not know if client B had lost and/or regressed in skills as there were no additional monthly reviews since May 2014.</p> <p>9-3-4(a)</p> <p>483.440(f)(1)(iii) PROGRAM MONITORING &amp; CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to</p>		<p>Area Director will track progress reviews a minimum of monthly to ensure they are being completed in a timely manner and are available for review as needed.</p> <p>Responsible Party: Program Director, Area Director</p>	

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	<p>situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.</p> <p>Based on interview and record review for 1 of 4 sampled clients (B), the Qualified Intellectual Disabilities Professional (QIDP) failed to revise the client's Individual Support Plan/ISP objectives when the client failed to demonstrate progress.</p> <p>Findings include:</p> <p>1. Client B's record was reviewed on 9/24/14 at 11:40 AM. Client B's 3/5/14 ISP indicated the client had the following objectives:</p> <ul style="list-style-type: none"> <li>-To write components of a check 85% of the time with 1 one verbal prompt for 3 consecutive months.</li> <li>-To shave his face without having to be prompted by staff 85% of the time for 3 consecutive months.</li> <li>-To complete a chore from the chore list every evening 80% of the time for 3 consecutive months.</li> <li>-To state 2 side effects of his Adderall (Attention Deficit Hyperactivity Disorder) medication 85 % of the time with 1 verbal prompt for 3 consecutive</li> </ul>	W000257	<p>An audit will be completed on all consumers' goals and objectives to assess level of completion. All goals and objectives that the consumer has failed to complete will be revised as needed to allow for further progress.</p> <p>The Program Director will receive retraining to include ensuring that all consumers goals and objectives are reviewed a minimum of monthly and assessed a minimum of quarterly to review level of completion. If consumers are failing to complete objectives, they will be revised as needed to allow for further progress.</p> <p>The Area Director will review the next 3 ISPs completed by this Program Director to review if consumers goals and objectives are being reviewed and revised as needed when consumers are failing to complete objectives as identified in the individual program plans.</p> <p>Responsible Party: Program Director, Area Director</p>	10/25/2014

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W000258	<p>months.</p> <p>-To interact "appropriately" with peers without having to be redirected by staff 85% of the time for 3 consecutive months.</p> <p>Client B's record and/or ISP indicated client B's above mentioned objectives were last reviewed in May 2014 as the last monthly review, present in the client's record, was dated May 2014.</p> <p>Interview with administrative staff #1 on 9/24/14 at 1:50 PM indicated client B's QIDP was on vacation. Administrative staff #1 indicated she could not locate any additional monthly reviews for client B's ISP objectives. Administrative staff #1 indicated she did not know if client B had failed to demonstrate progress on his objectives.</p> <p>9-3-4(a)</p> <p>483.440(f)(1)(iv) PROGRAM MONITORING &amp; CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is being considered for training towards new objectives.</p> <p>Based on interview and record review for</p>	W000258	An audit will be completed on all	10/25/2014

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	<p>1 of 4 sampled clients (B), the Qualified Intellectual Disabilities Professional (QIDP) failed to revise the client's Individual Support Plan/ISP objectives to consider the client for training toward new objectives.</p> <p>Findings include:</p> <p>1. Client B's record was reviewed on 9/24/14 at 11:40 AM. Client B's 3/5/14 ISP indicated the client had the following objectives:</p> <ul style="list-style-type: none"> <li>-To write components of a check 85% of the time with 1 one verbal prompt for 3 consecutive months.</li> <li>-To shave his face without having to be prompted by staff 85% of the time for 3 consecutive months.</li> <li>-To complete a chore from the chore list every evening 80% of the time for 3 consecutive months.</li> <li>-To state 2 side effects of his Adderall (Attention Deficit Hyperactivity Disorder) medication 85 % of the time with 1 verbal prompt for 3 consecutive months.</li> <li>-To interact "appropriately" with peers without having to be redirected by staff</li> </ul>		<p>consumers' goals and objectives to assess level of completion. All goals and objectives that the consumer has failed to complete will be revised as needed to allow for further progress.</p> <p>The Program Director will receive retraining to include ensuring that all consumers goals and objectives are reviewed a minimum of monthly and assessed a minimum of quarterly to review level of completion. If consumers are failing to complete objectives, they will be revised as needed to allow for further progress.</p> <p>The Area Director will review the next 3 ISPs completed by this Program Director to review if consumers goals and objectives are being reviewed and revised as needed when consumers are failing to complete objectives as identified in the individual program plans.</p> <p>Responsible Party: Program Director, Area Director</p>	

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W000262	<p>85% of the time for 3 consecutive months.</p> <p>Client B's record and/or ISP indicated client B's above mentioned objectives were last reviewed in May 2014 as the last monthly review, present in the client's record, was dated May 2014.</p> <p>Interview with administrative staff #1 on 9/24/14 at 1:50 PM indicated client B's QIDP was on vacation. Administrative staff #1 indicated she could not locate any additional monthly reviews for client B's ISP objectives. Administrative staff #1 indicated she did not know if client B should have been considered for training toward new objectives.</p> <p>9-3-4(a)</p> <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.</p> <p>Based on record review and interview for 3 of 3 sampled clients (B, C and D), the facility failed to ensure its Human Rights Committee (HRC) reviewed and/or approved clients' restrictive programs.</p>	W000262	<p>1. Client B Behavior Support Plan has been updated to include Adderall XR and Abilify into his Behavior Support Plan. Human Rights Committee Approval has been obtained for Client B</p>	10/25/2014

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	<p>Findings include:</p> <p>1. Client B's record was reviewed on 9/24/14 at 11:40 AM. Client B's 7/1/14 physician's orders indicated client B received Adderall XR (extended release) 20 milligrams every morning (Attention Deficit Hyperactivity Disorder) and Abilify 10 milligrams once daily for mood stabilization.</p> <p>Client B's September 2014 Behavioral Support Plan (BSP) indicated client B demonstrated "Aggressive Outburst", "Resistance to Instruction" and "Elopement." Client B's 9/14 BSP indicated if client B demonstrated physical aggression, facility staff could utilize PIA (Physical Intervention Alternatives-physical restraints) techniques to prevent injury to others.</p> <p>Client B's 6/12/14 "Supervision Protocol for Client B" indicated client B was on 15 minute checks while the client was in his bedroom at night and was in line of sight of staff during awake hours. Client B's record, BSP and/or 6/12/14 supervision protocol did not indicate the facility's HRC reviewed and/or approved the above mentioned restrictive techniques.</p> <p>Interview with administrative staff #2 on</p>		<p>psychotropic medications and restrictive programs including use of PIA to prevent injury to self and/or others, 15 minute overnight checks and line of sight supervision during waking hours</p> <p>1.Human Rights Committee Approval has been obtained for Client D psychotropic medications and restrictive programs including searching clients bags upon returning to the group home, monitoring phone calls and restricting Client D to 8 cups of coffee per day per doctor recommendations.</p> <p>1.Human Rights Committee Approval has been obtained for Client C psychotropic medications and restrictive programs including use of PIA to prevent injury to self and/or others and responsibility to replace items/property destroyed out of Client C personal bank account.</p> <p>The Home Manager and Program Director will receive retraining to include ensuring that all psychotropic medications have Human Rights Committee approval before use of any psychotropic medications is implemented. Training will include ensuring that documentation is available for review of Human Rights Committee approvals of any additions or increases to psychotropic medications and/or</p>				

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	<p>9/24/14 at 1:50 PM indicated the facility's HRC reviewed and/or approved client B's Restrictive programs on 9/16/14. Administrative staff #1 indicated she was not able to locate any documentation of the facility's HRC review/approval for client B. Administrative staff #1 indicated a phone case conference had been done on 9/16/14.</p> <p>2. Client D's record was reviewed on 9/24/14 at 11:40 AM. Client D's 7/1/14 physician's orders indicated client D received Divalproex ER (extended release) 500 milligrams 2 tablets at bedtime for "Behaviors," Invega 3 milligrams every morning and Invega 9 milligrams at 5:00 PM for mood stabilizer. Client D's physician's orders also indicated client D received Trazodone 50 milligrams at bedtime for mood stabilizer and Escitalopram 20 milligrams two times a day for Depression.</p> <p>Client D's 7/11/14 Interdisciplinary Team Meeting (IDT) Note indicated client D's guardian wanted facility staff to search client D's bags upon his return to the group home. The IDT note also indicated client D's was being restricted to 8 cups of coffee a day as recommended by the client's doctor. The IDT note indicated the client's IDT approved the above</p>		<p>restrictive programs.</p> <p>For the next 3 months, the Program Director will provide documentation to the Area Director that Human Rights Committee approval has been obtained for any additions or increases to consumers' psychotropic medications prior to their implementation or restrictive programming. After the 3 month period, the Area Director will review the documentation that Human Rights Committee has approved any additions or increases to consumers' psychotropic medications or restrictive programs a minimum of quarterly to ensure that these requirements continue to be met.</p> <p>Responsible Party: Home Manager, Program Director, Area Director</p>	

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	<p>restrictions. Client D's 7/16/14 HRC form indicated the facility's HRC approved the client's coffee being limited to 8 cups a day, but did not indicate the facility's HRC reviewed/approved the searching of client D's bags.</p> <p>Client D's March 2014 BSP indicated client D demonstrated elopement, irritability and suicidal threats/behavior. Client D's BSP indicated facility staff was to listen to client D's phone calls (be within hearing range) "...to ensure he is not enlisting help in following through his threats...." The BSP indicated client D was to be placed on "round the clock surveillance" when he demonstrated threats of suicide. Client D's record and/or March 2014 BSP did not indicate client B's restrictive program had been reviewed and/or approved by the facility's HRC.</p> <p>Interview with administrative staff #2 on 9/24/14 at 1:50 PM indicated the facility's HRC reviewed and/or approved client D's Restrictive programs on 9/16/14. Administrative staff #1 indicated she was not able to locate any documentation of the facility's HRC review/approval for client D. Administrative staff #1 indicated a phone case conference had been done on 9/16/14.</p> <p>3. Client C's record was reviewed on</p>			

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W000289	<p>9/24/14 at 10:50 AM. Client C's BSP, dated November 2013 indicated client C received Geodon 80 milligrams (Bipolar Disorder) and Zoloft 100 milligrams for Depression. Client C's BSP indicated the facility could utilize PIA techniques when the client demonstrated physical aggression. Client C's BSP also indicated client C would be responsible to replace items/properties he destroyed out of his personal savings account. Client C's BSP indicated the facility's Human Rights Committee had not reviewed and/or approved the rights restrictions as there were no signatures indicating it had been approved.</p> <p>Interview with AS (Administrative staff) #1 on 9/24/14 at 11:00 AM indicated that the client's BSP had not been reviewed by the facility's Human Rights Committee.</p> <p>9-3-4(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual</p>			

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	<p>program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on interview and record review for 1 of 3 sampled clients (B) with restrictive interventions, the facility failed to ensure the client's Behavioral Support Plan (BSP) included the specific physical intervention techniques which could be utilized when the client demonstrated physical aggression toward others.</p> <p>Findings include:</p> <p>Client B's record was reviewed on 9/24/14 at 11:40 AM. Client B's September 2014 BSP indicated client B demonstrated "Aggressive Outburst" defined as "...physically responding to others with an aggressive physical posture, invasion of personal space, or angry facial expression and/or Purposefully (sic) damaging own, peer's, agency, or public property resulting in minor or major replacement costs and/or Purposeful (sic) physical attacks directed at others including kicking, hitting, pulling hair or glasses, and/or throwing objects toward others (sic)." Client B's BSP indicated when client B demonstrated aggression towards "...If needed, use Indiana Mentor-approved PIA (Physical Intervention Alternatives-physical restraints) techniques to prevent injury. Use the</p>	W000289	<p>The Program Director will work with the Behavior Consultant to revise Client B Behavior Support Plan to include specific Physical Intervention techniques that could be utilized when Client B demonstrates physical aggression toward others.</p> <p>The Program Director will receive retraining including the need to ensure that all restrictive practices are included in consumers BSP's and appropriate approvals by Guardian and HRC are obtained.</p> <p>For the next 3 months, the Area Director will review all of this Program Director's Behavior Support Plans to ensure any restrictive measures are incorporated into them.</p> <p>Responsible Party: Program Director, Area Director, Behavior Consultant</p>	10/25/2014

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W009999	<p>minimum amount of physical assistance needed to stop the behaviors...." Client B's September 2014 BSP did not specify which PIA techniques should be utilized when the client demonstrated "Aggressive Outburst" toward others.</p> <p>Interview with administrative staff #1 on 9/24/14 at 1:50 PM indicated client B's BSP should include the specific techniques to be used with the client.</p> <p>9-3-5(a)</p> <p>STATE FINDINGS:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>(1) 460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin (TB) test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the</p>	W009999	<p>A current mantoux test was completed for Staff #3 to ensure they were free of TB.</p> <p>Home Manager and Program Director will receive retraining to include ensuring they are reviewing the Staff Development list a minimum of monthly to review which staff are outdated or coming due for their annual mantoux test so they can notify staff to obtain a current mantoux test to ensure they are free of TB.</p> <p>Human Resources tracks all staff annual mantoux test dates of completion. Area Director will work with Human Resources staff to ensure that updated staff development lists, which include</p>	10/25/2014

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	<p>skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>THE STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview for 1 of 3 personnel records reviewed (staff #3), the facility failed to obtain yearly PPD and/or a chest x-ray for an employed staff.</p> <p>Findings include:</p> <p>Staff #3's personnel record was reviewed on 9/24/14 at 1:15 PM. Staff #3's personnel record indicated staff #3 last had a Mantoux/Tuberculosis skin test on 12/10/12. Staff #3's personnel record indicated the staff person did not have a current chest x-ray and/or Mantoux test to ensure the staff person was free of TB.</p> <p>Interview with administrative staff #1 on 9/24/14 at 1:30 PM indicated staff #3 did not have a current TB test in his employee's record.</p>		<p>mantoux test dates, are available for review a minimum of monthly. Area Director will ensure that Home Manager and Program Director have these lists to review a minimum of monthly so they can notify staff if their mantoux test is outdated or expiring soon so current tests can be obtained.</p> <p>Responsible Party: Home Manager, Program Director, Area Director</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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