

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G319	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2015
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 3RD ST PERU, IN 46970
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W 0000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 7/21, 7/22, 7/23, 7/24, 7/27, 7/28, and 7/31/2015.</p> <p>Facility Number: 000837 Provider Number: 15G319 AIMS Number: 100243970</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0149 Bldg. 00	<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, record review, and interview, for 3 of 3 allegations of staff neglect (client #1), the facility neglected to implement its Abuse, Neglect, and/or Mistreatment and procedure to immediately report allegations of staff to client abuse, neglect, and/or mistreatment for client #1 to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law and neglected to complete thorough investigations.</p>	W 0149	<p>W149: All new employees are trained on the policy and the procedure for endangered adult/abuse/neglect and immediate reporting. The facility follows a protocol including assessment of client behavioral support plans, program goals and individual support plan to ensure the client needs and protection is met.</p> <p>The facility will train the direct support staff, Program Coordinator, and Program Director on incident management and the policy for endangered adult/abuse/neglect. Training will include immediate</p>	08/30/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Findings include:</p> <p>During observations on 7/21/15 from 3:30pm until 4:15pm, on 7/21/15 from 5:05pm until 5:35pm, and on 7/22/15 from 5:45am until 7:50am, client #1 was observed at the group home and on a community outing. On 7/21/15 at 4:15pm, client #1 stated she "walked home from work on 7/20/15." Client #1 stated she worked at a local Restaurant "over two (2) miles away." Client #1 stated she "tried to call the house phone" and then tried to call the RM (Residential Manager). Client #1 indicated after she could not reach anyone she walked home after 7:00pm at night. On 7/22/15 at 6:30am, GHS (Group Home Staff) #3 stated client #1 worked at a part time fast food restaurant from "5:00pm until 7:00pm" and staff "forgot to pick up [client #1]" from work on 7/20/15. GHS #3 indicated the restaurant was over two miles away, it was "getting dark" at 7:00pm, and client #1 was not safe while alone in the community. At 6:45am, the RM stated client #1 "walked home from work" on 7/20/15 because client #1 did not call for a ride after she got off of work. The RM indicated client #1 had not demonstrated her ability to be alone while in the community to cross the street, identify strangers, and navigate the area community. The RM indicated the</p>		<p>reporting, reportable incidents, and the review all client incidents to determine what should occur for future prevention. The training with include follow up on incidents to ensure corrective/protective measures are put in place to prevent reoccurrence of client incidents. The team will discuss the client behavior plan to make revisions of the behavior plan as necessary to address client behaviors.</p> <p>The facility will continue to train all employees to follow the reporting guidelines of behavior plans as written and initiation of behavioral intervention techniques, charting and calling supervisors per protocol as trained. The Program Coordinator will review client DSRs and behavior charts 3 times weekly for a month, then weekly thereafter. The Program Director will review DSRs once weekly for a month than monthly thereafter. The Area Director will review weekly all client incidents then develop a plan to follow up on recommendations to assess the effectiveness of the plans for the client behavior to ensure protection of all clients.</p> <p>Person responsible: Area Director</p>		

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	<p>allegation of neglect on 7/20/15 was not reported to BDDS in accordance with State Law.</p> <p>On 7/21/15 at 2:40pm, the facility's BDDS reports and investigations were reviewed from 7/21/15 through 4/10/15 and did not indicate a report for client #1 on 7/20/15, 7/7/15, and 6/16/15. The review of the facility's BDDS reports indicated the following for allegations of abuse, neglect, and/or mistreatment:</p> <p>-A 7/10/15 BDDS report for an incident on 7/9/15 at 3:00pm indicated client #1 "had been dating a boy off and on for about a year. He also is Mild MR (Mentally Retarded) and lives at home with his parents...[Client #1] told the [RM] that she was laying on the bed and [name of boyfriend] rolled her over and pulled her pants down and stuck his hand in her and she didn't like it so she went and told his mom...[RM] asked [boyfriends' mom] about it and mom said that [client #1] only said something to her about it after she caught [client #1] and [boyfriends' name] messing around and they were caught." The investigation was not thorough in that no investigation into the allegation regarding the specific incident that the boyfriend and client #1 was available for review. The report did not indicate documented witness</p>			

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	<p>statements were available for review.</p> <p>-A 6/16/15 "Investigative Summary" for an incident on 6/16/15 at 5:00pm reported on 6/17/15 by E-Mail to the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional), indicated client #1 "reported to her boyfriend's mom that she had been texting and snapchatting with a male staff [employee from the group home]. The boyfriend's mom then contacted the [RM]." The investigation indicated the male group home staff was "on vacation" when the incident allegedly occurred and was investigated. The investigation indicated "What action was taken by staff during the incident, following the incident...[Client #1] reported that while [the male staff] was on vacation that [the male staff] started texting her and snapchatting with her. She said that this was the first time that he had done that. He came back from vacation one day and that is when she was at her boyfriend's house and told [the boyfriend's] mom about it. The boyfriends mom reported it to the [RM]. When the [RM] called [the male staff] to tell him he was suspended pending an investigation, [the male staff] said he was just quitting and hung up on [the RM]." The investigation indicated "Factual Findings" which included the original allegation and documented that</p>			

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	<p>client #1 stated "[the male staff] was on vacation that (sic) she started getting texts from him asking her if she likes him and telling her that he is bisexual. She said that they were snapchatting but he never sent her any sexual pictures. She said that he never touched her in the house and that he had just started talking to her while he was on vacation..." The investigation did not include a BDDS report for the incident. The investigation did not indicate documented evidence of witness statements from client #1, the boyfriend's mom, or the male staff member from the group home. The investigation did not include documented witness statements of the events, staff interviews, other client interviews, and a review of the events regarding the allegation. The investigation was not thorough in that it did not include a review of client #1's ISP (Individual Support Plan), BSP (Behavior Support Plan), and/or risk plan. The investigation indicated "Conclusion: (a check mark) Evidence supports staff intervened appropriately." The investigation indicated the corrective measure was to encourage client #1 to report to staff if "anything is bothering her." The investigation did not include a written outcome.</p> <p>-A 7/7/15 "Investigation Summary" for</p>			

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	<p>an incident on 6/16/15 at 5:00pm indicated client #1 "supposedly reported to a friend at [name of workshop] regarding an incident that happened on 6/16/15 that a staff had asked her to have sex with him and had touched her butt on numerous occasions, but this is not what was reported back then." The investigation indicated that client #1 "stated to [name of workshop client] that [a male staff at the group home] had came (sic) into her room at the group home and asked [client #1] to have sex and she told him no so he left, and that [the male group home staff] also was always touching her butt." The investigation indicated a BDDS report was filed 7/7/15 but no BDDS report was available for review. The investigation indicated the workshop client reported what client #1 had told her regarding the group home staff. The investigation indicated client #1 stated "she did not tell [name of workshop client] that and that it is not true because they just started texting while [the male group home staff] was on vacation..." The investigation did not include documented witness statements of the events, staff interviews, client interviews, and a review of the events regarding the allegation. The investigation indicated "Conclusion: (a check mark) Evidence supports staff intervened appropriately." The</p>			

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	<p>investigation did not include a review of client #1's ISP (Individual Support Plan), BSP (Behavior Support Plan), and/or risk plan. The investigation indicated the corrective measure was to encourage client #1 to report to staff if "anything is bothering her."</p> <p>Client #1's record was reviewed on 7/23/15 at 10:00am. Client #1's 9/3/14 ISP (Individual Support Plan) and 5/2015 BSP indicated client #1 had targeted behaviors of Inappropriate Social Behaviors, Aggressive Outbursts, and Stealing. Client #1's ISP indicated she "required" twenty-four (24) hour staff supervision and transportation was provided by the agency. Client #1's 9/3/14 "Adaptive Evaluation Scale" indicated for "Community Orientation" can do but needs "staff supervision" to walk to a specific destination in the community, obeys traffic signals, and obeys traffic signs. Client #1's 9/3/14 "Independent Skills Assessment" indicated client #1 did not know the location of the police station, fire station, or the address/phone number for the group home.</p> <p>-Client #1's 8/17/14 "Risk Management Plan" indicated client #1 did not "defend self against abuse...did not engage in safe sex practices...[client #1] receives 24/7</p>			

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	<p>(twenty-four hours and day seven days a week) staff support and supervision... [client #1] is not able to speak up for herself depending on the situation. Will speak up if she feels she can control the situation...but will not speak up if she feels someone can over power her... [Client #1] is not able to remain alone in any environment due to living in a group home will have 24/7 awake supervision staff."</p> <p>An interview was conducted with PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) on 7/28/15 at 11:50am. The PD/QIDP indicated client #1's allegations were not reported immediately to the administrator and to BDDS in accordance with state law. The PD/QIDP indicated the facility staff neglected to follow the agency's policy and procedure to protect the client from abuse, neglect, and/or mistreatment. The PD/QIDP stated client #1 "required" twenty-four hour a day, seven days a week, staff supervision. The PD/QIDP indicated the facility followed the BDDS reporting policy and procedure for incidents and allegations. The PD/QIDP indicated client #1's ISP and BSP should include specific instructions or interventions regarding when staff should pick her up from her part time work. The PD/QIDP indicated client #1 had not</p>						

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	<p>demonstrated community safety and self protective techniques when alone in the community. The PD/QIDP stated "one of the staff" who was available at the group home completed client #1's assessment regarding community safety and that she had "signed off" without client #1 demonstrating appropriate personal safety skills. The PD/QIDP indicated the investigations did not include documented witness statements, interviews with other staff members, interviews with other clients, and client #1's information was not reviewed during the investigations. The PD/QIDP indicated no BDDS reports were available for review for client #1's 7/20/15, 7/7/15, and 6/16/15 allegations.</p> <p>The facility's policy and procedures were reviewed on 7/21/15 at 2:40pm. The facility's 4/2011 Quality and Risk Management policy indicated "Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services thorough oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The 4/2011 Quality and Risk Management Policy indicated failure to provide appropriate</p>			

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	<p>supervision, care or training was considered neglect. The 4/2011 Quality and Risk Management 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 or other employee. (1.) Investigation findings will be submitted to the AD (Area Director) for review wand development of further recommendations as needed within 5 days of the incident."</p> <p>On 7/21/15 at 2:40pm, the 4/2011 BDDS guidelines were reviewed. The policy on "Abuse, Neglect, and Exploitation" indicated the facility was to protect clients from possible abusive treatment, negligence, or exploitation on the part of staff, volunteers, or other consumers. Definition: Neglect: includes, but is not limited to, failure to provide appropriate supervision, care, training, a safe/clean/sanitary environment, food, medical care, medical supplies and equipment." The guidelines included the facility was to complete a thorough investigation.</p> <p>On 7/21/15 at 2:40pm, the BDDS 4/2011 "Procedures for Reporting abuse, neglect, and other Reportable or Unusual Incidents" indicated it was required by</p>			

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W 0153 Bldg. 00	<p>law of each person to report suspected instances of abuse, neglect, and exploitation.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, record review, and interview, for 2 of 3 allegations of staff neglect (client #1), the facility failed to immediately report allegations of staff to client abuse, neglect, and/or mistreatment for client #1 to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law.</p> <p>Findings include:</p> <p>During observations on 7/21/15 from 3:30pm until 4:15pm, on 7/21/15 from 5:05pm until 5:35pm, and on 7/22/15 from 5:45am until 7:50am, client #1 was observed at the group home and on a community outing. On 7/21/15 at 4:15pm, client #1 stated she "walked home from work on 7/20/15." Client #1 stated she worked at a local Restaurant</p>	W 0153	<p>W153: The facility currently has a written policy and procedure on mistreatment, neglect or abuse of a client and the reporting there of. All new employees are trained on the policy and the procedure for reporting injury of the clients to the proper authorities within and outside the agency. The Program Coordinator will train the direct support staff on the policies and procedure of immediately reporting an allegation of mistreatment, neglect or abuse of a client. The Area Director will retrain the Program Director to adhere to the reporting guidelines of reporting an incident within twenty-four hours for all clients in event of injury or bruising of unknown origin to ensure investigation of such incident is investigated and reported within 24 hours as mandated. The Program Coordinator will monitor the direct support records and</p>	08/30/2015	

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	<p>"over two (2) miles away." Client #1 stated she "tried to call the house phone" and then tried to call the RM (Residential Manager). Client #1 indicated after she could not reach anyone she walked home after 7:00pm at night. On 7/22/15 at 6:30am, GHS (Group Home Staff) #3 stated client #1 worked at a part time fast food restaurant from "5:00pm until 7:00pm" and staff "forgot to pick up [client #1]" from work on 7/20/15. GHS #3 indicated the restaurant was over two miles away, it was "getting dark" at 7:00pm, and client #1 was not safe while alone in the community. At 6:45am, the RM stated client #1 "walked home from work" on 7/20/15 because client #1 did not call for a ride after she got off of work. The RM indicated client #1 had not demonstrated her ability to be alone while in the community to cross the street, identify strangers, and navigate the area community. The RM indicated the allegation of neglect on 7/20/15 was not reported to BDDS in accordance with State Law.</p> <p>On 7/21/15 at 2:40pm, the facility's BDDS reports and investigations were reviewed from 7/21/15 through 4/10/15 did not indicate a report for client #1 on 7/20/15, 7/7/15, and 6/16/15. The review of the facility's BDDS reports indicated the following for allegations of abuse,</p>		<p>behavior support data daily to ensure client incidents are reported to the Program Director. Program Director will monitor the staff and documentation logs weekly to ensure that incidents that occur are reported in a timely manner in the future. Person responsible: Area Director Completion Date: 8/30/15</p>		

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	<p>neglect, and/or mistreatment:</p> <p>-A 6/16/15 "Investigative Summary" for an incident on 6/16/15 at 5:00pm reported on 6/17/15 by E-Mail to the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional), indicated client #1 "reported to her boyfriend's mom that she had been texting and snapchatting with a male staff [employee from the group home]. The boyfriend's mom then contacted the [RM]." The investigation indicated the male group home staff was "on vacation" when the incident allegedly occurred and was investigated. The investigation indicated "What action was taken by staff during the incident, following the incident...[Client #1] reported that while [the male staff] was on vacation that [the male staff] started texting her and snapchatting with her. She said that this was the first time that he had done that. He came back from vacation one day and that is when she was at her boyfriend's house and told [the boyfriend's] mom about it. The boyfriend's mom reported it to the [RM]. When the [RM] called [the male staff] to tell him he was suspended pending an investigation, [the male staff] said he was just quitting and hung up on [the RM]." The investigation indicated "Factual Findings" which included the original allegation and documented that</p>			

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	<p>client #1 stated "[the male staff] was on vacation that (sic) she started getting texts from him asking her if she likes him and telling her that he is bisexual. She said that they were snapchatting but he never sent her any sexual pictures. She said that he never touched her in the house and that he had just started talking to her while he was on vacation..." The investigation did not include a BDDS report for the incident.</p> <p>-A 7/7/15 "Investigation Summary" for an incident on 6/16/15 at 5:00pm indicated client #1 "supposedly reported to a friend at [name of workshop] regarding an incident that happened on 6/16/15 that a staff had asked her to have sex with him and had touched her butt on numerous occasions, but this is not what was reported back then." The investigation indicated that client #1 "stated to [name of workshop client] that [a male staff at the group home] had came (sic) into her room at the group home and asked [client #1] to have sex and she told him no so he left, and that [the male group home staff] also was always touching her butt." The investigation indicated a BDDS report was filed 7/7/15 but no BDDS report was available for review. The investigation indicated the workshop client reported what client #1 had told her regarding the</p>			

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W 0154 Bldg. 00	<p>group home staff. The investigation indicated client #1 stated "she did not tell [name of workshop client] that and that it is not true because they just started texting while [the male group home staff] was on vacation...." The investigation indicated "Conclusion: (a check mark) Evidence supports staff intervened appropriately."</p> <p>An interview was conducted with PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) on 7/28/15 at 11:50am. The PD/QIDP indicated client #1's allegations were not reported immediately to the administrator and to BDDS in accordance with state law. The PD/QIDP stated client #1 "required" twenty-four hour a day, seven days a week, staff supervision. The PD/QIDP indicated the facility followed the BDDS reporting policy and procedure for incidents and allegations. The PD/QIDP indicated no BDDS reports were available for review for client #1's 7/20/15, 7/7/15, and 6/16/15 allegations.</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</p>			

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	<p>investigated.</p> <p>Based on observation, record review, and interview, for 3 of 3 allegations of staff neglect (client #1), the facility failed to complete thorough investigations of allegations of neglect.</p> <p>Findings include:</p> <p>During observations on 7/21/15 from 3:30pm until 4:15pm, on 7/21/15 from 5:05pm until 5:35pm, and on 7/22/15 from 5:45am until 7:50am, client #1 was observed at the group home and on a community outing. On 7/21/15 at 4:15pm, client #1 stated she "walked home from work on 7/20/15." Client #1 stated she worked at a local Restaurant "over two (2) miles away." Client #1 stated she "tried to call the house phone" and then tried to call the RM (Residential Manager). Client #1 indicated after she could not reach anyone she walked home after 7:00pm at night. On 7/22/15 at 6:30am, GHS (Group Home Staff) #3 stated client #1 worked at a part time fast food restaurant from "5:00pm until 7:00pm" and staff "forgot to pick up [client #1]" from work on 7/20/15. GHS #3 indicated the restaurant was over two miles away, it was "getting dark" at 7:00pm, and client #1 was not safe while alone in the community. At 6:45am, the RM stated client #1 "walked home from</p>	W 0154	<p>W154: The facility currently has a written policy and procedure for immediately reporting all allegations of mistreatment, neglect or abuse and injuries of unknown origin. The procedures include completion of a thorough investigation of the origin of an injury. All new employees are trained on the policy and the procedure for reporting injury. The facility follows a protocol and regulation for the supervisor to be notified and a BDDS report sent for injuries of unknown origin, plus completion and documentation of the investigation of said unknown origin injury.</p> <p>The Area Director has trained the Program Director on the requirement to thoroughly investigate incidents as required by regulation. In addition, the training covered ensuring detailed information in reports to the Bureau of Developmental Disabilities Services. All investigations will be reviewed by the AD, and QA to ensure content is correct and develop recommendations to prevent reoccurrence.</p> <p>In the future, the facility will follow the protocol and the state regulation for the supervisor to be detailed in completing BDDS reports sent, plus completion and documentation of the investigation of client incidents. The Program Coordinator will review client DSRs and behavior charts 3 times weekly for a month, then weekly thereafter. The Program</p>	08/30/2015	

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	<p>work" on 7/20/15 because client #1 did not call for a ride after she got off of work. The RM indicated client #1 had not demonstrated her ability to be alone while in the community to cross the street, identify strangers, and navigate the area community.</p> <p>On 7/21/15 at 2:40pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed from 7/21/15 through 4/10/15, and indicated the following:</p> <p>-A 7/10/15 BDDS report for an incident on 7/9/15 at 3:00pm indicated client #1 "had been dating a boy off and on for about a year. He also is Mild MR (Mentally Retarded) and lives at home with his parents...[Client #1] told the [RM] that she was laying on the bed and [name of boyfriend] rolled her over and pulled her pants down and stuck his hand in her and she didn't like it so she went and told his mom...[RM] asked [boyfriends' mom] about it and mom said that [client #1] only said something to her about it after she caught [client #1] and [boyfriends' name] messing around and they were caught." The investigation was not thorough in that no investigation was available for review of the events which occurred on 7/9/15. No documented</p>		<p>Director will review DSRs once weekly for a month than monthly thereafter plus follow up as needed. Responsible Staff: Area Director Completion Date: 8/30/15</p>		

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	<p>witness statements were available for review.</p> <p>-A 6/16/15 "Investigative Summary" for an incident on 6/16/15 at 5:00pm reported on 6/17/15 by E-Mail to the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional), indicated client #1 "reported to her boyfriend's mom that she had been texting and snapchatting with a male staff [employee from the group home]. The boyfriend's mom then contacted the [RM]." The investigation indicated the male group home staff was "on vacation" when the incident allegedly occurred and was investigated. The investigation indicated "What action was taken by staff during the incident, following the incident...[Client #1] reported that while [the male staff] was on vacation that [the male staff] started texting her and snapchatting with her. She said that this was the first time that he had done that. He came back from vacation one day and that is when she was at her boyfriend's house and told [the boyfriend's] mom about it. The boyfriend's mom reported it to the [RM]. When the [RM] called [the male staff] to tell him he was suspended pending an investigation, [the male staff] said he was just quitting and hung up on [the RM]." The investigation indicated "Factual Findings" which included the</p>			

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	<p>original allegation and documented that client #1 stated "[the male staff] was on vacation that (sic) she started getting texts from him asking her if she likes him and telling her that he is bisexual. She said that they were snapchatting but he never sent her any sexual pictures. She said that he never touched her in the house and that he had just started talking to her while he was on vacation...." The investigation did not indicate documented evidence of witness statements from client #1, the boyfriend's mom, or the male staff member from the group home. The investigation did not include documented witness statements of the events, staff interviews, other client interviews, and a review of the events regarding the allegation. The investigation was not thorough in that it did not include a review of client #1's ISP (Individual Support Plan), BSP (Behavior Support Plan), and/or risk plan. The investigation indicated "Conclusion: (a check mark) Evidence supports staff intervened appropriately." The investigation indicated the corrective measure was to encourage client #1 to report to staff if "anything is bothering her." The investigation did not include a written outcome.</p> <p>-A 7/7/15 "Investigation Summary" for an incident on 6/16/15 at 5:00pm</p>						

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	<p>indicated client #1 "supposedly reported to a friend at [name of workshop] regarding an incident that happened on 6/16/15 that a staff had asked her to have sex with him and had touched her butt on numerous occasions, but this is not what was reported back then." The investigation indicated client #1 "stated to [name of workshop client] that [a male staff at the group home] had came (sic) into her room at the group home and asked [client #1] to have sex and she told him no so he left, and that [the male group home staff] also was always touching her butt." The investigation indicated the workshop client reported what client #1 had told her regarding the group home staff. The investigation indicated client #1 stated "she did not tell [name of workshop client] that and that it is not true because they just started texting while [the male group home staff] was on vacation..." The investigation did not include documented witness statements of the events, staff interviews, client interviews, and a review of the events regarding the allegation. The investigation indicated "Conclusion: (a check mark) Evidence supports staff intervened appropriately." The investigation did not include a review of client #1's ISP (Individual Support Plan), BSP (Behavior Support Plan), and/or risk plan. The investigation indicated the</p>			

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W 0227 Bldg. 00	<p>corrective measure was to encourage client #1 to report to staff if "anything is bothering her."</p> <p>An interview was conducted with PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) on 7/28/15 at 11:50am. The PD/QIDP indicated the facility followed the BDDS reporting policy and procedure for incidents and allegations. The PD/QIDP indicated the investigations were not thorough in that the investigations did not include documented witness statements, interviews with other staff members, interviews with other clients, and client #1's information was not reviewed during the investigations.</p> <p>9-3-2(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #2 and #4), the facility failed to develop a program to address client #2 and #4's identified incontinence needs at night.</p>	W 0227	<p>W227: The facility develops and utilizes the client Individual Support Plan from assessment and teaming input to develop programming goals to ensure the client needs are being met. Clients 2 and 4 currently have</p>	08/30/2015			

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	<p>Findings include:</p> <p>On 7/21/15 from 3:30pm until 4:15pm and on 7/22/15 from 5:45am until 7:50am, clients #2 and #4 were observed at the group home and were prompted and assisted by facility staff to use the bathroom. On 7/22/15 from 5:45am until 7:50am, observations and interviews were conducted at the group home. From 5:45am until 6:05am, clients #2 and #4 were in their upstairs bedroom. At 6:05am, GHS (Group Home Staff) #1 exited client #2 and #4's shared upstairs bedroom and indicated client #2 and #4's urine soaked bed linens were in piles beside client #2 and #4's beds. At 6:30am, GHS #1 stated clients #2 and #4 were "incontinent of urine about every morning" when he assisted the clients to get up from bed. At 7:05am, GHS #4 stated clients #2 and #4 were "incontinent of urine during the overnight" hours and neither client had goals and/or schedules to address their night time incontinence schedule available for review.</p> <p>Client #2's record was reviewed on 7/24/15 at 8:30am. Client #2's 8/26/2014 ISP (Individual Support Plan) indicated his toileting goal was to wash his hands after using the restroom. Client #2's 8/26/14 ISP did not include an objective</p>		<p>toileting goals to address incontinence. The toileting goals will be revised to include prompting the clients to get up during the night to use the bathroom. The Program Coordinator will Train the staff on the revised goals for clients 2 and 4 and documentation of client progress. In the future, the Program Coordinator will observe in the home and review program goal charting three times weekly for a month, then weekly thereafter. The Program Director will observe once weekly for a month than monthly thereafter plus follow up as needed to ensure that the staff are implementing the clients' goals.</p> <p>Responsible Staff: Area Director Completion Date: 8/30/15</p>		

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	<p>to address his incontinence of bowel and/or bladder at night. Client #2's ISP did not indicate he was incontinent and wore adult briefs at night. Client #2's record did not indicate evidence of training to address client #2's incontinence. Client #2's record indicated he could use the toilet during the day independently.</p> <p>Client #4's record was reviewed on 7/23/15 at 11:15am. Client #4's 4/16/2015 ISP indicated he was independent when walking. Client #4's 4/16/15 ISP did not include an objective to address his night time incontinence of bowel and/or bladder. Client #4's ISP did not indicate he was incontinent and wore adult briefs at night. Client #4's record did not indicate evidence of training to address client #4's incontinence.</p> <p>On 7/28/15 at 11:50am, an interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted. The PD/QIDP indicated clients #2 and #4 were incontinent of bowel and bladder during the night time hours and both clients could use the toilet independently during the day. The PD/QIDP indicated client #2 and #4's identified incontinence needs at night had not been addressed or an objective developed. The PD/QIDP</p>			

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W 0436 Bldg. 00	<p>indicated no further information was available for review.</p> <p>9-3-4(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (client #3) with adaptive equipment, the facility failed to teach and encourage client #3 to wear her prescribed eye glasses when opportunities existed.</p> <p>Findings include:</p> <p>On 7/22/15 from 9:30am until 10:20am, client #3 did not wear her prescribed eye glasses at the facility owned day services. During the observation period client #3 watched television, looked at magazines, completed writing on a sheet of paper, colored on paper, tossed bean bags at a game board, and slept on a sofa. During the observation periods client #3 was not observed taught or encouraged to wear her prescribed eye glasses. At 10:00am, Day Services Staff (DSS) #1 stated client</p>	W 0436	<p>W436 The facility will furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces and other devices identified by the interdisciplinary team as needed for the client.</p> <p>The Program Director has trained the residential and day staff to encourage client 3 to wear her glasses per doctor's order. The direct support professionals training included ensuring the implement of the goal for client 3 to wear the eyeglasses. In the future, the staff and Program Coordinator will assist the clients to make informed choices to wear their glasses. In addition, the Program Coordinator will review the goal documentation 3 times weekly for a month to ensure goals are being implemented.</p>	08/30/2015

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W 0439 Bldg. 00	<p>#3 had "not worn glasses" to the day services. DSS #1 stated he had worked at the facility owned day services for "just under one (1) year."</p> <p>On 7/23/15 at 11:50am, client #3's record was reviewed. Client #3's 12/10/14 ISP (Individual Support Plan) indicated client #3 wore prescribed eye glasses and did not include a goal/objective to teach client #3 to wear her eye glasses. Client #3's 4/21/15 visual examination indicated client #3 wore prescribed eye glasses to see and had stable Cataracts (a condition which causes blurred vision).</p> <p>On 7/28/15 at 11:50am and on 7/31/15 at 9:30am, an interview was conducted with the QIDP/PD (Qualified Intellectual Disabilities Professional). The QIDP/PD indicated client #3 did not wear her prescribed eye glasses during the observation period at the facility owned day services and should have been taught and encouraged to wear her glasses.</p> <p>9-3-7(a)</p> <p>483.470(h)(2) EMERGENCY PLAN AND PROCEDURES The facility must communicate, periodically review, make the plan available, and provide training to the staff. Based on observation, record review, and</p>	W 0439	<p>Person Responsible: Program Director Completion Date: 8/30/15</p> <p>W439: A fire drill schedule has been developed to inform Program</p>	08/30/2015	

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	<p>interview, for 1 of 1 client (client #8) who lived in the third floor bedroom, the facility failed to provide training for their emergency plan which addressed disaster preparedness for the third floor bedroom area for client #8.</p> <p>Findings include:</p> <p>On 7/22/15 at 7:15am, the facility's evacuation drills from 7/22/15 through 7/2014 were reviewed and did not include a completed evacuation drill for the second evacuation route for client #8's third floor bedroom.</p> <p>On 7/21/15 from 3:30pm until 4:15pm and on 7/22/15 from 5:45am until 7:50am, observation and interview were conducted at the group home and client #8 walked up/down the inside staircase to his third floor bedroom. On 7/22/15 at 6:30am, client #8 and GHS (Group Home Staff) #1 were interviewed inside client #8's third floor bedroom at the group home. At 6:30am, client #8 indicated he had one (1) evacuation route which was to exit down the inside third floor staircase. GHS #1 stated client #8 "had to make it to the second floor" location inside the group home during a fire and/or evacuation because the second floor had two (2) exits in case of emergency exits. GHS #1 stated client</p>		<p>Coordinator as to when drills are to be completed. This schedule allows for a drill to be completed for each shift of work every quarter as well as to allow for a barricade drill to be completed at least every quarter. The Program Coordinator has been trained of the necessity of ensuring that the safety drills are completed as scheduled on a monthly basis for all the clients and staff. The client 8 has been trained to utilize a ladder to exit his bedroom in event of a fire.</p> <p>In the future, the Program Coordinator will adhere to the calendar of drills to ensure the group home staff and clients have completed an evacuation drill at the designated time and date to meet safety guidelines. The Program Director will review the evacuation drills monthly to ensure completion, needed training and follow up as needed.</p> <p>Person Responsible: Program Director, Completion Date: 8/30/15</p>		

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	<p>#8 "had one (1)" exit "only." At 6:30am, when asked if he would throw a ladder out the third floor window to exit, Client #8 stated "I can't throw a ladder out the window. It would hurt someone." GHS #1 indicated the facility had not conducted an evacuation drill for client #8's third floor bedroom using a second route of exit and stated he "had no idea" what way client #8 would take to exit. At 7:15am, the Residential Manager (RM) indicated no evacuation drill for client #8's third floor bedroom had been completed with client #8 and/or the facility staff working at the group home. The RM stated the agency had purchased a "collapsible" ladder which was to be "thrown" out client #8's third floor bedroom window in the event of a fire or emergency blocking client #8's exit using the inside single staircase. The RM accompanied the Surveyor to the third floor and no collapsible ladder was located in the hallway, staircase, third floor landing area, and/or client #8's bedroom. The RM opened a door to a storage room on the third floor, entered the storage room, and began to search through boxes and storage cabinets/shelves for the collapsible ladder. The RM moved several boxes on the storage shelf, located a sealed packaged box, brought out the box into the hallway, and indicated the box</p>			

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 3RD ST PERU, IN 46970
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	<p>contained a new collapsible ladder. The RM indicated the ladder had not been removed from the original package for use. The RM indicated no completed staff training was documented for the use of the collapsible ladder from client #8's third floor group home window.</p> <p>On 7/28/15 at 11:50am, an interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted. The PD/QIDP indicated the facility had not completed an emergency drill during the past year which included the use of the chain link collapsible ladder from inside client #8's third floor bedroom window. The PD/QIDP indicated client #8's third floor bedroom did not have a second exit. The PD/QIDP indicated the facility's undated Fire Evacuation Procedures plan did not indicate the use of the chain link collapsible ladder and did not indicate instructions for exiting the third floor level during a disaster. The PD/QIDP stated "No" staff had not been trained on the how to exit the third floor level of the group home in the event of an emergency and the hallway staircase was blocked.</p> <p>9-3-7(a)</p>			

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W 0441 Bldg. 00	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills under varied conditions.</p> <p>Based on observation, record review, and interview, for 1 of 1 client (client #8) who lived in the third floor bedroom, the facility failed to hold evacuation drills under varied conditions using the second egress for client #8's third floor bedroom.</p> <p>Findings include:</p> <p>On 7/22/15 at 7:15am, the facility's evacuation drills from 7/22/15 through 7/2014 were reviewed and did not include a completed evacuation drill for the second evacuation route for client #8's third floor bedroom.</p> <p>On 7/21/15 from 3:30pm until 4:15pm and on 7/22/15 from 5:45am until 7:50am, observation and interview were conducted at the group home and client #8 walked up/down the inside staircase to his third floor bedroom. On 7/22/15 at 6:30am, client #8 and GHS (Group Home Staff) #1 were interviewed inside client #8's third floor bedroom at the group home. At 6:30am, client #8 indicated he had one (1) evacuation route which was to exit down the inside third floor staircase. GHS #1 stated client #8 "had to make it to the second floor" location inside the group home during a fire</p>	W 0441	<p>W441: A fire drill schedule has been developed to inform Program Coordinator as to when drills are to be completed. This schedule allows for a drill to be completed for each shift of work every quarter as well as to allow for a barricade drill to be completed at least every quarter. The Program Coordinator has been trained of the necessity of ensuring that the safety drills are completed as scheduled on a monthly basis for all the clients and staff. The client 8 has been trained to utilize a ladder to exit his bedroom in event of a fire. The Program Coordinator will ensure that drills are completed for all secondary routes as well as primary.</p> <p>In the future, the Program Coordinator will adhere to the calendar of drills to ensure the group home staff and clients have completed evacuation drills including secondary egress at the designated time and date to meet safety guidelines. The Program Director will review the evacuation drills monthly to ensure completion, needed training and follow up as needed.</p> <p>Person Responsible: Program Director, Completion Date: 8/30/15</p>	08/30/2015	

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	and/or evacuation because the second floor had two (2) exits in case of emergency exits. GHS #1 stated client #8 "had one (1)" exit "only." At 6:30am, when asked if he would throw a ladder out the third floor window to exit, Client #8 stated "I can't throw a ladder out the window. It would hurt someone." GHS #1 indicated the facility had not conducted an evacuation drill for client #8's third floor bedroom using a second route of exit and stated he "had no idea" what way client #8 would take to exit. At 7:15am, the Residential Manager (RM) indicated no evacuation drill for client #8's third floor bedroom had been completed with client #8 and/or the facility staff working at the group home. The RM stated the agency had purchased a "collapsible" ladder which was to be "thrown" out client #8's third floor bedroom window in the event of a fire or emergency blocking client #8's exit using the inside single staircase. The RM accompanied the Surveyor to the third floor and no collapsible ladder was located in the hallway, staircase, third floor landing area, and/or client #8's bedroom. The RM opened a door to a storage room on the third floor, entered the storage room, and began to search through boxes and storage cabinets/shelves for the collapsible ladder. The RM moved several boxes on			

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W 0460 Bldg. 00	<p>the storage shelf, located a sealed packaged box, brought out the box into the hallway, and indicated the box contained a new collapsible ladder. The RM indicated the ladder had not been removed from the original package for use. The RM indicated no completed staff training was documented for the use of the collapsible ladder from client #8's third floor group home window.</p> <p>On 7/28/15 at 11:50am, an interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted. The PD/QIDP indicated the facility had not completed an emergency drill during the past year which included the use of the chain link collapsible ladder from inside client #8's third floor bedroom window. The PD/QIDP indicated client #8's third floor bedroom did not have a second exit.</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review, and interview, for 3 of 4 sampled clients (clients #2, #3, and #4), the facility failed</p>	W 0460	<p>W460: The facility provides extensive training to all employees upon hire on all aspects of client health and</p>	08/30/2015			

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	<p>to ensure client #2, #3, and #4's modified diet texture was prepared in a planned consistency.</p> <p>Findings include:</p> <p>On 7/23/15 from 5:45am until 7:50am, clients #2, #3, and #4 were observed at the group home and Group Home Staff (GHS) #4 prepared client #2, #3, and #4's breakfast food in the kitchen.</p> <p>At 6:45am, GHS #4 prepared client #2, #3, and #4's breakfast of Scrambled Eggs, toast cut up into one inch by one inch pieces (not soaked), and cereal with milk. At 6:55am, client #4 walked to the dining room, GHS #4 served client #4 his prepared plate of food which included cut up toast without soaking the toast with fluid and client #4 fed himself the unsoaked toast pieces of food. At 7:05am, clients #2 and #3 walked to the dining room, GHS #4 served clients #2 and #3 their prepared breakfast which included cut up toast without soaking the toast with fluid, and clients #2 and #3 fed themselves the unsoaked toast pieces of food. No toast was softened with fluid.</p> <p>Client #2's record was reviewed on 7/24/15 at 8:30am. Client #2's 8/26/14 Individual Support Plan (ISP) indicated he was on a Mechanical Soft diet with</p>		<p>safety. The staff receive on the job training and client specific training prior to working with the clients in the program to enable the staff to perform their duties effectively. The Program Director has re-trained the Program Coordinator and staff on the correct diets for clients 2, 3, and 4 in the home. The client diet type is located in the Medication Administration Record for reference and acknowledgement by staff. In the future, the Program Coordinator will monitor the diets of each client by observation and reviewing the Medication Record three times weekly for one month then weekly thereafter. The Program Director will review the observations and follow up as needed.</p> <p>Responsible Staff: Area Director Completion Date: 8-30-15</p>		

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	<p>Honey Thickened Liquids. Client #2's 6/17/15 Physician's Order indicated he was to receive a Mechanical Soft diet with Honey Thickened Liquids. Client #2's 6/12/15 Nutritional assessment completed by the Registered Dietician indicated client #2 was to receive a Mechanical Soft diet with Honey Thickened Liquids. Client #2's 2/28/2014 Dining Plan indicated he was at risk to choke, needed one on one staff supervision during meals, and his breads were to be cut and softened with fluid.</p> <p>Client #3's record was reviewed on 7/23/15 at 11:50am. Client #3's 12/10/2014 ISP, 2/2015 Dining Plan, and 6/17/2015 Physician's Order indicated client #3 was to receive a Regular with chopped meat diet and to provide crushed medications because client #3 was at risk to choke.</p> <p>Client #4's record was reviewed on 7/23/15 at 11:15am. Client #4's 4/16/15 ISP, 6/11/13 Dining Plan, 5/23/13 "Modified Barium Swallow" Study, and 6/17/15 Physician's Order indicated client #4 was on a Mechanical Soft Diet with chopped meats and Nectar Thickened Liquids because he was at risk to choke.</p> <p>On 7/28/15 at 11:50am, a review of the facility's undated "Mechanical Soft Diet</p>			

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	<p>-Ground (Chopped) Meat" policy and procedure indicated "...3. Bread is broken in approximately 1" (sic) squares, cookies, cake, crackers, biscuits, buns, Pop Tarts, etc. are broken at table side. These items may need to be soaked" with fluids.</p> <p>On 7/28/15 at 11:50am, an interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) and the agency LPN (Licensed Practical Nurse) was conducted. The PD/QIDP and the LPN both indicated clients #2, #3, and #4's cut up toast should be soaked with milk before clients consumed the bites of food. The PD/QIDP and the LPN indicated clients #2, #3, and #4 were at risk to choke when their toast was not soaked with fluid.</p> <p>9-3-8(a)</p>			