

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G466	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/28/2014
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1926 W 75TH PL INDIANAPOLIS, IN 46260
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W000000	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of complaints #IN00154440 and #IN00151839.</p> <p>Complaint #IN00154440: Substantiated, a federal and state deficiency related to the allegation is cited at W149.</p> <p>Complaint #IN00151839: Substantiated, no deficiencies related to the allegation are cited.</p> <p>Dates of Survey: 8/25/14, 8/26/14, 8/27/14 and 8/28/14.</p> <p>Facility Number: 000980 Provider Number: 15G466 AIMS Number: 100244620</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/11/14 by Ruth Shackelford, QIDP.</p>	W000000		

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

TITLE

(X6) DATE

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

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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 record review and interview for 1 of 4 sampled clients (B) plus 3 additional clients (E, F and G), the facility failed to implement its policy and procedures to prevent neglect of clients B and F regarding supervision, to ensure an allegation of sexual misconduct was investigated regarding client G and to ensure the investigation of an allegation of staff mistreatment regarding client E was thorough.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 8/25/14 at 4:03 PM.</p> <p>1. BDDS report dated 8/8/14 indicated, "At 5:38 PM, the [HM #1 (Home Manager)] arrived to (sic) the group home to find both [client B] and [client F] in the group home van with the windows up (and) unsupervised. The [HM #1] walked into the group home to find a staff member whom told the [HM #1] that she did not know those 2 clients, [client B] and [client F], were in the group home's van but did know they were</p>	W000149	<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 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>	09/27/2014

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	<p>in the front yard and did not think that would be a problem. [PD (Program Director) #1] went to the site and relieved the staff member from her shift at the home and that staff member is suspended pending investigation."</p> <p>Summary of Internal Investigation Report (SIIR) dated 8/13/14 regarding the 8/8/14 incident indicated there was one staff on duty at the group home during the incident due to a series of staff call offs and the HM's personal family emergency. The SIIR dated 8/13/14 indicated two staff should have been on duty to supervise the clients. The 8/13/14 SIIR indicated clients B and F were found in the group home van with the keys to the van. The 8/13/14 SIIR indicated, "Evidence supports [staff #1] was not aware clients were sitting in the van unsupervised."</p> <p>Client B's record was reviewed on 8/26/14 at 11:07 AM. Client B's BSP (Behavior Support Plan) dated 2/2014 indicated client B's targeted behaviors included but were not limited to vacating/elopement from supervision. Client B's BSP dated 2/2014 indicated, "Staff should be aware of [client B's] whereabouts at all times." Client B's ISP (Individual Support Plan) dated 5/4/14 indicated client B required 24 hour a day</p>			

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	<p>supervision.</p> <p>Client F's record was reviewed 8/26/14 at 10:50 AM. Client F's ISP dated 6/3/13 indicated client F required 24 hour a day supervision.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 8/26/14 at 3:50 PM. QIDP #1 indicated staff #1 was working alone at the group home during the incident regarding clients B and F. QIDP #1 indicated the facility had scheduled a second staff to work the shift with staff #1 but the staff had called off for their shift. QIDP #1 indicated HM #1 was at the group home to cover the shift when she received an emergency phone call regarding her husband. HM #1 left the group home and staff #1 alone with the clients. When HM #1 returned to group home she discovered clients B and F alone, unsupervised and with the group home's van keys. QIDP #1 indicated HM #1 directed clients B and F to return to the house and questioned staff #1 about the incident. QIDP #1 indicated staff #1 reported clients B and F were on the front porch within eyesight, however, staff #1 had been assisting others clients in the home and not been aware of clients B and F's activity. QIDP #1 indicated staff #1 was suspended for not properly</p>						

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	<p>monitoring clients B and F.</p> <p>2. BDDS report dated 4/1/14 reviewed on 8/25/14 at 4:03 PM indicated, "On 4/1/14 at 8:00 AM, [PD (Program Director) #1] asked [client G] for her jeans that reportedly have holes in the vagina area. [PD #1] intended to take a look at them since [client G's] roommate reported that while they are at work at [workshop], [client G's] boyfriend sticks his fingers in those holes and [client G] lets him." The 4/1/14 BDDS report indicated, "At 9:30 AM, [PD #1] had a phone conversation with [day service manager #1] at which time he was informed of the allegation that [client G's] boyfriend there at [workshop] tries to put his fingers in the holes in her pants where her vagina is and that [client G] blocks him. [Day service manager] informed that [workshop] was unaware of this and could not validate whether it happened or not...."</p> <p>The review did not indicate an investigation regarding the 4/1/14 allegation of sexual misconduct regarding client G.</p> <p>3. BDDS report dated 3/17/14 reviewed on 8/25/14 at 4:03 PM indicated, "At 9:00 PM, it was reported to the on-call HM by staff that [client E] said that another staff, [staff #3], allegedly pulled</p>				

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	<p>her by her arms and legs as well as smacked her in the face in the morning."</p> <p>SIIR dated 3/21/14 regarding client E's 3/17/14 allegation of staff mistreatment indicated client E and 4 staff members were interviewed regarding the allegation. The 3/21/14 SIIR did not indicate documentation of clients A, B, C, D, F or G being interviewed regarding client E's allegation of staff mistreatment. The 3/21/14 SIIR's written interview statement from staff #2 indicated "[Staff #2] said [client C] has complained that [staff #3] does not knock before entering her bedroom...." The 3/21/14 SIIR did not indicate documentation of direct interview of client C to clarify her concerns regarding staff #3.</p> <p>AD (Administrative Staff) #1 was interviewed on 8/26/14 at 3:50 PM. AD #1 indicated the facility's abuse and neglect policy should be implemented. AD #1 indicated all allegations of abuse, neglect and mistreatment should be thoroughly investigated.</p> <p>The facility's policies and procedures were reviewed on 8/28/14 at 5:41 PM. The facility's policy entitled Quality and Risk Management dated April 2011 indicated, "Indiana Mentor promotes a high quality of service and seeks to</p>			

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	<p>protect individuals receiving Indiana Mentor services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed."</p> <p>The facility's policy entitled Quality and Risk Management dated April 2011 indicated, "Indiana Mentor follows the BDDS incident reporting policy as outlined in the provider standards. An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS (e.) failure to provide appropriate supervision, care or training.... (4.)(c.) Elopement of an individual that results in evasion of required supervision ad described in the ISP (Individual Support Plan) for health and welfare; (d.) Missing person when an individual wanders away and no one knows where they are.... Inadequate staff support for an individual, including inadequate supervision, with the potential for: (1.) Significant harm or injury to an individual; or (2.) Death of an individual."</p> <p>The facility's policy entitled Quality and Risk Management dated April 2011 indicated, "Indiana Mentor is committed to completing a thorough investigation</p>			

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W000154	<p>for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee(s)."</p> <p>This federal tag relates to complaint #IN00154440.</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 record review and interview for 2 of 15 allegations of abuse, neglect and mistreatment reviewed, the facility failed to ensure an allegation of sexual misconduct was investigated regarding client G and to ensure the investigation of an allegation of staff mistreatment regarding client E was thorough.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 8/25/14 at 4:03 PM.</p> <p>1. BDDS report dated 4/1/14 reviewed on 8/25/14 at 4:03 PM indicated, "On 4/1/14 at 8:00 AM, [PD (Program Director) #1]</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 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</p>	09/27/2014

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	<p>asked [client G] for her jeans that reportedly have holes in the vagina area. [PD #1] intended to take a look at them since [client G's] roommate reported that while they are at work at [workshop], [client G's] boyfriend sticks his fingers in those holes and [client G] lets him." The 4/1/14 BDDS report indicated, "At 9:30 AM, [PD #1] had a phone conversation with [day service manager #1] at which time he was informed of the allegation that [client G's] boyfriend there at [workshop] tries to put his fingers in the holes in her pants where her vagina is and that [client G] blocks him. [Day service manager] informed that [workshop] was unaware of this and could not validate whether it happened or not...."</p> <p>The review did not indicate an investigation regarding the 4/1/14 allegation of sexual misconduct regarding client G.</p> <p>2. BDDS report dated 3/17/14 reviewed on 8/25/14 at 4:03 PM indicated, "At 9:00 PM, it was reported to the on-call HM by staff that [client E] said that another staff, [staff #3], allegedly pulled her by her arms and legs as well as smacked her in the face in the morning."</p> <p>SIIR dated 3/21/14 regarding client E's 3/17/14 allegation of staff mistreatment</p>		<p>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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W000159	<p>indicated client E and 4 staff members were interviewed regarding the allegation. The 3/21/14 SIIR did not indicate documentation of clients A, B, C, D, F or G being interviewed regarding client E's allegation of staff mistreatment. The 3/21/14 SIIR's written interview statement from staff #2 indicated "[Staff #2] said [client C] has complained that [staff #3] does not knock before entering her bedroom...." The 3/21/14 SIIR did not indicate documentation of direct interview of client C to clarify her concerns regarding staff #3.</p> <p>AD (Administrative Staff) #1 was interviewed on 8/26/14 at 3:50 PM. AD #1 indicated all allegations of abuse, neglect and mistreatment should be thoroughly investigated.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 3 of 4 sampled clients (B, C and D), the QIDP (Qualified Intellectual Disabilities</p>	W000159	1.An audit will be completed on all consumers' goals and objectives to assess level of completion. All goals and objectives that the	09/27/2014

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	<p>Professional) failed to coordinate, integrate and monitor clients B, C and D's active treatment programs by failing to ensure client D's formal training objectives were developed, by failing to ensure clients B, C and D had Comprehensive Functional Assessments (CFAs) completed and by failing to review client B's medication administration training objective.</p> <p>Findings include:</p> <p>1. Client B's record was reviewed on 8/26/14 at 11:07 AM. Client B's ISP (Individual Support Plan) dated 5/4/14 indicated, "Daily, during the AM medication pass, [client B] will wash her hands or use hand sanitizer with 3 or less verbal prompts 65% of the time for three consecutive months." The 5/4/14 ISP indicated client B's medication administration objective should be reviewed monthly and quarterly. Client B's QIDP Monthly Summary form dated 6/9/14 indicated the QIDP had reviewed client B's formal training objectives data for the month of May 2014. The 6/9/14 QIDP Monthly Summary did not indicate documentation of tracking/data or review of client B's medication administration goal. Client B's QIDP Monthly Summary form dated 7/10/14 indicated the QIDP had</p>		<p>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. The Program Director will complete a formal monthly review of each consumer's goals and objectives to document goal progress. The Program Director will assess the consumers goal progress a minimum of quarterly to review the level of completion and make any changes to goals and objectives as necessary based on the consumers' needs and abilities.</p> <p>The Area Director will review the Program Directors monthly reviews each month to ensure completion. The Area Director will review the quarterly assessments for each consumer a minimum of quarterly to ensure that the Program Director is making changes to goals and objectives as needed based on the consumers level of goal completion as well as the consumers' needs and abilities. The Area Director will provide a list of monthly and quarterly dates of review to the Program Director for each consumer so that the</p>	

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9-3-3(a)	<p>reviewed client B's formal training objectives data for the month of June 2014. The 7/10/14 QIDP Monthly Summary did not indicate documentation of tracking/data or review of client B's medication administration goal.</p> <p>AD (Area Director) #1 was interviewed on 8/28/14 at 9:00 AM. AD #1 indicated the QIDP should review client B's medication administration goal on a monthly and quarterly basis.</p> <p>2. Client B's record was reviewed on 8/26/14 at 11:07 AM. Client B's ISP dated 6/25/14 indicated client B's DOA (Date of Admission) was 12/11/13. Client B's record did not indicate documentation of the development of formal training objectives from client B's 12/11/13 DOA through April 2014.</p> <p>AD #1 was interviewed on 8/28/14 at 9:00 AM. AD #1 indicated client B's formal training objectives should have been developed and monitored within 30 days of her 12/11/13 DOA.</p> <p>3. The QIDP failed to ensure clients B, C and D had Comprehensive Functional Assessments completed. Please see W210.</p>		<p>Program Director is aware of what reports are needed each month.</p> <p>2. Goal tracking sheets have been developed for Client B based on her ISP. Staff have been trained and goals have been implemented for Client B.</p> <p>Program Director will receive retraining on ensuring that goals are developed, staff are trained and goals are implemented once the ISP is completed 30 days after admission.</p> <p>Ongoing, the Program Director will ensure that Comprehensive Functional assessments, goals and objectives and an ISP are completed for each consumer within 30 days of admission and a minimum of annually on an ongoing basis. The Area Director will communicate with the Program Director at the 30 day post-admission time to ensure that all assessments and goals have been completed as needed.</p> <p>3. The Program Director and Home Manager will work to complete CFAs for all Clients including Clients B, C, D.</p> <p>The Program Director and Home Manager will be retrained on completing CFAs for all clients. This training will include the importance of these CFA's, the reason for them, how to complete</p>	

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview for 3 of 4 sampled clients (B, C and D), the facility failed to ensure clients B, C and D had Comprehensive Functional Assessments (CFAs) completed.</p>	W000210	<p>them, and when to complete them. Program Director will receive retraining on ensuring that all assessments, including a Comprehensive Functional assessment are completed for each consumer within 30 days of admission and reviewed and updated a minimum of annually on an ongoing basis.</p> <p>Ongoing, the Program Director will ensure that Comprehensive Functional assessments are completed for each consumer within 30 days of admission and a minimum of annually on an ongoing basis. The Area Director will communicate with the Program Director at the 30 day post-admission time to ensure that all assessments and goals have been completed as needed.</p> <p>Responsible Party: Home Manager, Program Director, Area Director</p> <p>The Program Director and Home Manager will work to complete CFAs for all Clients including Clients B, C, D.</p> <p>The Program Director and Home Manager will be retrained on</p>	09/27/2014	

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	<p>Findings include:</p> <p>1. Client B's record was reviewed on 8/26/14 at 11:07 AM. Client B's ISP (Individual Support Plan) dated 6/25/14 indicated client B's DOA (Date of Admission) was 12/11/13. Client B's CFA was completed on 6/25/14. The review indicated client B's CFA was not completed within 30 days of her 12/11/13 DOA.</p> <p>2. Client C's record was reviewed on 8/26/14 at 2:10 PM. Client C's ISP dated 5/7/14 indicated client C's DOA was 1/11/07. Client C's record did not indicate documentation of a completed and/or dated CFA.</p> <p>3. Client D's record was reviewed on 8/26/14 at 1:20 PM. Client D's ISP dated 10/17/13 indicated client D's DOA was 9/23/10. Client D's record did not indicate documentation of a completed and/or dated CFA.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 8/26/14 at 3:50 PM. QIDP #1 indicated there was not additional documentation available for review regarding clients B, C or D's CFA.</p> <p>9-3-4(a)</p>		<p>completing CFAs for all clients. This training will include the importance of these CFA's, the reason for them, how to complete them, and when to complete them. Program Director will receive retraining on ensuring that all assessments, including a Comprehensive Functional assessment are completed for each consumer within 30 days of admission and reviewed and updated a minimum of annually on an ongoing basis.</p> <p>Ongoing, the Program Director will ensure that Comprehensive Functional assessments are completed for each consumer within 30 days of admission and a minimum of annually on an ongoing basis. The Area Director will communicate with the Program Director at the 30 day post-admission time to ensure that all assessments and goals have been completed as needed.</p> <p>Responsible Party: Home Manager, Program Director, Area Director</p>		

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 4 sampled clients (A) plus one additional client (F), the facility nursing services failed to meet the health needs of clients A and F.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 8/26/14 at 12:34 PM. Client A's POs (Physician's Orders) form dated 7/31/14 indicated client A had a laboratory order for client A's CMP (Complete Metabolic Panel), Lipids and TSH (Thyroid Stimulating Hormone) levels to be checked every 6 months. Client A's record did not indicate documentation of her CMP, Lipids or TSH levels being tested.</p> <p>AD (Area Director) #1 was interviewed on 8/26/14 at 3:50 PM. AD #1 indicated she would text message the facility nurse regarding client A's most recent CMP, Lipid and TSH laboratory documentation. AD #1 indicated the facility nurse was not available at the time of the interview.</p> <p>AD #1 was interviewed on 8/27/14 at</p>	W000331	<p>1.Labs have been requested for Client A. Home Manager and Program Nurse will receive retraining to include ensuring that all physician recommendations, such as lab work every 6 months is completed as requested by the physician and documentation is available for review. Program Nurse will receive retraining to include ensuring that all recommendations for follow up from any medical appointments, such as labwork, are reviewed, scheduled and/or completed as needed as soon as possible after the medical appointment.</p> <p>Ongoing, the Program Nurse will review all consumers' medical appointment forms within 48 hours of the appointment to determine if any follow up treatment is needed. If any follow up is needed the Program nurse will work with the Home Manager and/or Program Director to ensure that appointments are scheduled, medications are ordered, etc. If regular lab work is recommended by the physician for client (such as every month or every 6 months) the program nurse will work with the Home Manager to ensure the lab work is</p>	09/27/2014			

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	<p>2:00 PM. AD #1 indicated the facility nurse had not provided additional documentation regarding client A's laboratory orders for CMP, Lipids and TSH.</p> <p>2. Observations were conducted at the group home on 8/26/14 from 6:09 AM through 8:15 AM. At 6:26 AM, Staff #1 administered client F's morning medications. Staff #1 placed client F's bottle of Flonase 0.05% nasal spray (allergies) on the medication administration table. Client F stated, "I'm not taking that stuff" and placed the bottle of Flonase 0.05% nasal spray back into the medication administration cabinet. Client F then returned to her bedroom and staff #1 began administering the next client's medications.</p> <p>The 8/2014 MAR (Medication Administration Record) was reviewed on 8/26/14 at 10:37 AM. The MAR indicated staff #1 had placed the letter 'R' on client F's administration record for Flonase 0.05% nasal spray for 7:00 AM on 8/26/14. Staff #1 did not circle the letter 'R' and did not complete a narrative note regarding client F's refusal of her Flonase 0.05% nasal spray.</p> <p>LPN (Licensed Practical Nurse) #1 was</p>		<p>scheduled as directed and documentation is available for review. Ongoing, the Program Nurse will review each consumers medical charts a minimum of monthly to determine if any medical follow up, lab work, etc. needs to be scheduled. The Program Nurse will provide a list the Home Manager of what needs to be completed for that month. The following month the Program Nurse will review the list of what was to be completed the previous month. If there are any outstanding items, the Program Nurse will work with the Home Manager to get outstanding items completed as soon as possible. If there are ongoing issues with things not being completed, the Program Nurse will bring it to the attention of the Program Director and/or Area Director for further follow up.</p> <p>1.All direct care staff will receive retraining on medication administration procedures including documenting any refusals of medications in the MAR and behavior tracking sheet. Training will also include informing the Program Nurse of any medication refusals.</p> <p>For 4 weeks, the Home Manager and/or Program Director will complete Medication observations a minimum of twice weekly to ensure staff are administering medications as</p>		

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W000440	<p>interviewed via AD (Area Director) #1's phone on 8/26/14 at 2:05 PM. LPN #1 indicated she was not notified regarding client F's refusal of her Flonase 0.05% nasal spray.</p> <p>AD #1 was interviewed on 8/26/14 at 2:06 PM. AD #1 indicated staff #1 should document medication refusals on the back of the MAR form and notify the facility nurse.</p> <p>9-3-6(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 4 of 4 sampled clients (A, B, C and D) plus 3 additional clients (E, F and G), the facility failed to conduct evacuation drills for each quarter on each shift of staff.</p> <p>Findings include:</p> <p>The facility's evacuation drill record was reviewed on 8/26/14 at 10:56 AM. The review indicated the facility failed to conduct an evacuation drill for 7 of 7</p>	W000440	<p>prescribed and documenting medication administration accurately including any refusals.</p> <p>After the four weeks and ongoing, the Home Manager and/or the QIDP will complete a weekly medication administration observation to ensure the staff administer medications as prescribed and documenting medication administration accurately including any refusals. The HM and/or PD will be responsible for ensuring any necessary follow-up is completed for any errors made in the administration of medications</p> <p>Responsible Party: Program Nurse, Home manager, Program Director</p> <p>All Direct Support Professionals will receive a retraining to ensure that they understand the importance of completing the monthly fire drills. The training will include reviewing a copy of the fire drill schedule.</p> <p>Ongoing, the Direct Support Professionals will complete one fire drill per month (or more as needed) according to the schedule to ensure that the health and safety of the client's needs are met.</p>	09/27/2014

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W000484	<p>clients (A, B, C, D, E, F and G) for the fourth quarter, October, November and December 2013 for the day shift.</p> <p>AD (Area Director) #1 was interviewed on 8/26/14 at 3:50 PM. AD #1 indicated there was not additional documentation of evacuation drills available for review.</p> <p>9-3-7(a)</p> <p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation and interview for 1 of 4 sampled clients (D), the facility failed to ensure the group home dining room table was accessible for client D's wheelchair.</p> <p>Findings include:</p>	W000484	<p>The Home Manager will be retrained on the policy and procedures for the completion of evacuation drills.</p> <p>The Home Manager will be responsible for submitting a copy of the fire drill to the Program Director and Quality Assurance Specialist before the last day of each month.</p> <p>The Quality Assurance Specialist will review the report and request any necessary follow-up. The Program Director will be responsible for ensuring the needed follow-up is completed.</p> <p>Responsible Staff: Program Director, Home Manager, Quality Assurance Specialist</p>	09/27/2014

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	<p>Observations were conducted at the group home on 8/26/14 from 6:09 AM through 8:15 AM. At 7:45 AM, client D was participating in the group home's family style morning meal. Client D, who utilized a manual wheelchair for mobility, was seated in her wheelchair at the dining room table. Client D's wheelchair sat low to the ground. Client D's body/torso was lower than the dining room table and her chin was at level height with her plate as it sat on the table. AS (Administrative Staff) #1 stated, "That looks like it's uncomfortable. The table is too high." Client D replied, "Yeah, it is kind of."</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 8/26/14 at 3:50 PM. QIDP #1 indicated the group home's dining room table was too high for client D.</p> <p>9-3-8(a)</p>		<p>of the plate on the table.</p> <p>Direct care staff, HM and PD will receive retraining to include ensuring that all tables, chairs, eating utensils and dishes are designed to meet the developmental needs of each consumer. If there are issues with furniture, eating utensils and chairs not meeting clients developmental needs, staff will report the need to the HM and PD so that the issue can be resolved in a timely manner so that all consumers needs are being met.</p> <p>For 4 weeks the HM and/or PD will complete walkthroughs of the home and mealtime observations a minimum of twice weekly to ensure that all furniture, dishes, eating utensils are meeting consumers developmental needs. Ongoing, the HM and/or PD will complete walkthroughs of the home and mealtime observations a minimum of weekly to ensure that all furniture, dishes, eating utensils are meeting consumers developmental needs. Any needs that need to be addressed will be brought to the attention of the Program Director, Area Director and/or Program Nurse as needed to ensure needs are getting resolved in a timely manner. Responsible Party: Home Manager, Program Director, Area Director</p>	