STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G578	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSTON GROUP HOMES INC	2805 W 50 N LEBANON, IN 46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	This visit was for a fundamental recertification and state licensure survey. Survey dates: May 23 and 24, 2012. Facility number: 001092 Provider number: 15G578 AIMS number: 100245550 Surveyor: Brenda Nunan, RN, CDDN, Public Health Nurse Surveyor III These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed on June 1, 2012 by Dotty Walton, Medical Surveyor III.	W0000	The facility Executive Director had a conversation with the QMRP, the Residential Supervisor and with the Director of Nursing on May24, 2012. The purpose of the meeting was to correct deficiency tag numbers W-149, W-154 & W-323 cited during the Indiana State Department of Health annual re-certification survey completed on May24, 2012. **W-0000** The facility Director reviewed the policy for Reporting Allegations of Mistreatment of and Individual and will ensure that all investigations are done for every incident report. No incident reports will be accepted and signed by the Director until there is a complete investigation per our policy. (See Attachment A.) **Completion Date: May 30, 2012** **W-0000** The facility Director met with the Executive Director and the Adult Services Director of the day service on May25, 2012 to discuss setting up an in-service on reportable incident investigations. The meeting was set up for Wednesday May 30, 2012 at 10:00 am. Director of the facility reviewed the Components of a Thorough Investigation originally presented by Steve Croya on March 17, 2011, with the Executive Director, the Adult Services Director and the Adult Services Program Manager for	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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NAME OF PROVIDER OR SUPPLIER HOUSTON GROUP HOMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2805 W 50 N LEBANON, IN 46052	

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			the Day Service Programs. (See Attachment B). The agreement with the Day Service is that they will report all incidents that happen in their facility and they will be thoroughly investigated. The Director of the facility offered any help they may need for the investigation by giving them copies of Houston Group Homes, Inc. Investigation forms. (See Attachment C) The Director of the facility informed the Attendees that the Houston Group Homes, Inc. Director, QMRP and the Residential Supervisor will monitor all incident report and ensure that they are all properly investigated. **Completion Date: May 30, 2012** **W-0000** The facility Director met with the Director of Nursing and the Residential Supervisor on May 24m 2012 to discuss plans for training on proper documentation on yearly physical forms. Training was conducted on June 4,2012 for the Residential Supervisor and Residential Trainer. (See Attachment D.) Client number 1 and 3 were taken back to the physician's office and given an eye exam. (See Attachment E.) The vision portion of the General Medical Examination form has a vision section, the Residential Supervisor and or the Residential Trainer will ensure that the physician fills in the form completely before leaving the office. **Completion Date:**	

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			June 7, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G578	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/24/2012

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W0149	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, the facility failed to implement its policy and procedures in regard to investigating abuse for 1 of 1 allegations reviewed for abuse/neglect (client #8). Findings include: The facility's policy and procedures were reviewed on 05/23/2012 at 3:00 p.m. The facility's undated policy, titled, "REPORTING ALLEGATIONS OF MISTREATMENT OF AN INDIVIDUAL" indicated, "...Allegations of mistreatment to an individual will be investigated by the interdisciplinary team. The IDT (Interdisciplinary Team) may consist of the individual client, the Residential Supervisor, the Registered Nurse, the QMRP (Qualified Mental Retardation Professional), and the Executive Director...The investigation process and results will be documented...." The facility's reportable incidents were reviewed on 05/24/2012 at 12:40 p.m. An Indiana Division of Disability and Rehabilitative Services Incident Report, dated 08/12/2011 at 11:00 a.m., indicated,	W0149	The facility Executive Director had a conversation with the QMRP, the Residential Supervisor and with the Director of Nursing on May24, 2012. The purpose of the meeting was to correct deficiency tag numbers W-149, W-154 & W-323 cited during the Indiana State Department of Health annual re-certification survey completed on May 24, 2012. **W-149** The facility Director reviewed the policy for Reporting Allegations of Mistreatment of and Individual and will ensure that all investigations are done for every incident report. No incident reports will be accepted and signed by the Director until there is a complete investigation per our policy. (See Attachment A.) **Completion Date: May 30, 2012**	05/30/2012

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	client #3 bit client #8 on his left upper arm. The record did not indicate the allegation of abuse had been investigated. During an interview on 05/24/2012 at 1:30 p.m., the Executive Director indicated the incident had not been investigated. 9-3-2(a)			

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W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, the facility failed to thoroughly investigate 1 of 1 incident reviewed for an allegation of abuse (client #8). Findings include: The facility's reportable incidents were reviewed on 05/24/2012 at 12:40 p.m. An Indiana Division of Disability and Rehabilitative Services Incident Report, dated 08/12/2011 at 11:00 a.m., indicated, client #3 bit client #8 on his left upper arm. The record did not indicate the allegation of abuse had been investigated. During an interview on 05/24/2012 at 1:30 p.m., the Executive Director indicated the incident had not been investigated. 9-3-2(a)	W0154	The facility Director met with the Executive Director and the Adult Services Director of the day service on May25, 2012 to discuss setting up an in-service on reportable incident investigations. The meeting was set up for Wednesday May 30, 2012 at 10:00 am. Director of the facility reviewed the Components of a Thorough Investigation originally presented by Steve Croya on March 17, 2011, with the Executive Director, the Adult Services Director and the Adult Services Program Manager for the Day Service Programs. (See Attachment B). The agreement with the Day Service is that they will report all incidents that happen in their facility and they will be thoroughly investigated. The Director of the facility offered any help they may need for the investigation by giving them copies of Houston Group Homes, Inc. Investigation forms. (See Attachment C) The Director of the facility informed the Attendees that the Houston Group Homes, Inc. Director, QMRP and the Residential Supervisor will monitor all incident report and ensure that they are all properly investigated. **Completion Date: May 30, 2012**	05/30/2012

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W0323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview, the facility failed to ensure an annual physical, which included a vision evaluation, was completed for 2 of 4 sampled clients (client #1 and client #3). Findings include: 1. Client #1's record was reviewed on 05/24/2012 at 6:50 a.m. There was no documentation in the client's record to indicate a vision screening had been completed during the past year. 2. Client# #3's record was reviewed on 05/23/2012 at 3:00 p.m. There was no documentation in the client's record to indicate a vision screening had been completed during the past year. During an interview on 05/24/2012 at 1:00 p.m., the Residential Supervisor indicated vision screening should have been completed and documented on client #1's and #3's annual physical forms. 9-3-6(a)	W0323	The facility Director met with the Director of Nursing and the Residential Supervisor on May 24m 2012 to discuss plans for training on proper documentation on yearly physical forms. Training was conducted on June 4,2012 for the Residential Supervisor and Residential Trainer. (See Attachment D.) Client number 1 and 3 were taken back to the physician's office and given an eye exam. (See Attachment E.) The vision portion of the General Medical Examination form has a vision section, the Residential Supervisor and or the Residential Trainer will ensure that the physician fills in the form completely before leaving the office. **Completion Date: June 7, 2012**	06/07/2012

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