

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/21/2016
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
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W 0000 Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00193099.</p> <p>Complaint #IN00193099-Substantiated, Federal/State deficiencies related to the allegation are cited at W104, W140, W148, W149 and W153.</p> <p>Survey Dates: 3/8, 3/9, 3/10, 3/14 and 3/21/16.</p> <p>Facility Number: 001113 Provider Number: 15G599 AIM Number: 100245610</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed on 3/29/16 by #09182.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), the governing</p>	W 0104	<p>Indiana Mentor has policies and procedures in place for the health, well-being, finances, and safety of individuals in the homes. All staff are trained upon these policies upon hire and annually</p>	04/20/2016

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>body failed to exercise general policy, budget and operating direction over the facility to ensure the facility purchased a needed lunch container for a client's lunch, ensured a floor was replaced in clients' bedrooms, to ensure the day program's floor was maintained/cleaned on a regular basis, and to ensure the facility developed a written policy and procedure in regard to clients' financial/personal information being compromised.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 3/8/16 at 12:20 PM. The facility's 2/4/16 reportable incident reports for clients A, B, C, D, E, F, G and H indicated "On 2/4/16 management was notified that the financial book for the 65th group home was missing. This included a combined total amount of \$66.56 of all consumers' petty cash. APS (Adult Protective Services) and local Police were notified and Indiana Mentor will replace all petty cash. Management immediately started an investigation including a complete search of the consumers' home. Individual's (sic) bank accounts were checked and no activity was noted. The bank has frozen accounts per agency's request...."</p>		<p>thereafter. Staff is trained on client finances and proper receipt and data collect upon hire and annually as well. Indiana Mentor also has maintenance personnel for the group homes and day programs to ensure proper upkeep of the homes is kept. Mentor contacted the maintenance in regards to the flooring in the group home and scheduled it be fixed. Mentor is also conducting an environmental review at its remaining programs to ensure issues have been addressed. Day program staff will be retrained by management on proper cleaning methods and professional floor cleaner is being brought in by 4/20/2016. New lunch boxes have been purchased for all clients in the group home. Management checked on other belongings to ensure no replacements were needed and checked the other group home as well to ensure items were in good condition. Quality Improvement has developed a new client protection procedure that staff will be trained on by 4/20/2016. Agency also used a credit monitoring service to check accounts of individuals who had data compromised, and checked with the bank found no suspicious activity before closing accounts and opening new ones. Mentor is using credit monitoring for 6 months on the affected clients to ensure client's information is not compromised.</p>	

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	<p>The facility's 2/5/16 Summary of Internal Investigation Report indicated clients A, B, C, D, E, F, G and H's funds and the clients' personal identification/information were taken along with the clients' checkbooks. The facility's 2/5/16 investigative report indicated clients A, B, C, D, E, F, G and H's finances (cash on hand), checkbooks and personal information came up missing on 1/28/16 but was not reported to the facility's administrator until 2/4/16.</p> <p>Client C's record was reviewed on 3/10/16 at 11:40 AM and indicated client C's state identification card and her social security card were not accounted for.</p> <p>Client D's record was reviewed on 3/10/16 at 9:50 AM. Client D's record indicated the client's personal state identification card was not accounted for.</p> <p>Client B's record was reviewed on 3/10/16 at 10:25 AM. Client B's record indicated the client's personal state identification card was not accounted for.</p> <p>Client A's record was reviewed on 3/10/16 at 12:29 PM. Client A's record indicated the client's personal state identification card was not accounted for.</p>		<p>Agency is implementing new cleaning procedures at the day services that will be reviewed by a member of management weekly. For repairs a maintenance log will be kept by management and environmental checklist will be turned into the QIDP monthly by the program managers to ensure maintenance related items have been completed. Responsible Party: QIDP, Program Manager Complete Date: 4/20/16</p>	

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	<p>The facility's policy and procedures were reviewed on 3/8/16 at 12:15 PM and on 3/9/16 at 11:35 AM. The facility's policy and procedures indicated the facility did not have a policy and procedure in regard to how the facility would handle the compromising of clients' personal identification/financial information to ensure the clients' identities would be protected.</p> <p>Interview with the Program Director (PD) on 3/8/16 at 3:20 PM indicated the clients' money came up missing on 1/28/16 as facility staff had counted the funds on 1/27/16. The PD indicated the facility staff documented the clients' financial book was missing in the staff's communication book on 1/28/16. The PD indicated the group home manager did not report the client's money/financial records and/or clients' identification cards missing until 2/4/16.</p> <p>Interview with the PD and the Area Director (AD) on 3/9/16 at 12:02 PM and on 3/10/16 at 1:19 PM indicated clients A, B, C, D, E, F, G and H's personal identification cards and checkbooks were missing along with the clients' finances. The PD indicated she was not aware any social security cards were missing. The PD did not know what happened to client C's social security card. When asked</p>			

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	<p>how the facility was protecting the clients' identities/personal information, the AD indicated the facility obtained a company to monitor the clients' social security numbers/identities. The AD indicated the company ran a report on 3/9/16 (first report) and the clients' personal information had not been used. When asked if the facility had a policy and procedure in regard to compromising clients' personal information/identities, the AD indicated he did not think so and he would check to see. At 12:10 PM on 3/9/16, the AD indicated the facility did not have a policy and procedure in regard to compromising clients' personal information/identifications.</p> <p>2. During the 3/8/16 observation period between 3:38 PM and 7:00 PM at the group home, client B's lunch container's lid was torn away from the client's lunchbox. The lunchbox materiel covering the container was also stained.</p> <p>During the 3/9/16 observation period between 5:45 AM and 8:20 AM at the group home, clients D and E's bedroom linoleum tile was buckled near the door and the dresser of client D. The linoleum was torn into large pieces around the base of client D's dresser and the baseboard of the wall.</p>						

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	<p>Interview with staff #11 on 3/9/16 at 7:55 AM indicated clients D and E's bedroom floor had been fixed in the past. Staff #11 stated client D and E's floor was due to client D "moving or dragging" his furniture/dresser. Staff #11 indicated the flooring around and under client D's bed was also torn and buckled.</p> <p>Interview with the PD on 3/9/16 at 11:15 AM indicated she had planned to walk through the group home with the maintenance man to identify repairs and items that needed to be replaced. The PD indicated she was hoping to replace the clients' bedroom floor this year. The PD indicated client B would get a new lunch box/container.</p> <p>3. During the 3/9/16 observation period between 9:18 AM and 10:15 AM at the facility's owned day program, the floors were soiled, stained and covered with black marks.</p> <p>Interview with the PD on 3/9/16 at 11:15 AM indicated the day program staff should be mopping the floors and keeping the floors clean.</p> <p>Interview with the AD and the PD on 3/10/16 at 1:19 PM indicated the facility was in the process of replacing some of the floors at the day program. The AD</p>			

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W 0140 Bldg. 00	<p>indicated he hoped to have the new floors completed within a month.</p> <p>This federal tag relates to complaint #IN00193099.</p> <p>9-3-1(a)</p> <p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), the facility failed to maintain a complete accounting of the clients' funds. The facility failed to ensure its system for monitoring receipts/expenditures was accurate and/or ensured facility staff obtained receipts versus handwriting receipts when possible.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 3/8/16 at 12:20 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p>	W 0140	<p>Indiana mentor has policies and procedures in place in regards to client finances. The agency staff and management are trained on these policies upon hire and annually thereafter. Mentor staff is being retrained on agencies financial procedures with an emphasis on the receipts, and accurate entries by 4/20/2016. The QIDP is auditing the client finances for all homes and day program by 4/20/2016. The Program Manager is reviewing the consumer finances at least 2x month to ensure accuracy including receipts present for purchases. The QIDP will reconcile all accounts monthly to bank statements and check for receipt accuracy as well. The QIDP audit of accounts will be turned into a client financial specialist monthly to verify completion and accuracy. Responsible Party: Finance,</p>	04/20/2016

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	<p>-2/15/16 "When staff went to day program on 2/15/2016 it was discovered that day program has been broken into over the weekend and that the entire safe containing the petty cash had been stolen from the locked cabinet it resided in. Staff called police to report the break in as safe was locked in place on end of business on Friday 2/12/2016. Agency is putting in reimbursement of consumer funds. Police have taken a report into incident (sic) and stated will follow up with agency and agency has started its own investigation as well. Agency is meeting to discuss possible additional security measures." The facility's 2/15/16 reportable incident report indicated clients A, B, D, C, F, G and H's monies were affected.</p> <p>The facility's 2/17/16 Summary of Internal Investigation Report indicated "...All clients attend Indiana MENTOR (parent company of REM) Day Services and keep a small amount of cash funds for outings during the week..." The facility's investigation indicated 2/15/16 "...the second set of doors was unlocked, it was frozen and they couldn't lock it..." The facility's investigation indicated day program staff did not notice the safe was missing prior to the door being found unlocked. The facility's investigation</p>		QIDP Complete Date: 4/20/2016				

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	<p>indicated the day program staff had found the door unlocked in the past. The investigation indicated "...[Day program staff #4] that the second set of doors wouldn't lock all the time. [day program staff #4] stated at one point, they had moved a refrigerator in front of the doors but they had to move it because it was a fire hazard..." The facility's investigation indicated the staff at the day program had not reported problems with locking/securing the day program door.</p> <p>The facility's investigation indicated "Additional Information: This writer (Quality Improvement Specialist #1) observed the 2nd (second) set of doors which is reportedly not used on a regular basis and discovered that the lock on the internal set of doors had been removed and turned around so the lock was only able to be locked from between the doors. In addition, this writer observed that one side of the outer set of doors had a lock that made the door stationary from the bottom and the top and if this was not secured, the doors could be opened from the outside. The outer side of the exterior door could not be opened from the outside unless the secured side was unlocked. The strike plate also looked as if it could have been tampered with however, the latch bolt on the door also drags against the strike plate when</p>			

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	<p>opening from outside. Maintenance personnel did change the locks on all doors and also turned around the lock on interior set of doors at the 2nd exit. Maintenance personnel also acknowledged that one of the tiles in the ceiling is raised and the other room could be accessed from the ceiling...Evidence could not be found to determine where the client petty cash funds contained inside the money safe disappeared to. The following is the amount of funds for each client that is missing and will be reimbursed.</p> <p>-[Client B] 7.33 -[Client F] 6.03 -[Client D] 8.72 -[Client G] 11.55 -[Client C] 3.59 -[Client A] 7.31 -[Client H] 10.56...."</p> <p>-2/4/16 Reportable incident reports for clients A, B, C, D, E, F, G and H indicated "On 2/4/16 management was notified that the financial book for the 65th group home was missing. This included a combined total amount of \$66.56 of all consumers' petty cash. APS (Adult Protective Services) and local Police were notified and Indiana Mentor will replace all petty cash. Management immediately started an investigation</p>			

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	<p>including a complete search of the consumers' home. Individual's (sic) bank accounts were checked and no activity was noted. The bank has frozen accounts per agency's request...."</p> <p>The facility's 2/5/16 Summary of Internal Investigation Report indicated clients A, B, C, D, E, F, G and H's funds and the clients' personal identification/information were taken along with the clients' checkbooks. The facility's 2/5/16 investigative report indicated clients B and D's finances (cash on hand), checkbooks and personal information came up missing on 1/28/16 but was not reported to the facility's administrator until 2/4/16. The facility's investigation indicated staff #1 went to the group home on 1/27/16 and found the clients' financial book in an unlocked cabinet in the dining room. The facility's investigation indicated staff #1 put the clients' finance book/money in a "...locked cabinet and write (sic) a note for staff to keep it out away there." The facility's investigation indicated "...[Staff #1] stated the financial books are usually kept in the second drawer of the file cabinet in the back laundry room. He stated there is one book for the males and one for the females and another with all the client IDs (identifications) and checkbooks...." The facility's</p>			

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	<p>investigation indicated facility staff were to count the money on each shift and to initial the money and documentation sheets matched.</p> <p>-11/12/15 "While reviewing finances for [client G's] return to day services \$25 for [client G] was not able to be located. Agency immediately started an investigation into the missing funds." The reportable incident report indicated the time/date the missing funds went missing was not known.</p> <p>The facility's 11/16/15 Summary of Internal Investigation Report indicated "On 11/12/2015 Program Director [PD #2] was notified of a discrepancy in regards to [client G's] finances at the day program. One Program Coordinator believed \$25 for [client G] had already been at the day program and another thought it was not there. The \$25 is unaccounted for and an investigation was started on 11/12/2015."</p> <p>The facility's 11/19/15 follow-up report indicated "Agency investigated the missing funds and determined the funds were not in any of [client G's] books or in her residential setting. The agency submitted a reimbursement form for the funds for [client G]. The investigator could not pinpoint the date the funds</p>			

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	<p>went missing. The Director of the program (PD #2) is no longer employed by the agency. The day program is implementing enhanced financial checks and documentation to help prevent future issues."</p> <p>Clients A, B, C, D, E, F, G and H's financial records were reviewed on 3/9/16 at 11:40 AM. The clients' financial records did not indicate the facility reimbursed client G's \$25.00 in regard to the 11/12/15 incident, reimbursed the clients in regard to the 2/4/16 missing funds, and/or in regard to the 2/15/16 missing funds from the day program.</p> <p>Interview with the Program Director (PD) on 3/8/16 at 3:20 PM indicated the clients' money came up missing on 1/28/16 as facility staff had counted the funds on 1/27/16. The PD indicated the facility staff documented the clients' financial book was missing in the staff's communication book on 1/28/16. The PD indicated the group home manager did not report the clients' money/financial records and/or clients' identification cards missing until 2/4/16. The PD indicated she had received the funds/checks to reimburse clients A, B, C, D, E, F, G and H in regard to the 2/4/16 missing funds. The PD indicated she had not deposited</p>			

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	<p>the reimbursed funds into the client's accounts. The PD did not provide any additional documentation/evidence of the reimbursement. The PD also indicated the clients' money kept at the group home was kept in a file cabinet but not always locked. The PD indicated the money was now being kept locked at the group home. The PD indicated the day program's doors were fixed the same day the clients' day program funds came up missing. When asked who had the code to the day program door to get to the key to unlock the day program, the PD stated "Just management now." The PD indicated management staff would have to unlock the doors to allow day program staff to enter the building. When asked if the clients' money had been replaced at the day program, the PD stated "Still in process of being replaced." The PD indicated in regard to client G's missing money at the day program, client G had been off on medical leave. The PD indicated when client G returned the client's money could not be accounted for as the day program thought they had returned the money to the group home and the group home had indicated the money had not been returned. The PD indicated she did not know if client G's \$25.00 had been reimbursed.</p> <p>2. Client F's financial records were</p>			

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	<p>reviewed on 3/9/16 at 11:40 AM. Client F's financial records (Cash on Hand-COH Record) indicated the following (not all inclusive):</p> <ul style="list-style-type: none"> -2/1/16 Client F was to have \$10.28 COH, but the client did not have any COH. -11/1/15 Client F went to a local pizza restaurant and spent \$7.64. The facility had a hand written Indiana Mentor Group Home Client Receipt for the pizza purchase. -10/17/15 Client F made a purchase at a local shopping store for \$10.68. The facility did not have a receipt for this purchase. -7/2/15 Client F spent \$6.00 at a water park. The facility did not have a receipt for this expenditure/purchase. -5/21/15 Client F withdrew \$11.08. The COH record did not indicate any documentation on what the \$11.08 was withdrawn for, and did not indicate the facility had a receipt for the \$11.08 withdrawal/expense. <p>Client D's financial records were reviewed on 3/9/16 at 11:40 AM. Client D's COH Records and receipts indicated the following (not all inclusive):</p> <ul style="list-style-type: none"> -2/1/16 Client D was to have \$9.82 COH, but the client did not have any cash on 			

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	<p>hand.</p> <p>-11/1/15 Client D spent \$7.64 at a local pizza restaurant. The facility had a hand written Indiana Mentor Group Home Client Receipt for the pizza purchase.</p> <p>Client A's financial records were reviewed on 3/9/16 at 11:40 AM. Client A's COH Records and/or receipts indicated the following (not all inclusive):</p> <p>-2/1/16 Client A was to have \$10.91 COH, but the client did not have any COH.</p> <p>-11/1/15 Client A spent \$7.64 at a local pizza restaurant. The facility had a hand written Indiana Mentor Group Home Client Receipt for the pizza purchase.</p> <p>-7/21/15 Client A went to a water park and spent \$6.00. The facility did not have a receipt for the \$6.00 expenditure/purchase. Client A's checking account ledger indicated client A went to a local shopping center and spent \$100.97 on 7/17/15. The facility did not have a receipt for 7/17/15 expenditure/purchase. On 6/23/15, client A's checking account ledger indicated client A spent \$106.97 at a local shoe store. The facility did not obtain a receipt for the 6/23/15 purchase/expenditure.</p> <p>Client B's financial records were</p>			

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	<p>reviewed on 3/9/16 at 11:40 AM. Client B's COH records and/or receipts indicated the following (not all inclusive):</p> <p>-2/1/16 Client B was to have \$10.00 COH, but the client did not have any COH.</p> <p>-11/1/15 Client B spent \$7.64 at a local pizza restaurant. The facility had a hand written Indiana Mentor Group Home Client Receipt for the pizza purchase.</p> <p>-7/21/15 Client B went to a water park and spent \$6.00. The client did not have a receipt for the \$6.00 expenditure/purchase. Client B's checking account ledger indicated the client spent \$271.07 at a local shopping center on 8/6/15. The client did not have a receipt for this purchase/expenditure. Client B also spent \$28.88 8/6/15 and \$53.48 on 8/23/15 at 2 different shoe stores. Client B's financial records indicated the facility did not have any receipts for the purchases.</p> <p>Client C's financial records were reviewed on 3/9/16 at 11:40 AM. Client C's COH records and/or receipts indicated the following (not all inclusive):</p> <p>-2/1/16 Client C was to have \$3.25 COH, but the client did not have any COH.</p>			

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	<p>-12/10/15 Client C went to a local restaurant and spent \$9.99. The facility had a hand written receipt for the meal purchase.</p> <p>-11/1/15 Client C spent \$7.64 at a local pizza restaurant. The facility had a hand written receipt for the pizza purchase.</p> <p>-9/16/15 Client C spent \$6.61 purchasing snacks at a gas station. The facility had a hand written receipt for the purchase/expenditure.</p> <p>-7/1/15 Client C spent \$6.00 at a water park. The facility had a hand written receipt for the purchase/expenditure.</p> <p>Client G's financial records were reviewed on 3/9/16 at 11:40 AM. Client G's COH records and/or receipts indicated the following (not all inclusive):</p> <p>-2/1/16 Client G was to have \$9.81 COH, but the client did not have any COH.</p> <p>-11/1/15 Client G spent \$7.64 at a local pizza restaurant. The facility had a hand written receipt for the pizza purchase.</p> <p>-11/28/15 Client G spent \$5.00 at a pizza restaurant. The facility had a hand written receipt for the purchase/expenditure.</p> <p>9/21/15 Client G spent \$6.96 at a local chicken restaurant. The facility did not have a receipt for this expenditure/purchase.</p>						

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	<p>Client H's financial records were reviewed on 3/9/16 at 11:40 AM. Client H's COH records and/or receipts indicated the following (not all inclusive):</p> <ul style="list-style-type: none"> -2/1/16 Client H was to have \$12.28 COH, but the client did not have any COH. -11/1/15 Client H spent \$7.64 at a local pizza restaurant. The facility had a hand written receipt for the pizza purchase. -11/28/15 Client H withdrew \$5.00 for lunch. The facility had a hand written receipt, and the receipt did not indicate where the client spent the \$5.00. 5/21/15 Client H spent \$13.83 at a local restaurant. The facility did not have a receipt for the client's 5/21/15 expenditure/purchase. <p>Interview with the PD on 3/8/16 at 3:20 PM indicated clients A, B, C, D, E, F, G and H did not have any cash on hand at the group home. The PD indicated the client's money came up missing on 1/28/16. The PD indicated the facility contacted the police and the facility conducted an investigation into the clients' missing funds. The PD indicated the facility was not able to determine what happened to the clients' funds. The PD indicated the previous manager sent</p>			

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W 0148 Bldg. 00	<p>her a lot of paperwork in regard to the client's finances. The PD indicated she did not know why facility staff did not obtain a receipt for known restaurants and/or other stores. The PD indicated she would attempt to locate receipts for some of the above mentioned purchases. The PD did not provide any additional receipts and/or documentation in regard to clients A, B, C, D, E, F, G and H's finances.</p> <p>This federal tag relates to complaint #IN00193099.</p> <p>9-3-2(a)</p> <p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on interview and record review for 2 of 4 sampled clients (B and D), the facility failed to ensure the clients' legally appointed representatives were informed of the theft of the clients' funds and/or identification cards/personal information of the clients.</p> <p>Findings include:</p>	W 0148	Indiana Mentor trains it's management team on communication during supervisor training. This includes ensuring guardian are informed of any BDDS reportable incidents. Management was retrained on BDDS reporting in regards to guardian contact and communication with guardians. On- going Area Director will be	04/20/2016

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	<p>The facility's reportable incident reports were reviewed on 3/8/16 at 12:20 PM.</p> <p>The facility's 2/4/16 reportable incident reports for clients B and D indicated "On 2/4/16 management was notified that the financial book for the 65th group home was missing. This included a combined total amount of \$66.56 of all consumers' petty cash. APS (Adult Protective Services) and local Police were notified and Indiana Mentor will replace all petty cash. Management immediately started an investigation including a complete search of the consumers' home.</p> <p>Individual's (sic) bank accounts were checked and no activity was noted. The bank has frozen accounts per agency's request...." Client B's 2/4/16 reportable incident report indicated client B's guardian was notified on 2/5/16. Client D's reportable incident report indicated "N/A" (non-applicable) was checked in regard to contacting the client's guardian.</p> <p>The facility's 2/5/16 Summary of Internal Investigation Report indicated client B and D's funds, and personal identification/information were taken along with the clients' checkbooks. The facility's 2/5/16 investigative report indicated client B and D's finances (cash on hand), check books and personal information came up missing on 1/28/16</p>		<p>reviewing all incident reports and having the QIDP indicate the date the guardian was contacted on reports send to the Area Director. These reports will be tracked and logged by the Area Director to ensure proper communication was maintained. Responsible Party: QIDP, Area Director Complete Date: 4/20/16</p>	

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	<p>but was not reported to the facility's administrator until 2/4/16.</p> <p>Client B's financial records were reviewed on 3/9/16 at 11:40 AM. Client B's 1/27/16 Cash On Hand (COH) Record/entry indicated client B had \$10.00 which came up missing as the client's funds was last counted on 1/27/16.</p> <p>Client D's financial records were reviewed on 3/9/16 at 11:40 AM. Client D's 1/27/16 COH Record indicated client D had \$9.82 which came up missing as the client's funds was last counted on 1/27/16.</p> <p>Client B's record was reviewed on 3/10/15 at 10:25 AM. Client B's 2/22/16 Individual Support Plan (ISP) indicated client B's father was the client's guardian.</p> <p>Client D's record was reviewed on 3/10/16 at 9:50 AM. Client D's 4/16/15 ISP indicated client D had a legal guardian.</p> <p>Interview with client B's guardian on 3/14/16 at 6:14 AM indicated client B's father was client B's guardian. Client B's guardian indicated he was not informed of client B's theft of funds, missing checkbook, and/or theft of the client's</p>			

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W 0149 Bldg. 00	<p>personal information/identification card.</p> <p>Interview with client D's guardian on 3/14/16 at 7:05 AM indicated she was client D's guardian. Client D's guardian indicated the facility did not notify/inform client D's guardian of client D's theft of funds, missing checkbook, and/or of the client's personal information/identification card.</p> <p>Interview with the Program Director (PD) on 3/14/16 at 10:17 AM, by phone, indicated she told staff #1 to contact clients B and D's guardians to let them know of the theft of the clients' funds on 2/4/16. The PD indicated staff #1 told her the clients' guardians had been contacted/informed.</p> <p>This federal tag relates to complaint #IN00193099.</p> <p>9-3-2(a)</p> <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 interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), the facility failed to implement its</p>	W 0149	Indiana Mentor has policies and procedures in place in regards to abuse/neglect/exploitation of clients. These policies are trained upon hire and annually thereafter.	04/20/2016

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	<p>written policy and procedures to prevent abuse/exploitation of the clients' funds at the group home and the day program. The facility failed to implement its written policy and procedures to ensure facility staff immediately reported clients' missing funds, conducted thorough investigations in regard to all allegations of abuse and/or neglect, and to ensure the facility implemented its recommended corrective actions in regard to an allegation of neglect in regard to a client's medication.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 3/8/16 at 12:20 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-2/15/16 "When staff went to day program on 2/15/2016 it was discovered that day program has been broken into over the weekend and that the entire safe containing the petty cash had been stolen from the locked cabinet it resided in. Staff called police to report the break in as safe was locked in place on end of business on Friday 2/12/2016. Agency is putting in reimbursement of consumer funds. Police have taken a report into</p>		<p>All management is trained on how to handle allegations of such and following up after investigations have been completed. The staff involved in reporting late the finances missing is no longer employed by Mentor. All staff will be retrained on agencies abuse/neglect/exploitation policy by 4/20/2016. Management will also be retrained in investigation procedures and follow up by 4/20/2016. All investigations for abuse, neglect, exploitation will be turned into the Area Director for review and sent to Quality improvements, operation, and HR for review. Staff recommendations from investigations will be sent to QA for review of completion Responsible Party: QIDP, Area Director Complete Date: 4/20/2016</p>	

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	<p>incident (sic) and stated will follow up with agency and agency has started its own investigation as well. Agency is meeting to discuss possible additional security measures." The facility's 2/15/16 reportable incident report indicated clients A, B, D, C, F, G and H's monies were affected.</p> <p>The facility's 2/17/16 Summary of Internal Investigation Report indicated "...All clients attend Indiana MENTOR (parent company of REM) Day Services and keep a small amount of cash funds for outings during the week..." The facility's investigation indicated 2/15/16 "...the second set of doors was unlocked, it was frozen and they couldn't lock it..." The facility's investigation indicated day program staff did not notice the safe was missing prior to the door being found unlocked. The facility's investigation indicated the day program staff had found the door unlocked in the past. The investigation indicated "...[Day program staff #4] that the second set of doors wouldn't lock all the time. [day program staff #4] stated at one point, they had moved a refrigerator in front of the doors but they had to move it because it was a fire hazard..." The facility's investigation indicated the staff at the day program had not reported problems with locking/securing the day program door.</p>			

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	<p>The facility's investigation indicated "Additional Information: This writer (Quality Improvement Specialist #1) observed the 2nd (second) set of doors which is reportedly not used on a regular basis and discovered that the lock on the internal set of doors had been removed and turned around so the lock was only able to be locked from between the doors. In addition, this writer observed that one side of the outer set of doors had a lock that made the door stationary from the bottom and the top and if this was not secured, the doors could be opened from the outside. The outer side of the exterior door could not be opened from the outside unless the secured side was unlocked. The strike plate also looked as if it could have been tampered with however, the latch bolt on the door also drags against the strike plate when opening from outside. Maintenance personnel did change the locks on all doors and also turned around the lock on the interior set of doors at the 2nd exit. Maintenance personnel also acknowledged that one of the tiles in the ceiling is raised and the other room could be accessed from the ceiling...Evidence could not be found to determine where the client petty cash funds contained inside the money safe disappeared to. The following is the amount of funds for</p>			

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	<p>each client that is missing and will be reimbursed.</p> <p>-[Client B] 7.33 -[Client F] 6.03 -[Client D] 8.72 -[Client G] 11.55 -[Client C] 3.59 -[Client A] 7.31 -[Client H] 10.56...."</p> <p>-2/4/16 Reportable incident reports for clients A, B, C, D, E, F, G and H indicated "On 2/4/16 management was notified that the financial book for the 65th group home was missing. This included a combined total amount of \$66.56 of all consumers' petty cash. APS (Adult Protective Services) and local Police were notified and Indiana Mentor will replace all petty cash. Management immediately started an investigation including a complete search of the consumers' home. Individual's (sic) bank accounts were checked and no activity was noted. The bank has frozen accounts per agency's request...."</p> <p>The facility's 2/5/16 Summary of Internal Investigation Report indicated clients A, B, C, D, E, F, G and H's funds and the clients' personal identification/information were taken along with the clients' checkbooks. The</p>			

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	<p>facility's 2/5/16 investigative report indicated clients B and D's finances (cash on hand), checkbooks and personal information came up missing on 1/28/16 but was not reported to the facility's administrator until 2/4/16. The facility's investigation indicated staff #1 went to the group home on 1/27/16 and found the clients' financial book in an unlocked cabinet in the dining room. The facility's investigation indicated staff #1 put the client's finance book/money in a "...locked cabinet and write a note for staff to keep it put away there." The facility's investigation indicated "...[Staff #1] stated the financial books are usually kept in the second drawer of the file cabinet in the back laundry room. He stated there is one book for the males and one for the females and another with all the client IDs (identifications) and checkbooks...." The facility's investigation indicated facility staff were to count the money on each shift and to initial the money and documentation sheets matched.</p> <p>-11/12/15 "While reviewing finances for [client G's] return to day services \$25 for [client G] was not able to be located. Agency immediately started an investigation into the missing funds." The reportable incident report indicated the time/date the missing funds went</p>			

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	<p>missing was not known.</p> <p>The facility's 11/16/15 Summary of Internal Investigation Report indicated "On 11/12/2015 Program Director [PD #2] was notified of a discrepancy in regards to [client G's] finances at the day program. One Program Coordinator believed \$25 for [client G] had already been at the day program and another thought it was not there. The \$25 is unaccounted for and an investigation was started on 11/12/2015."</p> <p>The facility's 11/19/15 follow-up report indicated "Agency investigated the missing funds and determined the funds were not in any of [client G's] books or in her residential setting. The agency submitted a reimbursement form for the funds for [client G]. The investigator could not pinpoint the date the funds went missing. The Director of the program (PD #2) is no longer employed by the agency. The day program is implementing enhanced financial checks and documentation to help prevent future issues."</p> <p>Clients A, B, C, D, E, F, G and H's financial records were reviewed on 3/9/16 at 11:40 AM. The clients' financial records did not indicate the facility reimbursed client G's \$25.00 in</p>						

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	<p>regard to the 11/12/15 incident, reimbursed the clients in regard to the 2/4/16 missing funds, and/or in regard to the 2/15/16 missing funds from the day program.</p> <p>Interview with the Program Director (PD) on 3/8/16 at 3:20 PM indicated the clients' money came up missing on 1/28/16 as facility staff had counted the funds on 1/27/16. The PD indicated the facility staff documented the clients' financial book was missing in the staff's communication book on 1/28/16. The PD indicated the group home manager did not report the client's money/financial records and/or clients' identification cards missing until 2/4/16. The PD indicated she had received the funds/checks to reimburse clients A, B, C, D, E, F, G and H in regard to the 2/4/16 missing funds. The PD indicated she had not deposited the reimbursed funds into the client's accounts. The PD did not provide any additional documentation/evidence of the reimbursement. The PD also indicated the clients' money, kept at the group home, was kept in a file cabinet but not always locked. The PD indicated the money was now being kept locked at the group home. The PD indicated the day program's doors were fixed the same day the clients' day program funds came up missing. When asked who had the code</p>			

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	<p>to the day program door to get to the key to unlock the day program, the PD stated "Just management now." The PD indicated management staff would have to unlock the doors to allow day program staff to enter the building. When asked if the clients' money had been replaced at the day program, the PD stated "Still in process of being replaced." The PD indicated in regard to client G's missing money at the day program, client G had been off on medical leave. The PD indicated when client G returned the client's money could not be accounted for as the day program thought they had returned the money to the group home and the group home had indicated the money had not been returned. The PD indicated she did not know if client G's \$25.00 had been reimbursed.</p> <p>2. The facility failed to ensure facility staff reported clients A, B, C, D, E, F, G and H's missing finances/personal identification cards immediately to the administrator when the financial book was discovered missing. The facility failed to ensure the facility immediately reported missing funds from the day program to state officials in a timely manner. Please see W153.</p> <p>3. The facility failed to conduct thorough investigations in regard to the staff to</p>			

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	<p>client allegations of abuse/neglect incidents involving client G. Please see W154.</p> <p>4. The facility failed to implement its recommended corrective actions for client G in regard to an allegation of neglect involving the client's medication. Please see W157.</p> <p>The facility's policy and procedures were reviewed on 3/8/16 at 12:15 PM and on 3/9/16 at 11:35 AM. The facility's April 2011 policy entitled Quality Risk Management indicated "A. Indiana MENTOR promotes a high quality of service and seeks to 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. B. Indiana MENTOR follows the BDDS (Bureau of Developmental Disabilities Services) 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: 1. Alleged, suspected, or actual abuse, neglect, or exploitation of an individual...." The facility's policy and procedure indicated</p>			

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	<p>the facility staff would report all allegations to the administrator so the initial report would be made within 24 hours to BDDS. The facility's investigation indicated "...Indiana MENTOR is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee...." The facility's April 2011 policy indicated "...Indiana MENTOR is committed to ensuring the individuals we serve are provided with a safe and quality living environment. In order to ensure the highest standard of service delivery (sic) specific staff will be assigned to the monitoring and review of Quality Assurance. These staff will assist in providing Individual Support Teams with corporate supports. recommendations and resources for incident management and will review the effectiveness of the recommendations...."</p> <p>The facility's April 2011 policy entitled Management of an Individual's Funds indicated "...Procedures are in place in all programs to ensure accountability and to protect individuals from financial exploitation...." The facility's policy and/or procedures indicated "...All cash being held for individuals will be kept in a secure lock box. No more than \$25.00 per individual will be maintained in the</p>			

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W 0153 Bldg. 00	<p>lock box. The Program Director, Home Manager, and the Area Director will be the only staff with access to the lock box...Misuse of funds belonging to individuals in Network care is not tolerated, this is a violation of both State and Federal law and is reported accordingly."</p> <p>This federal tag relates to complaint #IN00193099.</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.</p> <p>Based on interview and record review for 2 of 8 allegations of abuse, neglect, exploitation, and/or injuries of unknown source reviewed, the facility failed to ensure facility staff reported clients A, B, C, D, E, F, G and H's missing finances/personal identification cards immediately to the administrator when the financial book was discovered missing. The facility failed to ensure the facility immediately reported missing funds from the day program to state officials in a timely manner.</p>	W 0153	<p>Indiana Mentor has policies and procedures in place in regards to abuse/neglect/exploitation of clients. These policies are trained upon hire and annually thereafter. All management is trained on how to handle allegations of such and following up after investigations have been completed. The staff involved in reporting late the finances missing is no longer employed by Mentor. All staff will be retrained on agencies abuse/neglect/exploitation policy by 4/20/2016 including timelines for reporting. Reporting</p>	04/20/2016

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	<p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 3/8/16 at 12:20 PM. The facility's 2/4/16 reportable incident reports for clients B and D indicated "On 2/4/16 management was notified that the financial book for the 65th group home was missing. This included a combined total amount of \$66.56 of all consumers' petty cash. APS (Adult Protective Services) and local Police were notified and Indiana Mentor will replace all petty cash. Management immediately started an investigation including a complete search of the consumers' home. Individual's (sic) bank accounts were checked and no activity was noted. The bank has frozen accounts per agency's request...." Clients A, B, C, D, E, F, G and H's 2/4/16 reportable incident reports indicated the facility's Date of Knowledge was 2/4/16.</p> <p>The facility's 2/5/16 Summary of Internal Investigation Report indicated clients A, B, C, D, E, F, G and H's funds and the clients' personal identification/information were taken along with the clients' checkbooks. The facility's 2/5/16 investigative report indicated clients B and D's finances (cash</p>		<p>procedures will be covered monthly in house meetings for the next 3 months and then quarterly thereafter for next year. All investigations for abuse, neglect, exploitation will be turned into the Area Director for review and sent to Quality improvements, operation, and HR for review. Staff recommendations from investigations will be sent to QA for review of completion. Responsible Party: QIDP, Area Director Complete Date: 4/20/2016</p>	

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	<p>on hand), checkbooks and personal information came up missing on 1/28/16 but was not reported to the facility's administrator until 2/4/16. The facility's investigation indicated facility staff left a message in the staff's communication book on 1/28/16 about the clients' missing financial records/funds. The facility's investigation indicated the facility staff did not report the missing funds as the facility staff thought staff #1 had the financial book to do his end of month paperwork. The facility's investigation indicated staff #1 did not report the clients missing funds/records to the administrator until 2/4/16.</p> <p>Interview with the Program Director (PD) on 3/8/16 at 3:20 PM indicated the clients' money came up missing on 1/28/16 as facility staff had counted the funds on 1/27/16. The PD indicated the facility staff documented the clients' financial book was missing in the staff's communication book on 1/28/16. The PD indicated the group home manager did not report the client's money/financial records and/or clients' identification cards missing until 2/4/16.</p> <p>2. The facility's reportable incident reports were reviewed on 3/8/16 at 12:20 PM. The facility's 11/16/15 reportable incident report indicated "[Client G]</p>			

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	<p>stated the (sic) she did not like how DSP (Direct Support Professional) [staff #3] talked in the house and alleged that she is rough with the clients. [Staff #3] was suspended pending an investigation." The facility's 11/16/15 reportable incident report indicated the incident/allegation occurred on 11/13/15 but was not reported to state officials until 11/16/15.</p> <p>The facility's 11/17/15 Summary of Internal Investigation Report indicated "An anonymous report was made on 11/16/15 stating that an allegation of abuse had been reported to [Program Director-PD] #2 on 11/13/15 and she (PD #2) stated that she would handle it on Monday...." The facility's reportable incident report indicated facility staff (a relief staff person) (staff #4) reported the allegation of abuse to the Day Program Coordinator, who then attempted to call PD #2 on 11/13/15. The facility's investigative report indicated when the Day Program Coordinator (DPC) could not reach PD #2, the DPC called staff #1 and had staff #4 make the report to staff #1. The facility's investigation indicated the DPC indicated PD #2 called her back on 11/13/15 and the DPC reported what was told to her by staff #4. The facility's investigation indicated "...[DPC] stated that [PD #2] said she would call [staff #1]...." The facility's investigation</p>			

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W 0154 Bldg. 00	<p>indicated "...[PD #2] stated that [DPC] had called her and reported that DSP [staff #4] reported [client G] told her that she didn't like how [staff #3] was talking to clients and how she was handling them. [PD #2] stated no further detail was given. [PD #2] stated [DPC] stated she was informing [staff #1] of this as well and she [PD #2] never heard more from either [DPC] or [staff #1] in regards to the incident." The facility's 11/17/15 investigation indicted PD #2 was informed of the allegation on 11/13/15.</p> <p>Interview with the PD on 3/14/16 at 10:15 AM, by phone, indicated she would have to check to see why the previous PD (PD #2) did not report the allegation of abuse until 11/16/15 when she was aware of the incident on 11/13/15. The PD did not provide any additional information.</p> <p>This federal tag relates to complaint #IN00193099.</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. Based on interview and record review for</p>	W 0154	Indiana Mentor has policies and procedures in place in regards to	04/20/2016

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	<p>2 of 8 allegations of abuse, neglect, and/or injuries of unknown source reviewed, the facility failed to conduct thorough investigations in regard to the staff to client allegations of abuse/neglect incidents involving client G.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports were reviewed on 3/8/16 at 12:20 PM. The facility's 11/16/15 reportable incident report indicated "[Client G] stated the (sic) she did not like how DSP (Direct Support Professional) [staff #3] talked in the house and alleged that she is rough with the clients. [Staff #3] was suspended pending an investigation."</p> <p>The facility's 11/17/15 Summary of Internal Investigation Report indicated client G was the only client interviewed in regard to the allegation of staff to client abuse. The facility's investigation indicated client G and staff #3 did not get along. The facility's investigation indicated "...[Client G] stated that [staff #3] comes in with an attitude and she doesn't like how she talks. [Client G] stated that [staff #3] tells her what to do. [Client G] stated that [staff #3] grabs at others in the house. [Client G] stated that she doesn't grab her because if she did, she (client G) would punch her (staff #3)</p>		<p>abuse/neglect/exploitation of clients and for investigation procedures for such incidents. Additionally Mentor has policies and procedures in place for incidents outside of A/N/E that require investigations. Agency has assigned investigators that go through training to ensure investigations are thorough and meet the quality standards. Area investigators have been retraining completing thorough and complete investigations in regards to abuse and neglect and other incidents needing an investigation. ANE investigations will be sent to QA, operations, and HR for review. Any recommendations for staff will be sent to QA once completed to ensure follow up is being done. Non ANE investigations are reviewed and tracked by Area Director and recommendations will be sent to them and staff Responsible Party: QIDP, Area Director Complete Date: 4/20/2016</p>	

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	<p>in the face...[Client G] could not say who [staff #3] did this too. [Client G] stated that if she showed me what she did, she would hurt me. This writer (Quality Improvement Specialist #1) told [client G] that was fine but it would really help if she could show me exactly what she saw. [Client G] then pulled the staff's shirt and then cupped her hand around this writers arm and gently squeezed. [Client G] then said this is what she does. When asked again who [staff #3] had done this to, [client G] stated me. When asked if she had done it anyone else, [client G] said maybe [client B] but [client B] won't be able to tell you. [Client G] stated that this happened a couple of months ago...[Client G] again brought up that staff didn't like [staff #3] and that she (staff #3) shouldn't be working there...." The facility's 11/17/15 investigation indicated "Conclusion: Evidence could not be found to support the allegation that [staff #3] is mistreating or abusing clients." The facility's investigation indicated no additional clients were interviewed and only 2 other staff besides staff #3, from the group home, were interviewed in regard to the allegation of abuse.</p> <p>Interview with the PD on 3/14/16 at 10:15 AM, by phone, indicated she did not know why any other client was not</p>			

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	<p>interviewed and/or why only 3 group home staff were interviewed. The PD indicated she would have to check to see if she could locate anymore information in regard to the 11/16/15 reportable incident report. The PD did not provide any additional information.</p> <p>2. The facility's reportable incident reports were reviewed on 3/8/16 at 12:20 PM. The facility's 6/1/15 reportable incident report indicated "on 06-01-15 Program Director received a phone call from Home Manager [staff #5] about a 7 am med (medication) Ciprofloxacin (antibiotic) 500mg (milligrams) given every 12 hours (7am & (and) 7pm) that was initialed for 5 days. The tablets are still present in the med cabinet, therefore were not administered (to client G). Our nurse contacted [name of doctor] who is the primary care physician that prescribed the med. We will continue to ensure the health and safety of our clients."</p> <p>The facility's 6/1/15 Investigation Summary indicated client G's medication was still in the "...bubble pack and there was no documentation on the MAR (Medication Administration Record). There was only one staff working with [client G] at the time the medication was to be administered for each day. The staff is DSP [staff #6]." The facility's</p>			

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W 0157 Bldg. 00	<p>investigation indicated client G had not been given her medication for 5 days. The facility's investigation indicated "...Evidence supports that staff did not followed (sic) med administration procedures..." The facility's 6/1/15 investigation indicated the facility did not include any additional information/investigation in regard to why staff #6 did not administer the client's medication as ordered.</p> <p>Interview with the PD, the Area Director (AD) and RN (Registered Nurse) #1 on 3/10/16 at 1:19 PM indicated an investigation was conducted in regard to the medication error with client G. The AD and the RN did not know why staff #3 did not administer client G's antibiotic for 5 days.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 1 of 8 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to implement its recommended corrective actions for client G.</p>	W 0157	Indiana Mentor has policies and procedures in place in regards to abuse/neglect/exploitation of clients and for investigation procedures for such incidents. Additionally Mentor has policies and procedures in place for incidents outside of A/N/E that require investigations. Agency	04/20/2016

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	<p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 3/8/16 at 12:20 PM. The facility's 6/1/15 reportable incident report indicated "on 06-01-15 Program Director received a phone call from Home Manager [staff #5] about a 7 am med (medication) Ciprofloxacin (antibiotic) 500mg (milligrams) given every 12 hours (7am & (and) 7pm) that was initialed for 5 days. The tablets are still present in the med cabinet, therefore were not administered (to client G). Our nurse contacted [name of doctor] who is the primary care physician that prescribed the med. We will continue to ensure the health and safety of our clients."</p> <p>The facility's 6/1/15 Investigation Summary indicated client G's medication was still in the "...bubble pack and there was no documentation on the MAR (Medication Administration Record). There was only one staff working with [client G] at the time the medication was to be administered for each day. The staff is DSP [staff #6]." The facility's investigation indicated client G had not been given her medication for 5 days. The facility's investigation indicated "...Evidence supports that staff did not followed (sic) med administration procedures...." The facility's 6/1/15</p>		<p>has assigned investigators that go through training to ensure investigations are thorough and meet the quality standards. Area investigators have retraining regarding thorough and complete investigations in regards to abuse and neglect and other incidents needing an investigation, and this will be done by 4/20/2016. ANE investigations will be sent to QA, operations, and HR for review. Any recommendations for staff will be sent to QA once completed to ensure follow up is being done. Non ANE investigations are reviewed and tracked by Area Director and recommendations will be sent to them and staff Responsible Party: QIDP, Area Director Complete Date: 4/20/2016</p>		

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W 0159 Bldg. 00	<p>investigation indicated the facility would "Re train (sic) staff on the agency's policy and procedure for medication pass." The 6/1/15 investigation and/or reportable incident report did not indicate when the facility retrained staff #6.</p> <p>Interview with the PD, the Area Director (AD) and RN (Registered Nurse) #1 on 3/10/16 at 1:19 PM indicated an investigation was conducted in regard to the medication error with client G. The AD and the PD indicated they would have to check to see when staff #6 was retrained. The AD and/or the PD did not provide any additional documentation in regard to the recommended corrective action.</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 interview and record review for 1 of 4 sampled clients (D), the Qualified Intellectual Disabilities Professional (QIDP) failed to monitor the clients' data/objectives to ensure the client had made progress and/or regressed in the client's skills as there were no monthly</p>	W 0159	Indiana Mentor has policies and procedures in place in regards to client programming. Each programs developed and reviewed by a certified QIDP. QIDP is trained in agency requirements including monthly documentation, goal review, progress and implementation.	04/20/2016

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	<p>summaries in regard to the client's identified Individual Support Plan (ISP) objectives for the entire year (4/14 to 3/16).</p> <p>Findings include:</p> <p>Client D's record was reviewed on 3/10/16 at 9:50 AM. Client D's 4/16/15 Individual Support Plan (ISP) indicated client D had the following objectives:</p> <ul style="list-style-type: none"> -Staff will ask client D to show them how he does his chore daily with 4 verbal prompts or less 60% (percent) of the time for 3 consecutive months. -Client D will get a cup of water for his evening medication pass for 3 consecutive months. -Client D will make a purchase with staff giving him 2 verbal prompts or less 80% of the time for 3 consecutive months. -Client D will fold or hang up his clothes with staff assistance with 2 verbal prompts or less 80% of the time for 3 consecutive months. -Client D will brush/floss his teeth for 2 minutes with 1 verbal prompt or less for 90% of the time for 3 consecutive months. -Client D will carry his identification card on him and show it to staff when asked daily for 3 consecutive months. -Client D will complete some form of 		<p>The agency had relieved a former QIDP earlier in the year for not meeting performance standards. Current QIDP has been retrained on ISP implementation including monthly and goal review. Additionally all individuals in the house will have programming reviewed for past year to ensure completion. These items will be completed by 4/20/2016. The summaries for client D will be brought up to date by 4/20/2016 as well. The QIDP will be submitting monthlies to the Area Director for review by the 10th of the following month. Mentor will also conduct periodic random audits of program files to ensure competition. Goal data will be checked Responsible Party: QIDP, Area Director Complete Date: 4/20/2016</p>	

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W 0227 Bldg. 00	<p>exercise for 30 minutes with 2 verbal prompts 80% of the time for 3 consecutive months. Client D's record indicated the QIDP failed to monitor the client's above mentioned objectives as the client had no monthly summaries since the client's ISP was initiated in 4/16/15.</p> <p>Interview with the PD on 3/10/16 at 1:19 PM indicated she would check to see if client D had any monthly summaries. The PD did not provide any additional information/documentation of the QIDP's monitoring of the client's ISP objectives.</p> <p>9-3-3(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, interview and record review for 1 of 4 sampled clients (A), the client's Individual Support Plan (ISP) failed to address the client's identified behavioral need.</p> <p>Findings include:</p> <p>During the 3/9/16 observation period between 5:45 AM and 8:20 AM at the group home, client A carried around used</p>	W 0227	Indiana Mentor has policies and procedures in place in regards to client programming. Each program is developed and reviewed by a certified QIDP. QIDP is trained in agency requirements including monthly documentation, goal review, progress and implementation. Mentor works with behavioral companies to ensure known behaviors are known and the IDT and HRC review plans to ensure	04/20/2016

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	<p>plastic bags when he moved from one location to another. At 7:20 AM, client A was verbally prompted to come to the back of the house to get his morning medication. Client A took his morning medications but held the pills/medications in his mouth. Client A then walked to the dining room table where staff #9 verbally redirected the client to eat his breakfast. Client A refused to eat and sat at the dining room table holding his morning medications in his mouth while clutching his multiple plastic bags. Client A kept asking staff #9 for another plastic bag. Staff #9 verbally reminded client A he needed to swallow his medication and eat his breakfast before he could get another plastic bag. At 7:42 AM, client A stood up from his seat and walked over to the trash can and spit out/threw up his medications. Staff #9 stated client A's pills had dissolved in his mouth except for the "blue and white pills." Client A then proceeded to eat his breakfast.</p> <p>Client A's record was reviewed on 3/10/16 at 12:29 PM. Client A's 4/7/15 Behavioral Support Plan (BSP) indicated client A demonstrated the targeted behaviors of resistance to instructions, aggressive outbursts and self-injurious behaviors. Client A's BSP did not address the client's behavior of obsessing</p>		<p>they are accurate and meets client's needs. Client A behavior plan has been amended to include the identified behavior. Training for staff will be completed by 4/20/2016. The QIDP and the behavioralist will complete a review of all individuals behavior plans to ensure all targeted behaviors have been identified in plans. The behavior support specialist and the QIDP are to meet at least monthly to review plans and ensure no new targeted behaviors need to be included and the active ones are still relevant. Any recommended changes will be addressed with the IDT and HRC approval Responsible Party: QIDP, Area Director, behavior specialist Complete Date: 4/20/2016</p>	

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	<p>over bags and/or spitting out/throwing up his medications.</p> <p>Interview with staff #9 on 3/9/16 at 7:55 AM stated client A would hold his medications in his mouth and would try to spit them out and/or "throw them up." Staff #9 indicated client A wanted a plastic bag. Staff #9 stated client A had an "obsession" with plastic bags. Staff #9 indicated client A would put items in the bags and carry them around. When asked how often client A would hold his pills in his mouth and then spit them out/throw up, staff #9 stated client A had to be "watched" to keep the client from spitting out/throwing up his pills.</p> <p>Interview with the Program Director (PD), Area Director (AD) and Registered Nurse (RN) #1 on 3/10/16 at 1:19 PM indicated client A did not have a behavior plan for his obsession with plastic bags. RN #1 indicated she was only aware of client A spitting out his medications/pills 2 times in the past year. The PD stated facility staff should use "verbal redirection" and/or offer the client another "preferred activity to break his attention from the bags." The PD indicated client A's BSP would need to be updated.</p> <p>9-3-4(a)</p>			

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W 0249 Bldg. 00	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D), the facility failed to implement the clients' Individual Support Plan (ISP) objectives and/or behavioral objectives when formal and/or informal training opportunities existed.</p> <p>Findings include:</p> <p>1. During the 3/8/16 observation period between 3:38 PM and 7:00 PM at the group home, client D stayed in his bedroom except to shower and eat. Client D sat on his bed, and/or stood on his knees at his dresser removing clothes and putting them back in his dresser drawers repeatedly. Facility staff #7, #8 and/or #9 did not redirect the client to participate in a more meaningful activity and/or training.</p> <p>During the 3/9/16 observation period between 5:45 AM and 8:20 AM at the</p>	W 0249	<p>Indiana Mentor has policies and procedures in place to active treatment. All staff are trained on active treatment and client specific goals prior to working in the programs. Management is retraining staff on active treatment both formal and informal. This will be completed by 4/20/2016. Management is doing 10 observations per month for the first 3 months and will include variety of shifts then at least 5x months afterwards to ensure active treatment has been maintained. Active treatment will be covered in the next 3 staff meetings then quarterly thereafter for next year. Responsible Party: QIDP, Area Director Complete Date: 4/20/2016</p>	04/20/2016

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	<p>group home, client D stayed in his bedroom except to eat his breakfast and to receive his morning medications. Client D laid on his bed and/or stood maneuvering his clothes in his dirty clothes basket. Facility staff #9, #10 and #11 did not redirect the client to participate in an alternate activity and/or training.</p> <p>The facility's reportable incident reports were reviewed on 3/8/16 at 12:20 PM. The facility's 2/4/16 reportable incident report for client D indicated "On 2/4/16 management was notified that the financial book for the 65th group home was missing. This included a combined total amount of \$66.56 of all consumers' petty cash. APS (Adult Protective Services) and local Police were notified and Indiana Mentor will replace all petty cash...."</p> <p>The facility's 2/5/16 Summary of Internal Investigation Report indicated D's funds, personal identification/information was taken along with the client's checkbook.</p> <p>Client D's record was reviewed on 3/10/16 at 9:50 AM. Client D's 4/16/15 ISP indicated client D had objectives to show staff how client D completed his daily chore, to make a purchase with staff, to carry his identification card on</p>			

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	<p>him daily, and an objective to complete some form of exercise daily which facility staff did not implement when formal and/or informal training opportunities existed.</p> <p>Client D's 11/18/15 Behavioral Support Plan (BSP) indicated client D had a targeted behavior of having an obsession with clothes/excessive use of the washing machine. Client D's BSP indicated facility staff were to offer the client choices throughout the day.</p> <p>Interview with staff #9 on 3/9/16 at 7:55 AM indicated client D had objectives to participate in activities with others, to place his wallet in his pocket and to fold clothes. Staff #9 indicated facility staff would have to bring client D out of his room to be around others. Staff #9 stated client D was "OCD (obsessive compulsive disorder) about laundry and clothes." Staff #9 indicated there was no petty cash in the home as the clients' money had been stolen. Staff #9 indicated the group home did not have any money/petty cash to implement the clients' money training objectives with.</p> <p>Interview with the Program Director (PD) and the Area Director (AD) on 3/10/16 at 1:19 PM indicated facility staff should implement the client's objectives as stated</p>			

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	<p>in the client's ISP. The AD stated clients should be "prompted every 15 minutes for active treatment and engagement."</p> <p>2. During the 3/9/16 observation period between 5:45 AM and 8:20 AM at the group home, client B laid on the couch in the living room curled up into a fetal position with her eyes closed except to get up and eat her breakfast meal and to receive her morning medication. Facility staff #9, #10 and #11 did not redirect the client to participate in an alternate activity and/or training.</p> <p>During the 3/8/16 observation period between 3:38 PM and 7:00 PM and the 3/9/16 observation period between 5:45 AM and 8:20 AM at the group home, client B was deaf (not able to hear) and non-verbal in communication in that the client could not speak. Facility staff (#7, #8, #9, #10 and #11) would stomp their feet on the floor when they wanted the client's attention. Facility staff would then gesture and/or make a sign to the client (eat and pills) when it was time for the client to eat and/or take her medications. Facility staff would grab an area of the staff's clothes to indicate client B would need to take off her coat and/or change. Facility staff did not encourage client B to sign and/or use any communication pictures/book to</p>			

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	<p>communicate with. During the above mentioned observation periods, client B wore a gait belt. Client B ambulated around the house independently. Facility staff did not consistently walk with client B when she stood and walked to a different area of the house. Also during the above mentioned observation periods, client B allowed surveyor to periodically sit on the couch where the client sat and/or laid. Client B did not demonstrate any aggression/targeted behaviors (aggression/self-injurious behavior). Facility staff did not praise and/or reward the client.</p> <p>The facility's reportable incident reports were reviewed on 3/8/16 at 12:20 PM. The facility's 2/4/16 reportable incident report for client B indicated "On 2/4/16 management was notified that the financial book for the 65th group home was missing. This included a combined total amount of \$66.56 of all consumers' petty cash. APS (Adult Protective Services) and local Police were notified and Indiana Mentor will replace all petty cash...."</p> <p>The facility's 2/5/16 Summary of Internal Investigation Report indicated B's funds, and personal identification/information was taken along with the client's checkbook.</p>			

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	<p>Client B's record was reviewed on 3/10/16 at 10:25 AM. Client B's 2/22/16 ISP indicated client B had the following objectives which facility staff did not implement when formal and/or informal training opportunities existed (not all inclusive):</p> <ul style="list-style-type: none"> - When staff show pictures and signs, client B will give staff the sign back to each picture shown. -Client B will exercise for 30 minutes. -To sort petty cash coins into denominations. <p>Client B's 2/11/16 Gait Belt Protocol indicated client B wore a gait belt due to the client's "cerebral palsy and unsteady gait." The risk plan indicated "Encourage and remind client that gait belt and assistance is needed. Always use gait belt when walking with, or transferring client...Always assist client when they are walking or transferring...."</p> <p>Client B's 5/20/15 BSP indicated "... [Client B] has difficulty appropriately engaging in activities with peers. Differential reinforcement for omission of behavior can be implemented to reduce target behaviors and reward for appropriate behavior during an activity. For instance, if [client B] is sitting on the</p>			

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	<p>couch and a peer attempts to sit on the couch next to her and she doesn't engage in target behaviors for a certain time frame, she should be rewarded...." Client B's BSP also indicated facility staff should utilize picture schedules to assist the client to make her wants and needs known which facility staff did not implement and/or utilize.</p> <p>Interview with staff #9 on 3/9/16 at 7:55 AM stated when facility staff "stomps their foot she knows stomp means get up and come." When asked what training client B received, staff #9 stated we use "word card with her. Sign language does not work." Staff #9 indicated there was no petty cash in the home as the clients' money had been stolen. Staff #9 indicated the group home did not have any money/petty cash to implement the clients' money training objectives with.</p> <p>Interview with the PD and the AD on 3/10/16 at 1:19 PM indicated facility staff should implement the client's objectives as stated in the client's ISP. The AD stated clients should be "prompted every 15 minutes for active treatment and engagement."</p> <p>3. During the 3/9/16 observation period between 5:45 AM and 8:20 AM at the group home, client C sat in the living</p>			

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	<p>room in her wheelchair watching TV, sat looking around and/or sat without an activity/training except to set the dining room table for breakfast. Facility staff #9, #10 and #11 did not offer the client an alternate activity/training.</p> <p>The facility's reportable incident reports were reviewed on 3/8/16 at 12:20 PM. The facility's 2/4/16 reportable incident report for client C indicated "On 2/4/16 management was notified that the financial book for the 65th group home was missing. This included a combined total amount of \$66.56 of all consumers' petty cash. APS (Adult Protective Services) and local Police were notified and Indiana Mentor will replace all petty cash...."</p> <p>The facility's 2/5/16 Summary of Internal Investigation Report indicated C's funds, and personal identification/information was taken along with the client's checkbook.</p> <p>Client C's record was reviewed on 3/10/16 at 11:40 AM. Client C's 7/13/15 ISP indicated client C had objectives to engage in some form of exercise with staff, to repeat what each picture is when shown pictures of objects/items, and an objective to give \$5.00 from her petty cash to take to the store to pick out an</p>			

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	<p>item she would like to purchase which facility staff did not implement when formal and/or informal training opportunities existed.</p> <p>Interview with staff #9 on 3/9/16 at 7:55 AM stated when facility staff "stomps their foot she knows stomp means get up and come." When asked what training client B received, staff #9 stated we use "word card with her. Sign language does not work." Staff #9 indicated there was no petty cash in the home as the clients' money had been stolen. Staff #9 indicated the group home did not have any money/petty cash to implement the clients' money training objectives with.</p> <p>Interview with the PD and the AD on 3/10/16 at 1:19 PM indicated facility staff should implement the client's objectives as stated in the client's ISP. The AD stated clients should be "prompted every 15 minutes for active treatment and engagement."</p> <p>4. The facility's reportable incident reports were reviewed on 3/8/16 at 12:20 PM. The facility's 2/4/16 reportable incident report for client A indicated "On 2/4/16 management was notified that the financial book for the 65th group home was missing. This included a combined total amount of \$66.56 of all consumers'</p>			

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W 0262 Bldg. 00	<p>petty cash. APS (Adult Protective Services) and local Police were notified and Indiana Mentor will replace all petty cash...."</p> <p>The facility's 2/5/16 Summary of Internal Investigation Report indicated A's funds, personal identification/information was taken along with the client's checkbook.</p> <p>Client A's record was reviewed on 3/10/16 at 12:29 PM. Client A's 4/16/15 ISP indicated client A had an objective to make a purchase for a meaningful item. Client A's 3/16 data collection sheet for the above mentioned objective indicated facility staff documented "N/A" (non-applicable).</p> <p>Interview with staff #9 on 3/9/16 at 7:55 AM indicated there was no petty cash in the home as the clients' money had been stolen. Staff #9 indicated the group home did not have any money/petty cash to implement the clients' money training objectives with.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other</p>			

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	<p>programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on interview and record review for 2 of 4 sampled clients (A and B) with restrictive programs, the facility failed to ensure its Human Rights Committee (HRC) periodically reviewed and/or approved the clients' restrictive programs.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client A's record was reviewed on 3/10/16 at 12:29 PM. Client A's 12/22/15 physician's orders and undated Annual HealthCare Assessment indicated client A received Seroquel XR 200 milligrams at bedtime for behavior, Lorazepam 0.5 milligrams at bedtime for Anxiety and Mirtazapine 15 milligrams at bedtime for sleep. <p>Client A's 4/7/15 Behavioral Support Plan (BSP) indicated client A demonstrated the behaviors of "resistance to Instruction," aggressive outbursts, and self-injurious behavior (SIB). Client A's BSP did not indicate the facility's HRC approved and/or periodically reviewed the client's restrictive behavior plan in the past year (3/15 to 3/16) as the client's BSP indicated client A did not have any restrictions, and did not receive any behavioral medications.</p>	W 0262	<p>Indiana Mentor has policies and procedures in place in regards to restrictions of client's rights and the use of a Human Rights Committee. Mentor had a Human Rights Committee meeting on 3/24/2016 to review all clients programming and medication. HRC members signed off on current programs and reviewed BSP plans to ensure they met clients needs. Area Director will train QIDP on HRC approval process by 4/20/2016. Mentor has scheduled on going HRC meetings on a quarterly basis and has established a system for approvals for events prior to the quarterly reviews. Responsible Party: QIDP, Area Director Complete Date: 4/20/2016</p>	04/20/2016

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	<p>Interview with the Program Director (PD), the Area Director (AD) and RN (Registered Nurse) #1 on 3/10/16 at 1:19 PM indicated client A was on behavioral controlling medication. The PD indicated she would check to see when client A's restrictive BSP was approved and/or reviewed. The PD did not provide any additional documentation.</p> <p>2. Client B's record was reviewed on 3/10/16 at 10:25 AM. Client B's 12/22/15 physician's orders and client B's 1/14/15 Annual Healthcare Assessment indicated client B received Fluvoxamine 100 milligrams 1 tablet in the morning and 2 tablets in the evening for the client's "OCD (Obsessive Compulsive Disorder) symptoms" and Lorazepam 1 milligram every night for anxiety.</p> <p>Client B's 5/20/15 BSP indicated client B did not receive any behavioral medications. Client B's BSP indicated client B demonstrated the targeted behaviors of physical aggression and self-injurious behavior. Client B's 5/20/15 BSP indicated facility staff could utilize "response blocking" when the client demonstrated SIB and/or physical aggression. Client B's BSP indicated "...If [client B] is in danger of harming herself, staff should immediately</p>			

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W 0263 Bldg. 00	<p>intervene by implementing response blocking techniques with either their limb or a soft object (i.e. pillow, blanket etc) that can block the SIB...." Client B's BSP indicated the facility's HRC had not reviewed and/or approved the client's restrictive program plan in the past year.</p> <p>Interview with the AD, the PD and RN #1 on 3/10/16 at 1:19 PM indicated client B received behavioral medications for her behavior. The PD indicated she would need to check to see when the facility's HRC reviewed and/or approved client B's restrictive BSP. The PD did not provide any additional documentation.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review for 2 of 4 sampled clients (A and D) with restrictive programs, the facility failed to obtain written informed consent from the clients' legal guardians regarding the clients' restrictive programs.</p> <p>Findings include:</p>	W 0263	Indiana Mentor has policies and procedures in place in regards to restrictions of client's rights and the use of a Human Rights Committee and guardian approval. Mentor had a Human Rights Committee meeting on 3/24/2016 to review all clients programming and medication. HRC members signed off on current programs and reviewed	04/20/2016

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	<p>1. Client A's record was reviewed on 3/10/16 at 12:29 PM. Client A's 12/22/15 physician's orders and undated Annual Healthcare Assessment indicated client A received Seroquel XR 200 milligrams at bedtime for behavior, Lorazepam 0.5 milligrams at bedtime for Anxiety and Mirtazapine 15 milligrams at bedtime for sleep.</p> <p>Client A's 4/16/5 Individual Support Plan (ISP) indicated client A had a legal guardian.</p> <p>Client A's 4/7/15 Behavioral Support Plan (BSP) indicated client A demonstrated the behaviors of "resistance to Instruction," aggressive outbursts, and self-injurious behavior (SIB). Client A's BSP and/or record indicated the facility did not obtain written informed consent from client A's guardian regarding the client's restrictive medications/BSP.</p> <p>Interview with the Program Director (PD), the Area Director (AD) and RN (Registered Nurse) #1 on 3/10/16 at 1:19 PM indicated client A was on behavioral controlling medication. The PD indicated client A had a legal guardian. The PD indicated she would check to see when client A's guardian gave written informed consent for the client's restrictive program. The PD did not</p>		<p>BSP plans to ensure they met clients needs. The QIDP is also contacting guardians to update approvals by 4/20/2016. Area Director will train QIDP on HRC and guardian approval process by 4/20/2016. Mentor has scheduled on going HRC meetings on a quarterly basis and has established a system for guardian and HRC approvals for events prior to the quarterly reviews. The Area Director will review restrictions toe nsure approval has been granted prior to implementation. Responsible Party: QIDP, Area Director Complete Date: 4/20/2016</p>	

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	<p>provide any additional documentation of the written informed consent.</p> <p>2. Client D's record was reviewed on 3/10/16 at 9:50 AM. Client D's 4/16/15 ISP indicated the client had a legal guardian.</p> <p>Client D's 3/1/16 physician's orders indicated client D received Seroquel, Clonazepam and Divalproex for behaviors.</p> <p>Client D's 11/18/15 BSP indicated client D demonstrated physical aggression, resistance to instructions, agitation, excessive use of washing machine and invading personal space. Client D's BSP indicated facility staff could utilize "response blocking" when the client demonstrated physical aggression and/or excessive use of the washing machine. Client B's 11/18/15 BSP indicated the client's guardian did not give written informed consent for the client's restrictive program.</p> <p>Interview with the PD, the AD and RN #1 on 3/10/16 at 1:19 PM indicated client D was on behavioral controlling medication. The PD indicated she would check to see when client D's guardian gave written informed consent for the client's restrictive program. The PD did</p>			

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W 0312 Bldg. 00	<p>not provide any additional documentation of the written informed consent.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 3 of 4 sampled clients (A, B and C) who used behavior controlling medications, the facility failed to ensure medications used to treat behaviors were incorporated into the clients' restrictive program plans with an active treatment program to address each behavior for which the medications were prescribed.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 3/10/16 at 12:29 PM. Client A's 12/22/15 physician's orders and undated Annual HealthCare Assessment indicated client A received Seroquel XR 200 milligrams at bedtime for behavior, Lorazepam 0.5 milligrams at bedtime for Anxiety and Mirtazapine 15 milligrams at bedtime for sleep.</p>	W 0312	<p>Indiana Mentor works with behavioral agencies to ensure targeted behaviors and drugs for these behaviors are listed in the individual's treatment plan. The IDT and HRC reviews these plans upon implementation and approves amendments to these plans The behavior medications have been added to the plans for clients A, B, and C and additionally all clients' plans were reviewed to ensure the medications matched the plans and approvals had been sought through HRC. On going the behavioralist is meeting with the QIDP at least monthly to review plans and update as needed. HRC has been set up and QIDP has been trained on approval process. Responsible Party: QIDP, Area Director Complete Date: 4/20/2016</p>	04/20/2016

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	<p>Client A's 4/7/15 Behavioral Support Plan (BSP) indicated client A did not receive any behavioral medications. Client A's BSP also indicated the client did not have an active treatment program to address the client's sleeplessness at night. Client A's record and/or 4/7/15 BSP did not track client A's sleep at night to determine if the client's Mirtazapine was needed/effective. Client A's 4/7/15 BSP addressed the targeted behaviors of resistance to instructions, aggressive outbursts and self-injurious behavior. The behavioral medications were not addressed in programming which included withdrawal criteria.</p> <p>Interview with the Program Director (PD), the Area Director (AD) and RN (Registered Nurse) #1 on 3/10/16 at 1:19 PM indicated client A was on behavioral controlling medication. RN #1 and the AD indicated the client's behavioral medications would need to be added to the client's BSP.</p> <p>2. Client B's record was reviewed on 3/10/16 at 10:25 AM. Client B's 12/22/15 physician's orders and client B's 1/14/15 Annual HealthCare Assessment indicated client B received Fluvoxamine 100 milligrams 1 tablet in the morning and 2 tablets in the evening for the client's "OCD (Obsessive Compulsive</p>			

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	<p>Disorder) symptoms" and Lorazepam 1 milligram every night for anxiety.</p> <p>Client B's 5/20/15 BSP indicated client B did not receive any behavioral medications. Client B's BSP indicated client B demonstrated the targeted behaviors of physical aggression and self-injurious behavior. Client B's 5/20/15 BSP did not specifically define and/or indicate if client B had an active treatment program for the client's OCD/symptoms. Client B's BSP did not include a withdrawal criteria for the medication.</p> <p>Interview with the AD, the PD and RN #1 on 3/10/16 at 1:19 PM indicated client B received behavioral medications for her behavior. The AD indicated client B's medications should be a part of the client's BSP. The AD and the PD indicated the facility's behavioral consultant would need to revise and update client B's to address the client's behavioral medications and/or behaviors.</p> <p>3. Client C's record was reviewed on 3/10/16 at 11:40 AM. Client C's 12/22/15 physician's orders and/or 2/9/16 Annual HealthCare Assessment indicated client C received Sertraline 50 milligrams every morning for Depression and Quetiapine (Seroquel) 200 milligrams</p>			

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	<p>and Quetiapine 50 milligrams two times a day for the client's Psychosis. Client C's healthcare assessment indicated client C's diagnosis included, but was not limited to, Schizophrenia.</p> <p>Client C's November 2015 BSP indicated client C demonstrated verbal aggression, physical aggression, and resistance to instructions. Client C's November 2015 BSP did not indicate client C had an active treatment program which addressed the client's Depression and/or included the client's Sertraline in the client's BSP as the client's BSP only indicated client C received Quetiapine for her behaviors/Psychosis. Client C's BSP did not include a withdrawal criteria for the client's medication for Depression.</p> <p>Interview with the AD, the PD and RN #1 on 3/10/16 at 1:19 PM indicated client C received medications for her Psychosis and Depression. The AD indicated client C's Sertraline should be a part of the client's BSP. The AD and the PD indicated the facility's behavioral consultant would need to revise and update client B's to address the client's behavioral medication of Sertraline/Depression.</p> <p>9-3-5(a)</p>			

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W 0331 Bldg. 00	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 3 of 4 sampled clients (A, B and C), the facility's nursing services failed to monitor the clients' health in regard to updating a risk plan in regard to a client's edema and to ensure seizure records were available for staff to document clients' seizures.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 3/10/16 at 12:29 PM. Client A's undated Annual HealthCare Assessment indicated client A's diagnosis included, but was not limited to, Seizure Disorder.</p> <p>Client A's 12/22/15 physician's orders and the client's undated Annual HealthCare Assessment indicated client A received Levetiracetam 500 milligrams three tablets two times a day, Divalproex 125 milligrams two times a day and Topiramate two times a day for seizures.</p> <p>Client A's Appointment List indicated on 9/8/15, client A saw his Neurologist. The appointment list indicated "occasional seizures stable. F/U (follow-up) 3 months." Client A's appointment list</p>	W 0331	<p>Indiana Mentor has policies and procedures in regards to the health and safety of the clients. The agency employs an agency nurse who develops risk plans and protocols for individuals in care and monitors their health and well being. Mentors nurse has updates clients A,b, and C plans to cover the seizures records not being available and the edema risk plan. Additionally the agency nurse will review remaining risk plans for remaining individuals. Nurse and QIDP and meeting at least monthly to review client's plans. Nurse is filling out a monthly report that will be available to the director of nursing as well as QIDP. Random book audits including the nursing files will be conducted by agency to ensure completion. Responsible Party: QIDP, Area Director Complete Date: 4/20/2016</p>	04/20/2016

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
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	<p>indicated client A saw the neurologist on 2/2/16. The appointment list indicated labs were ordered and no medication changes were made. The appointment list indicated client A was to return to the Neurologist in 1 year.</p> <p>Client A's 4/16/15 Individual Support Plan indicated client A had a risk plan for seizures. Client A's 4/16/15 Seizure Protocol indicated facility staff were to document the client's seizures on a Seizure Description Record. Client A's chart/record did not indicate the client had a seizure record for 2015/2016 as there was no documentation found in regard to how many seizures client A had in the past year (3/15 to 3/16).</p> <p>Client B's record was reviewed on 3/10/16 at 10:25 AM. Client B's 12/22/15 physician's orders and/or 1/14/15 Annual Health Care Assessment indicated client B received Zonisamide 100 milligrams three times a day, Levetiracetam 750 milligrams 2 tablets by mouth every 12 hours and oxcarbazepine 600 milligrams 2 tablets two times a day for seizures. Client B's 1/14/15 Annual HealthCare Assessment indicated client B's diagnosis included, but was not limited to, Epilepsy.</p> <p>Client B's 2/22/16 Individual Support</p>			

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	<p>plan (ISP) indicated client B saw her Neurologist quarterly.</p> <p>Client B's February 2016 HealthCare Coordination/Monthly Health Review indicated on "2/4/16 Received report from staff that [client B] had a seizure at day service. It lasted 1 minute...." The February monthly note indicated client B also had "several seizures" on 2/11/16 where the client had "whole body jerking" from 2 minutes to 30 seconds. The 2/11/16 note indicated client B had a total of 11 seizures in 15 minutes.</p> <p>Client B's 2/16/16 Seizure Protocol indicated when client B had a seizure facility staff were to document the seizure in the "Daily Notes," an incident report and on a Seizure Description Record. Client B's chart/record did not indicate the client had a seizure record for 2015/2016 as there was no documentation found in regard to how many seizures client B had in the past year (3/15 to 3/16).</p> <p>Interview with RN (Registered Nurse) #1 indicated clients A and B demonstrated Seizures/Epilepsy. RN #1 indicated the facility staff were to document the clients' seizures on a seizure record kept at the group home. RN #1 indicated the facility would document on the seizure record for</p>			

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	<p>the year and then it would be filed into the clients' records at the end of the year. RN #1 indicated she would scan the seizure records. RN #1 did not provide and/or send any additional documentation facility staff were documenting client A and B's seizures when they occurred.</p> <p>2. During the 3/8/16 observation period between 3:38 PM and 7:00 PM and the 3/9/16 observation period between 5:45 AM and 8:20 AM at the group home, client C sat in a wheelchair for the entire above mentioned observation periods. Client C wore bilateral leg braces, compression stockings and had edema in both lower legs/feet. Client C's wheelchair did not have footrests. During both observation periods, facility staff did not encourage client C to elevate her feet.</p> <p>Client C's record was reviewed on 3/10/16 at 11:40 AM. Client C's 2/9/16 Annual HealthCare Assessment indicated client C's diagnosis included, but was not limited to, Pedal Edema. Client C's assessment also indicated client C had a history of blood clots.</p> <p>Client C's 3/6/16 Edema To Lower Legs And Feet Protocol indicated "...Elevate feet and legs when swollen...." Client C's 3/6/16 protocol was not specific in</p>			

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W 0426 Bldg. 00	<p>when/how facility staff should elevate the client's legs/feet when sitting in a wheelchair.</p> <p>Interview with RN #1 on 3/10/16 at 1:19 PM stated client C had "pitting edema." RN #1 indicated client C's legs/feet would swell even with elevating the client's feet/legs. RN #1 indicated client C's feet/legs should be elevated per the client's edema protocol. RN #1 stated client C's protocol "needs to be more specific."</p> <p>9-3-6(a)</p> <p>483.470(d)(3) CLIENT BATHROOMS</p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and H), the facility failed to ensure its water temperature did not exceed 110 degrees Fahrenheit when clients were not able to independently mix/regulate their own water temperatures.</p> <p>Findings include:</p>	W 0426	Indiana mentor has policies and procedures in place in regards to the safety and well being of individuals in service. Staff are trained on these policies and procedures upon hire and annually thereafter. Mentor contacted the maintenance to adjust the water temperature back below the 110 mark. Mentor also purchased new testing thermometers to test the water. Mentor staff will be trained in	04/20/2016

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	<p>During the 3/9/16 observation period between 5:45 AM and 8:20 AM at the group home, the water temperatures measured the following:</p> <p>-At 7:30 AM in the small bathroom at the sink, 120.9 degrees Fahrenheit. -At 7:32 AM at the kitchen sink 118.2 degrees Fahrenheit.</p> <p>Client D's record was reviewed on 3/10/16 at 9:50 AM. Client D's 4/16/15 Individual Support Plan (ISP) indicated client D's diagnoses included, but were not limited to, Glaucoma and Legal Blindness. Client D's 4/16/15 ISP indicated "...Assessment of ability to mix water safely: relies on staff..."</p> <p>Client B's record was reviewed on 3/10/16 at 10:25 AM. Client B's 2/22/16 ISP indicated "...Assessment of ability to mix water safely: relies on staff..."</p> <p>Client C's record was reviewed on 3/10/16 at 11:40 AM. Client C's 2/9/16 Annual Health Care Assessment indicated client C's diagnoses included, but were not limited to, Mild Intellectual Disability, Left Hemiplegia, Optic Atrophy and Macular Degeneration.</p> <p>Client C's 7/13/15 Risk Management</p>		<p>water regulation testing by 4/20/2016 and procedures on what to do if temperature exceeds 110. Mentor will do weekly water tests that will be turned into the program coordinator, who will turn it into the QIDP. Management will do independent water tests as well at least twice a month as well to verify the temps while doing checks. Responsible Party: QIDP, Area Director Complete Date: 4/20/2016</p>	

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	<p>Assessment Plan indicated client C was able to independently mix/adjust her own water temperature.</p> <p>Client A's record was reviewed on 3/10/16 at 12:29 PM. Client A's 7/13/15 Risk Management Assessment Plan indicated client A was able to mix/adjust his own water temperature.</p> <p>Client A's 1/25/15 Hot Water Temperature Control assessment indicated client A was not able to turn water on to cold, turn water onto hot and/or to adjust water to warm temperature.</p> <p>Interview with staff #10 on 3/9/16 at 7:32 AM indicated client D was the only client who was able to adjust the water temperature safely.</p> <p>Interview with the Program Director (PD), the Area Director (AD) and Registered Nurse (RN) #1 on 3/10/16 at 1:19 PM indicated client B was able to adjust her own water temperature. The RN indicated clients C and D would also be able to adjust their own water temperatures, but could not due to the clients' physical limitations and/or blindness. RN #1 and the AD indicated clients A, B, C, D, E, F and H would require staff assistance to adjust/regulate</p>			

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W 0436 Bldg. 00	<p>their water temperatures. The AD indicated the water temperatures should not exceed 110 degrees.</p> <p>9-3-7(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, interview and record review for 1 of 2 sampled clients (C) with adaptive equipment, the facility failed to obtain the recommended updates for the client's wheelchair.</p> <p>Findings include:</p> <p>During the 3/8/16 observation period between 3:38 PM and 7:00 PM and the 3/9/16 observation period between 5:45 AM and 8:20 AM at the group home, client C sat in a wheelchair for the entire above mentioned observation periods. Client C's wheelchair did not have footrests and/or a lap tray. Client C maneuvered her wheelchair with her feet.</p> <p>Client C's record was reviewed on 3/10/16 at 11:40 AM. Client C's 4/28/15</p>	W 0436	<p>Indiana Mentor has policies and procedures in regards to the health and safety of the clients. The agency employs an agency nurse who develops risk plans and protocols for individuals in care and monitors their health and well being. Agency nurse and QIDP work together to ensure recommendations are followed up on and equipment is in good repair. For client C a wheelchair company was called and came and completed an assessment on her wheelchair needs and did a follow up visit to the house for her needs. Mentor has contacted the PCP to get proper paperwork filled out for the replacement and needed repairs. Mentor QIPD and nurse will check adaptive equipment for remaining clients by 4/20/2016 and address any additional needs. Nurse and QIDP and meeting at least</p>	04/20/2016

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	<p>Physical Therapy (PT) Evaluation indicated client C was seen by PT for a wheelchair evaluation. The PT assessment indicated "I (client C) want to get a new w/c (wheelchair)." The PT assessment/evaluation indicated "...Unsafe ambulation. Decreased standing balance. Decreased cognition. Impaired functional mobility. Pt (patient) will benefit from a new w/c (hemichair). Since she is modified (sic) independent in w/c locomotion. At times might need stand by assist due to visual deficits. The one-handed drive will be appropriate so patient can propel w/c with one arm and leg to increase functional independence with mobility. She will benefit from a lap tray for her L UE (Left Upper Extremity) due to non function and to prevent deformity and to keep the L UE abducted. She will benefit from elevated leg/foot rest. This is due to B LE (Bilateral Lower Extremity) edema noted and requiring elevation. Armrest: Swing away-removable arms appropriate to increase ease and safety during transfers. Pt will benefit from a Jay cushion in order to optimize distribution and avoid skin breakdown...."</p> <p>Interview with the Program Director (PD), Area Director (AD) and the Registered Nurse (RN) #1 on 3/10/16 at 1:19 PM indicated client C had a new</p>		<p>monthly to review client's plans. Nurse is filling out a monthly report that will be available to the director of nursing as well as QIDP. Random book audits including the nursing files will be conducted by agency to ensure completion. QIDP and nurse will complete a monthly review of adaptive equipment to ensure needs are met and recommendations are followed. Responsible Party: QIDP, Area Director Complete Date: 4/20/2016</p>	

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W 0440 Bldg. 00	<p>wheelchair but she still needed to get the modifications as recommended by the PT wheelchair evaluation. RN #1 and the AD indicated client C did not have the recommended foot rests, lap tray, cushion and/or swing away arm rests. The AD indicated the facility was waiting on the client's insurance.</p> <p>9-3-7(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 interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), the facility failed to conduct quarterly evacuation drills on the evening shift for the third quarter (September, October and November 2015) and for the night shift of the fourth quarter (December 2015, January and February 2016).</p> <p>Findings include:</p> <p>The facility's fire drills were reviewed on 3/9/16 at 7:50 AM. The facility's fire drills indicated the facility did not conduct fire drills for clients A, B, C, D, E, F, G and H on the evening shift for the third quarter of September, October and November 2015 and on the night shift for</p>	W 0440	<p>Indiana mentor has policies and procedures in place in regards to the safety and well being of individuals. This includes the running of monthly safety drills to ensure clients can safely react in cases of emergencies. The staff and management have been retrained on the running of safety drills. The management and staff have also given a copy of Mentors drill schedule and schedule has been posted in home. Upon completion of monthly drills then drills are being sen tto QA and being tracked by the QIDP. Responsible Party:QIDP, Area Director Complete Date: 4/20/2016</p>	04/20/2016

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	<p>the fourth quarter of December 2015, January and February 2016.</p> <p>Interview with the Program Director (PD) and the Area Director (AD) on 3/10/16 at 1:19 PM indicated they would have to check to see if there were any additional fire drills for the group home. The PD and the AD did not provide any additional fire drills.</p> <p>9-3-7(a)</p>				