

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G471	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3031 E KESSLER INDIANAPOLIS, IN 46220		
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: December 2, 3, 4, and 5, 2013</p> <p>Surveyor: Tim Shebel, LSW</p> <p>Facility number: 000985 Provider number: 15G471 AIM number: 100244650</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed December 06, 2013 by Dotty Walton, QIDP.</p>	W000000			

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

TITLE

(X6) DATE

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

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W000104	<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 record review and interview, the facility's governing body failed to develop and implement a policy and procedure which indicated staff were to immediately report injuries of unknown injury to the administrator for 3 of 3 sampled clients (clients #1, #2, and #3, and 3 additional (clients #4, #5, and #6).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 12/2/13 at 10:47 A.M. The following incident of an injury of unknown origin was reviewed:</p> <p>- "Name: [Client #2], Incident Date: 11/2/2013, Date of Knowledge: 11/04/2013 Narrative: On 11/2/13, staff noticed a small mark on [client #2's] chin. When examining further, staff notice (sic) [client #2's] bottom lip was puffy, and his front tooth was chipped. Staff is unclear what caused [client #2's] injuries. Staff applied first aid, and HM (house manager) made an appointment to (sic) [client #2's] dentist {first available} to fix the chipped tooth. Plan to Resolve: A full investigation is being conducted by the program director to determine what</p>	W000104	<p>Indiana MENTOR's Quality Assurance team is reviewing the current policy and procedure and will create an update in which to specifically include the direct support professional role when reporting an incident. All Direct Support Professionals at the group home will be retrained on incident reporting. This retraining will include the updated policy and procedure and the BDDS reporting requirements. Indiana MENTOR's Basic Orientation training class that all staff must attend upon hire specifically trains all Direct Support Professionals on incident reporting at length. All current staff are required to attend Annual Recertification each year to review the standard guidelines, which specifically include incident reporting.</p> <p>Ongoing, Indiana MENTOR will continue to train all staff on incident reporting. This training will occur at the hire date, ongoing annually for the duration of the employment, and then more as needed throughout the year. Responsible Party: Quality Assurance Team, Home Manager and/or Program Director</p>	01/04/2014	

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	<p>caused this incident. To monitor the health and safety of [client #2] at all times."</p> <p>The facility's records were further reviewed on 12/2/13 at 11:07 A.M. A review of the investigation of the aforementioned 11/2/13 injury of unknown origin to client #2 indicated direct care staff who noticed the injury did not report it to the administrator until 11/4/13.</p> <p>Area Director #1 was interviewed on 12/3/13 at 12:23 P.M. Area Director #1 stated, "Staff were late in reporting the injury. Individual staff at the group home did not immediately notify me (of the 11/2/13 injury of unknown origin to client #2) because they thought another staff had already reported it. They are to report such injuries immediately."</p> <p>The facility's records were further reviewed on 12/3/13 at 1:58 P.M. Review of the facility's "Quality and Risk Management policy (Abuse/Neglect Policy)," dated 4/11, failed to indicate staff were to immediately report injuries of unknown origin to the administrator. This policy affected clients #1, #2, #3, #4, #5, and #6.</p> <p>Area Director #1 was interviewed on</p>						

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	<p>12/3/13 at 12:49 P.M. Area Director #1 reviewed the facility's "Quality and Risk Management policy (Abuse/Neglect Policy)", dated 4/11, and stated, "It doesn't indicate in here (within the policy) that staff are to immediately report injuries of unknown origin to the administrator. We train staff to report those injuries immediately in our training program. Quality Assurance (facility's quality assurance department) will need to look at the policy and see if that (staff reporting injuries of unknown origin immediately to the administrator) needs to be included."</p> <p>9-3-1(a)</p>			

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W000114	<p>483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.</p> <p>Based on record review and interview, the facility failed to assure the Comprehensive Functional Assessments for 2 of 3 sampled clients (clients #2 and #3) included the date the assessments were completed.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 12/3/13 at 10:28 A.M. A review of client #2's Camelot (brand name) Behavioral Checklist (Comprehensive Functional Assessment) failed to indicate the assessment was dated by the person completing the assessment.</p> <p>Client #3's record was reviewed on 12/3/13 at 11:33 A.M. A review of client #3's Camelot Behavioral Checklist (Comprehensive Functional Assessment) failed to indicate the assessment was dated by the person completing the assessment.</p> <p>Area Director #1 was interviewed on 12/3/13 at 12:23 P.M. Area Director #1 stated, "The Camelot Behavioral Checklist is our Comprehensive Functional Assessment. The Program</p>	W000114	<p>The Program Director and Home Manager will work to complete CFAs for client's 1, 2, 3, 4, 5, 6, 7, and 8. The Program Director and Home Manager will be retrained on completing CFAs for all clients. This training will include the importance of these CFA's, the reason for them, how to complete them, and when to complete them. Ongoing, the Area Director will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter.</p> <p>Responsible Party: Home Manager, Program Director, Area Director</p>	01/04/2014	

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	Director should have dated the assessments when they were completed." 9-3-1(a)				

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W000137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation and interview, the facility failed to assure direct care staff assisted or prompted 2 of 3 sampled clients (clients #1 and #2) to change their torn shirts.</p> <p>Findings include:</p> <p>Clients #1 and #2 were observed at the group home during the 12/2/13 observation period from 2:49 P.M. until 5:17 P.M. During the observation period, client #1 wore a tee shirt which had a 6" (inches) by 4" hole torn in the chest area of the shirt. Client #2 wore a tee shirt which had a 3 inch area torn at the collar. Direct care staff #1, #2, #3, and #4 did not assist or prompt clients #1 and #2 to put on shirts which were not torn.</p> <p>Area Director #1 was interviewed on 12/3/13 at 12:23 P.M. Area Director #1 stated, "Staff (direct care staff #1, #2, #3, and #4) should have made sure [clients #1 and #2] wore shirts which were not torn.</p> <p>9-3-2(a)</p>	W000137	The Home Manager and/or Program Director will retrain the direct care staff on client dignity, specifically physical appearance. This training will include ensuring that clients are not wearing old and torn clothing and that it is weather appropriate as well. The Home Manager and/or Program Director will go through each client's closets with the teams' approvals, and eliminate any inappropriate or old clothing. All clients will continue to purchase new clothing as needed to ensure that dignity is respected and that all clothing is appropriate. Ongoing, all Direct Care staff will ensure that clients are wearing appropriate clothing at all times. The Direct Care Staff will inform the Home Manager and Program Director when new clothing is needed for each of the clients. Responsible Party: Direct Support Professional, Home Manager and Program Director.	01/04/2014			

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed to implement their abuse/neglect policy to have evidence the administrator (area director) was notified of the findings of 1 of 1 reviewed investigation of an injury of unknown origin involving 1 of 3 sampled clients (client #2).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 12/2/13 at 10:47 A.M.. The following incident of an injury of unknown origin was reviewed:</p> <p>- "Name: [Client #2], Incident Date: 11/2/2013, Date of Knowledge: 11/04/2013 Narrative: On 11/2/13, staff noticed a small mark on [client #2's] chin. When examining further, staff notice (sic) [client #2's] bottom lip was puffy, and his front tooth was chipped. Staff is unclear what caused [client #2's] injuries. Staff applied first aid, and HM (house manager) made an appointment to (sic) [client #2's] dentist {first available} to fix the chipped tooth. Plan to Resolve: A full investigation is being conducted by the program director to determine what</p>	W000149	<p>The Program Director will be retrained on Indiana MENTOR's investigation policy and procedures. The Quality Assurance staff and/or Area Director will pair up with the Program Director to assist with the next three investigations to ensure that training completed is efficient and effective. All incomplete investigations are monitored by the QA staff to satisfy completion within the 5 day timeframe. Ongoing, the Program Director will complete all future investigations within the 5 day regulated timeframe. All investigations will continue to be reviewed and monitored by the Area Director and/or QA staff for accuracy and completion. Responsible Party: Program Director, Area Director, and QA staff.</p>	01/04/2014	

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	<p>caused this incident. To monitor the health and safety of [client #2] at all times."</p> <p>The facility's records were further reviewed on 12/2/13 at 11:07 A.M. A review of the investigation of the aforementioned 11/2/13 injury of unknown origin to client #2 indicated the administrator was notified of the investigative findings on 11/14/13.</p> <p>Area Director #1 was interviewed on 12/3/13 at 12:23 P.M. Area Director #1 stated, "I was notified of the findings of the investigation before November 14th (2013). We (Program Director #1 and Area Director #1) go back and forth over the telephone about such things." When asked if there was evidence she was notified prior to 11/14/13 of the investigative findings from the 11/2/13 injury of unknown origin to client #2, Area Director #1 stated, "No."</p> <p>The facility's records were further reviewed on 12/3/13 at 1:58 P.M. Review of the facility's "Quality and Risk Management policy (Abuse/Neglect Policy)", dated 4/11, indicated, in part, the following: "Investigative findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days</p>						

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, the facility failed to assure staff immediately notified the administrator (area director) of an injury of unknown origin involving 1 of 3 sampled clients (client #2).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 12/2/13 at 10:47 A.M. The following incident of an injury of unknown origin was reviewed:</p> <p>- "Name: [Client #2], Incident Date: 11/2/2013, Date of Knowledge: 11/04/2013 Narrative: On 11/2/13, staff noticed a small mark on [client #2's] chin. When examining further, staff notice (sic) [client #2's] bottom lip was puffy, and his front tooth was chipped. Staff is unclear what caused [client #2's] injuries. Staff applied first aid, and HM (house manager) made an appointment to (sic) [client #2's] dentist {first available} to fix the chipped tooth. Plan to Resolve: A full investigation is being conducted by the program director to determine what</p>	W000153	All staff will be retrained on Indiana MENTOR's policy and procedure for reporting unknown injuries. The Program Director will be retrained on Indiana MENTOR's investigation policy and procedures. All unknown injuries will be investigated by the Program Director to attempt to find a cause. Ongoing, the Home Manager and/or Program Director will complete random observations three times per week for the first four weeks, and then once a week on going. Ongoing, the Home Manager and/or Program Director will complete documentation reviews 3 times a week on Monday, Wednesday, and Friday, for the first 4 weeks. After the four initial weeks, the documentation reviews will continue at no less than twice a week. Responsible Party: Home Manager and Program Director and Area Director.	01/04/2014			

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	<p>caused this incident. To monitor the health and safety of [client #2] at all times."</p> <p>The facility's records were further reviewed on 12/2/13 at 11:07 A.M. A review of the investigation of the aforementioned 11/2/13 injury of unknown origin to client #2 indicated direct care staff who noticed the injury did not report it to the administrator until 11/4/13.</p> <p>Area Director #1 was interviewed on 12/3/13 at 12:23 P.M. Area Director #1 stated, "Staff were late in reporting the injury. Individual staff at the group home did not immediately notify me (of the 11/2/13 injury of unknown origin to client #2) because they thought another staff had already reported it. They are to report such injuries immediately."</p> <p>9-3-2(a)</p>						

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W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview, the facility failed to have evidence the administrator (area director) was notified of the findings of 1 of 1 reviewed investigation of an injury of unknown origin involving 1 of 3 sampled clients (client #2).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 12/2/13 at 10:47 A.M.. The following incident of an injury of unknown origin was reviewed:</p> <p>- "Name: [Client #2], Incident Date: 11/2/2013, Date of Knowledge: 11/04/2013 Narrative: On 11/2/13, staff noticed a small mark on [client #2's] chin. When examining further, staff notice (sic) [client #2's] bottom lip was puffy, and his front tooth was chipped. Staff is unclear what caused [client #2's] injuries. Staff applied first aid, and HM (house manager) made an appointment to (sic) [client #2's] dentist {first available} to fix the chipped tooth. Plan to Resolve: A full investigation is being conducted by</p>	W000156	All staff will be retrained on Indiana MENTOR's policy and procedure for reporting unknown injuries. The Program Director will be retrained on Indiana MENTOR's investigation policy and procedures. All unknown injuries will be investigated by the Program Director to attempt to find a cause. Ongoing, the Home Manager and/or Program Director will complete random observations three times per week for the first four weeks, and then once a week on going. Ongoing, the Home Manager and/or Program Director will complete documentation reviews 3 times a week on Monday, Wednesday, and Friday, for the first 4 weeks. After the four initial weeks, the documentation reviews will continue at no less than twice a week. Responsible Party: Home Manager and Program Director and Area Director.	01/04/2014	

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	<p>the program director to determine what caused this incident. To monitor the health and safety of [client #2] at all times."</p> <p>The facility's records were further reviewed on 12/2/13 at 11:07 A.M. A review of the investigation of the aforementioned 11/2/13 injury of unknown origin to client #2 indicated the administrator was notified of the investigative findings on 11/14/13.</p> <p>Area Director #1 was interviewed on 12/3/13 at 12:23 P.M. Area Director #1 stated, "I was notified of the findings of the investigation before November 14th (2013). We (Program Director #1 and Area Director #1) go back and forth over the telephone about such things." When asked if there was evidence she was notified prior to 11/14/13 of the investigative findings from the 11/2/13 injury of unknown origin to client #2, Area Director #1 stated, "No."</p> <p>9-3-2(a)</p>				

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3031 E KESSLER INDIANAPOLIS, IN 46220
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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview, the facility failed to assure 1 of 3 sampled clients (client #1) had a Dynavox Maestro (brand name) Communication Device as recommended by assessment.</p> <p>Findings include:</p> <p>Client #1 was observed at the group home on 12/2/13 from 2:49 P.M. until 5:17 P.M. and on 12/3/13 from 4:54 A.M. until 6:27 A.M. Client #1 was noted to be non-verbal and staff periodically prompted him to use sign language to communicate his wants and needs. When prompted, client #1 would sign for staff after several verbal requests. Client #1 did not use a Dynavox Maestro communication device or any other type of electronic communication device. Direct care staff #1, #2, #3, #4, and #5 did not prompt the client to use a Dynavox Maestro communication device or any other type of electronic communication device.</p> <p>Client #1's record was reviewed on 12/3/13 at 9:17 A.M. A review of a 6/9/11 Augmentative Communication Evaluation recommended the client use a "Dynavox Maestro" communication device.</p> <p>Area Director #1 was interviewed on 12/3/13 at 12:23 P.M. Area Director #1 stated, "This is an oversight. There was a different Area Director and Program Director working with [client #1] when this assessment (6/9/11 Augmentative</p>	W000227	The Area Director will retrain the Program Director on ensuring that recommendations made by a medical professional, etc, are followed up on and put into place as made. The Program Director will work with the team to get an evaluation completed to get a new order for the electronic speaking device. If the recommendations are still the same, the Program Director will work to put the electronic device in place. Ongoing, the Area Director and/or Clinical Supervisor will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area Director and/or Clinical Supervisor will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director and/or Clinical Supervisor will audit 1 book a quarter. Responsible Party: Direct Support Professional, Home Manager and Program Director.	01/04/2014
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	Communication Evaluation) was completed." 9-3-4(a)				

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W000259	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview, the facility failed to ensure the Comprehensive Functional Assessment for 1 of 3 clients (client #1) was reviewed at least annually.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 12/3/13 at 9:17 A.M. The review indicated the client's most current Camelot Behavioral Checklist (Comprehensive Functional Assessment) was dated 8/21/10.</p> <p>Area Director #1 was interviewed on 12/3/13 at 12:23 P.M. Area Director #1 stated, "The Camelot Behavioral Checklist is our Comprehensive Functional Assessment. [Client #1's] assessment (Comprehensive Functional Assessment) should be completed every year. This must be an oversight."</p> <p>9-3-4(a)</p>	W000259	<p>The Program Director and Home Manager will work to complete CFAs for client's 1, 2, 3, 4, 5, 6, 7, and 8. The Program Director and Home Manager will be retrained on completing CFAs for all clients. This training will include the importance of these CFA's, the reason for them, how to complete them, and when to complete them. Ongoing, the Area Director will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter. Responsible Party: Home Manager, Program Director, Area Director</p>	01/04/2014	

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W000268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, the facility failed to assure 1 of 3 sampled clients (client #2's) hair was neat and combed.</p> <p>Findings include:</p> <p>Client #2 was observed at the group home during the 12/2/13 observation period from 2:49 P.M. until 5:17 P.M. During the observation period, client #2's hair was disheveled and needed combing. Direct care staff #1, #2, #3, and #4 did not prompt or assist client #2 to comb his hair.</p> <p>Area Director #1 was interviewed on 12/3/13 at 12:23 P.M. Area Director #1 stated, "Staff (direct care staff #1, #2, #3, and #4) should have prompted or assisted [client #2] to comb his hair to have a nice appearance."</p> <p>9-3-5(a)</p>	W000268	The Home Manager and/or Program Director will retrain the direct care staff on client dignity, specifically physical appearance. This training will include ensuring that clients' appearances are appropriate with grooming. The Home Manager will continue to take each client for a routine haircut as needed and agreed upon with the teams. Ongoing, all Direct Care staff will ensure that clients are appropriately groomed at all times. The Direct Care Staff will continue to inform the Home Manager and Program Director when haircuts are needed intermittently. Responsible Party: Direct Support Professional, Home Manager and Program Director.	01/04/2014	

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W000336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview, the facility failed to assure quarterly nursing exams were conducted at least quarterly (every three months) for 3 of 3 sampled clients (clients #1, #2, and #3.)</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 12/3/13 at 9:17 A.M. A review of the client's quarterly nursing assessments from 12/2/12 to 12/3/13 indicated quarterly nursing assessments were completed on 12/5/12, 3/6/13, 6/4/13, and 11/30/13 and his annual physical was completed on 11/1/13. The review failed to indicate the client's quarterly nursing assessments were completed at least quarterly (every three months.)</p> <p>Client #2's records were reviewed on 12/3/13 at 10:28 A.M. A review of the client's quarterly nursing assessments from 12/2/12 to 12/3/13 indicated quarterly nursing assessments were completed on 12/6/12, 3/6/13, 6/4/13, and 11/30/13 and his annual physical was completed on 11/1/13. The review failed</p>	W000336	The Program Nurse will be retrained on Indiana MENTOR's policy and procedure regarding the Quarterly Nursing Assessments. This training will include, but is not limited to, completing, tracking, implementing, and following up on the results of the assessments. The Program Nurse states that all Quarterly Nursing Assessments for September 2013 were completed, however, not filed. The Program Nurse will file all past paperwork. The Program Nurse will be retrained on Indiana MENTOR's policy on documentation. This training will include, but is not limited to, completing the nursing documentation per the Program Nurse job responsibilities, but also filing the paperwork in the appropriate place according to the Medical Files Table of Contents. The Program Nurse will complete the Quarterly Nursing Assessments for December 2013 for clients 1, 2, 3, 4, 5, 6, 7, and 8. The Program Nurse will ensure that all documentation to support these completed assessments is in the file on or before the 10th of the	01/04/2014			

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	<p>to indicate the client's quarterly nursing assessments were completed at least quarterly (every three months.)</p> <p>Client #3's records were reviewed on 12/3/13 at 11:33 A.M. A review of the client's quarterly nursing assessments from 12/2/12 to 12/3/13 indicated quarterly nursing assessment were completed on 12/5/12, 3/6/13, 6/3/13, and 11/30/13 and his annual physical was completed on 10/28/13. The review failed to indicate the client's quarterly nursing assessments were completed at least quarterly (every three months.)</p> <p>Area Director was e-mailed on 12/4/13 at 5:25 A.M. and asked if the facility had any additional nursing quarterlies for clients #1, #2, and #3. Area Director #1 responded on 12/4/13 at 9:53 A.M. Area Director #1 had stated in her e-mail, "No, I am sorry. I don't believe we do (have any additional nursing quarterlies)."</p> <p>9-3-6(a)</p>		<p>following month. The Area Director and/or Clinical Supervisor will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter. Responsible Party: Program Nurse, Area Director, and/or Clinical Supervisor</p>		

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W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills on the overnight shift for staff (10:00 P.M. to 7:00 A.M.) during the fourth quarter of 2012(October 1st through December 31st), the first quarter of 2013 (January 1st through March 31st), during the second quarter of 2013 (April 1st through June 30th), during the third quarter of 2013 (July 1st through September 30th), and the evening shift for staff (2:00 P.M. to 10:00 P.M.) during the fourth quarter of 2012 and second quarter of 2013 which affected 3 of 3 sampled clients (clients #1, #2, and #3) and 3 additional clients living in the facility (clients #4, #5, and #6.)</p> <p>Findings include:</p> <p>The facility's records were reviewed on 12/2/13 at 10:55 A.M. The review failed to indicate the facility held an evacuation drill for clients #1, #2, #3, #4, #5, and #6 on the overnight shift for staff during the fourth quarter of 2012, the first quarter of 2013, the second quarter of 2013, and the third quarter of 2013. The review also indicated the facility failed to hold evacuation drills for clients #1, #2, #3, #4, #5, and #6 on the evening shift for staff</p>	W000440	The Direct Support Staff will be retrained on Indiana MENTOR's policy and Procedures for completing the monthly fire drills. The Home Manager and/or Program Director will work together to ensure that all staff have access to Indiana MENTOR's schedule for all expected fire drill dates and times. The Home Manager and/or Program Director will review all completed fire drills to ensure that they are completed correctly, at the right time, on the right day, and within the right timeframe, among other things. Responsible Party: Home Manager and/or Program Director	01/04/2014			

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	<p>during the fourth quarter of 2012 and the second quarter of 2013.</p> <p>Program Director #1 was interviewed on 12/3/13 at 12:11 P.M. Program Director #1 stated the facility was "missing some (evacuation) drills."</p> <p>9-3-7(a)</p>			