

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G438	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2013
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7555 GRANDVIEW DR INDIANAPOLIS, IN 46260
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W000000	<p>This visit was for investigation of complaint #IN00132371. This visit resulted in an Immediate Jeopardy.</p> <p>Complaint #IN00132371: Substantiated. Federal and state deficiencies related to the allegation are cited at W102, W104, W122, W149, W154, W157, W249, W252, W318 and W331.</p> <p>Dates of Survey: July 24, 25, 26, 29 and 30, 2013.</p> <p>Facility Number: 000952 Provider Number: 15G438 AIMS Number: 100244640</p> <p>Surveyor: Claudia Ramirez, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/5/13 by Ruth Shackelford, QIDP.</p>	W000000		

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

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

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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client A), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to exercise operating direction over the facility to ensure the facility implemented their policy and procedures to prevent neglect of client A and to ensure the timely health needs of client A were met.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The governing body failed, for 1 of 3 sampled clients (client A), to implement the facility's policy and procedure to prevent neglect by failing to ensure the facility met the needs of client A, and ensured a client's health needs were not neglected. Please see W104. The governing body failed to exercise general policy and operating direction over the facility in regards to meeting the Condition of Participation: Client Protections. The governing body neglected to implement their neglect policy and neglected to provide timely health care, for 1 of 3 sampled clients 	W000102	<p>1. All Direct Support staff, Home Manager and Program Director received retraining on exactly what PICA is, causes and symptoms of PICA and ways to prevent PICA by the Behavior Specialist. All Direct Care Staff were given a post-test to evaluate their knowledge of PICA.</p> <p>Client A's Behavior Support Plan was updated to include the increase in supervision levels and environmental checks. In addition, a separate behavior tracking sheet was developed for Client A to complete a structured ABC (antecedent-behavior-consequence) analysis of all of his targeted behaviors including his PICA. (see attachment) Staff received retraining on the updated behavior plan, updated behavior tracking sheet and the need to document on a narrative note any instances of PICA behaviors.</p> <p>Home Manager, Program Director, Area Director and any other staff assisting with Administrative Observations will review behavior tracking data and narrative notes to ensure that all are being completed as needed.</p> <p>Ongoing, after the initial 4 weeks</p>	08/29/2013	

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	<p>(client A). Please see W122.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility in regards to meeting the Condition of Participation, Health Care Services. The governing body failed to provide adequate health care monitoring and timely medical services for 1 of 3 sampled clients (client A). Please see W318.</p> <p>This federal tag relates to complaint #IN00132371.</p> <p>9-3-1(a)</p>		<p>of observations, the Home Manager and/or Program Director will complete observations a minimum of twice weekly to ensure implementation of plan is as prescribed and will review behavior tracking data and narrative notes to ensure that all are being completed as needed. In addition, the Behavior Consultant will review the behavior tracking data and narrative notes to ensure that all are being completed as needed a minimum of monthly when they are in the homes to collect data.</p> <p>2. The Program Director will receive retraining on investigation requirements to include what requires an investigation, what documents should be reviewed, who should be interviewed, when the investigation is to be completed, as well as how to write the report of findings. As soon as the retraining has been completed the Area Director and/or the Quality Assurance Specialist will complete a daily follow-up regarding any outstanding investigations to be completed by this Program Director. The Area Director will take corrective action if needed when investigation requirements have not been met. In addition the Area Director and/or the Quality Assurance Specialist will review all investigations completed by this Program Director and make</p>		

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			<p>recommendations as appropriate.</p> <p>3. Client A's supervision protocol was revised on 7/25/13. This protocol includes 1:1 staffing for Client A during waking hours and 15 minute visual check during the overnight hours and when Client A is napping. In addition, staff that are responsible for the 1:1 staffing are assigned by the Home Manager as noted on the "ER 1:1 assigned staff sheet" (see attachment). Staff have been trained that they are not to change who is assigned the 1:1 unless approved by the Home Manager. Staff that are providing the 1:1 staffing will have no other responsibilities other than to attend to Client A. Staff are to also complete an environmental checklist to scan for objects that Client A could possibly ingest. (see attachment) Staff are scanning the van prior to Client A getting on the van and checking Client A's pockets as well. When Client A is moving from room to room, staff will scan the room to check for objects that Client A could possibly ingest</p> <p>All Direct Care Staff were trained on this updated protocol prior to beginning their next shift of working with Client A. In addition, the Home Manager, On Call Supervisors, Program Director and any other staff that may assist with Administrative Observations were also trained on this updated protocol.</p>		

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			<p>Observations for the implementation of Client A's supervision protocol as prescribed by Indiana Mentor Administrative staff will occur as follows: 5 days per week on week 1; 4 days per week on week 2; 3 days per week on week 3; 2 days per week on week 4 until 1 day observation is reached. Assessment by the Area Director will occur at the end of each week to determine if further observation is needed. Notes from Administrative Observations will be recorded on the 1:1 Protocol Observation report. (see attachment) The Area Director will review the Observation reports at least weekly to determine if any further issues need to be addressed.</p> <p>Ongoing, after these 4 weeks of observations, the Home Manager and/or Program Director will complete observations a minimum of twice weekly to ensure implementation of plan is as prescribed.</p> <p>The Facility Nurse has updated the PICA protocol for Client A to specify that the Facility Nurse (or On Call Nurse) is to be called any time Client A eats anything non-edible. The Facility Nurse (or On Call Nurse) will make the determination if Client A needs to be evaluated at the Emergency Room based on what he ate and</p>	

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			<p>how much he ingested.</p> <p>All Direct Support staff, Home Manager and Program Director have been retrained on the need to ensure that if they are directed to take a consumer to the Emergency Room for evaluation, they do it as immediately as possible and not wait for the group home van to be available, even if this means using their personal vehicles. If a vehicle is not immediately available they will contact the Home Manager to make alternative arrangements. Ongoing, the Home Manager and Program Director will ensure that staff are taking consumers to the ER as immediately as possible after they have been directed to do so. The Home Manager or on call supervisor will continue to contact staff at 10 minute intervals until the consumer is able to be transported to the Emergency Room.</p> <p>Responsible Staff: Facility Nurse, Home Manager, Program Director, Area Director.</p> <p>The Facility Nurse has updated the PICA protocol for Client A to specify that the Facility Nurse (or On Call Nurse) is to be called any time Client A eats anything non-edible. The Facility Nurse (or On Call Nurse) will make the determination if Client A needs to be evaluated at the Emergency Room based on what he ate and how much he ingested.</p> <p>All Direct Support staff, Home Manager and Program Director</p>		

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			<p>have been retrained on the need to ensure that if they are directed to take a consumer to the Emergency Room for evaluation, they do it as immediately as possible and not wait for the group home van to be available, even if this means using their personal vehicles. If a vehicle is not immediately available they will contact the Home Manager to make alternative arrangements. Ongoing, the Home Manager and Program Director will ensure that staff are taking consumers to the ER as immediately as possible after they have been directed to do so. The Home Manager or On call supervisor will continue to contact staff at 10 minute intervals until the consumer is able to be transported to the Emergency Room. Responsible Staff: Facility Nurse, Home Manager, Program Director, Area Director</p>	

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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview, the governing body failed to exercise general policy and operating direction over the facility to ensure adequate supervision for 1 of 3 sampled clients (client A) was provided to prevent him from ingesting foreign bodies and to ensure timely medical services were received according to his medical needs.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Please see W149. The governing body failed to implement the facility's written policy and procedure to prevent neglect by failing to protect client A from ingesting foreign bodies. The governing body neglected to ensure client A's safety and to provide adequate supervision to prevent him from ingesting foreign bodies. Please see W331. The governing body failed to ensure nursing services met the needs of the client for 1 of 3 sampled clients (client A) by not ensuring the client received timely medical services after ingesting a foreign body. 	W000104	<p>1. All Direct Support staff, Home Manager and Program Director received retraining on exactly what PICA is, causes and symptoms of PICA and ways to prevent PICA by the Behavior Specialist. All Direct Care Staff were given a post-test to evaluate their knowledge of PICA.</p> <p>Client A's Behavior Support Plan was updated to include the increase in supervision levels and environmental checks. In addition, a separate behavior tracking sheet was developed for Client A to complete a structured ABC (antecedent-behavior-consequence) analysis of all of his targeted behaviors including his PICA. (see attachment) Staff received retraining on the updated behavior plan, updated behavior tracking sheet and the need to document on a narrative note any instances of PICA behaviors.</p> <p>Home Manager, Program Director, Area Director and any other staff assisting with Administrative Observations will review behavior tracking data and narrative notes to ensure that all are being completed as needed.</p> <p>Ongoing, after the initial 4 weeks</p>	08/29/2013			

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			<p>recommendations as appropriate.</p> <p>3. Client A's supervision protocol was revised on 7/25/13. This protocol includes 1:1 staffing for Client A during waking hours and 15 minute visual check during the overnight hours and when Client A is napping. In addition, staff that are responsible for the 1:1 staffing are assigned by the Home Manager as noted on the "ER 1:1 assigned staff sheet" (see attachment). Staff have been trained that they are not to change who is assigned the 1:1 unless approved by the Home Manager. Staff that are providing the 1:1 staffing will have no other responsibilities other than to attend to Client A. Staff are to also complete an environmental checklist to scan for objects that Client A could possibly ingest. (see attachment) Staff are scanning the van prior to Client A getting on the van and checking Client A's pockets as well. When Client A is moving from room to room, staff will scan the room to check for objects that Client A could possibly ingest</p> <p>All Direct Care Staff were trained on this updated protocol prior to beginning their next shift of working with Client A. In addition, the Home Manager, On Call Supervisors, Program Director and any other staff that may assist with Administrative Observations were also trained on this updated protocol.</p>		

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			<p>how much he ingested.</p> <p>All Direct Support staff, Home Manager and Program Director have been retrained on the need to ensure that if they are directed to take a consumer to the Emergency Room for evaluation, they do it as immediately as possible and not wait for the group home van to be available, even if this means using their personal vehicles. If a vehicle is not immediately available they will contact the Home Manager to make alternative arrangements. Ongoing, the Home Manager and Program Director will ensure that staff are taking consumers to the ER as immediately as possible after they have been directed to do so. The Home Manager or on call supervisor will continue to contact staff at 10 minute intervals until the consumer is able to be transported to the Emergency Room.</p> <p>Responsible Staff: Facility Nurse, Home Manager, Program Director, Area Director.</p> <p>The Facility Nurse has updated the PICA protocol for Client A to specify that the Facility Nurse (or On Call Nurse) is to be called any time Client A eats anything non-edible. The Facility Nurse (or On Call Nurse) will make the determination if Client A needs to be evaluated at the Emergency Room based on what he ate and how much he ingested.</p> <p>All Direct Support staff, Home Manager and Program Director</p>		

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 of 3 sampled clients (client A). The facility failed to implement its written policies and procedures to prevent neglect by failing to protect client A from ingesting foreign bodies. The facility neglected to ensure client A's safety and to provide adequate supervision to prevent him from ingesting foreign bodies which required examination in the Emergency Room (ER). This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 07/25/13 at 3:10 PM. The Area Director (AD) was notified of the Immediate Jeopardy on 07/25/13 at 3:10 PM. The Immediate Jeopardy began on 07/04/13.</p> <p>On 07/26/13, the Area Director (AD) submitted a plan to remove the Immediate Jeopardy. The Plan indicated, "The following actions and protective measures are in place or are in process to abate the immediate jeopardy in regards to client protections for [client A].</p> <p>Program Director will be retrained on review of QDDP (Qualified</p>	W000122	<p>1. All Direct Support staff, Home Manager and Program Director received retraining on exactly what PICA is, causes and symptoms of PICA and ways to prevent PICA by the Behavior Specialist. All Direct Care Staff were given a post-test to evaluate their knowledge of PICA.</p> <p>Client A's Behavior Support Plan was updated to include the increase in supervision levels and environmental checks. In addition, a separate behavior tracking sheet was developed for Client A to complete a structured ABC (antecedent-behavior-consequence) analysis of all of his targeted behaviors including his PICA. (see attachment) Staff received retraining on the updated behavior plan, updated behavior tracking sheet and the need to document on a narrative note any instances of PICA behaviors.</p> <p>Home Manager, Program Director, Area Director and any other staff assisting with Administrative Observations will review behavior tracking data and narrative notes to ensure that all are being completed as needed.</p> <p>Ongoing, after the initial 4 weeks of observations, the Home</p>	08/29/2013			

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	<p>Developmental Disability Professional) responsibilities related to recognizing behavioral and medical patterns and ensuring effective corrective action is taken to prevent future occurrences.</p> <p>1:1 (one staff to one client) protocol and environmental checklist were immediately implemented on 07/25/13 for client (client A) protection. An IDT (Inter-disciplinary Team) meeting will convene by Aug[ust] 1 to review 1:1 protocol to determine if any revisions are needed. IDT will review and update Behavior Development Plan (BDP), develop alternative activities and alternative plans for behavior prevention.</p> <p>Environmental assessments will be completed by the 1:1 staffing with the home environment as well as on the van prior to transport to watch for and remove small objects within reach. Day Program will be included in IDT to evaluate current environment and assess whether the supervision protocol can be implemented as required.</p> <p>Each staff responsible for the implementation of the 1:1 protocol will be trained prior to assuming that responsibility.</p> <p>Staff will be retrained on BDP, alternative</p>		<p>Manager and/or Program Director will complete observations a minimum of twice weekly to ensure implementation of plan is as prescribed and will review behavior tracking data and narrative notes to ensure that all are being completed as needed. In addition, the Behavior Consultant will review the behavior tracking data and narrative notes to ensure that all are being completed as needed a minimum of monthly when they are in the homes to collect data.</p> <p>2. The Program Director will receive retraining on investigation requirements to include what requires an investigation, what documents should be reviewed, who should be interviewed, when the investigation is to be completed, as well as how to write the report of findings. As soon as the retraining has been completed the Area Director and/or the Quality Assurance Specialist will complete a daily follow-up regarding any outstanding investigations to be completed by this Program Director.</p> <p>The Area Director will take corrective action if needed when investigation requirements have not been met. In addition the Area Director and/or the Quality Assurance Specialist will review all investigations completed by this Program Director and make recommendations as appropriate.</p>	

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	<p>activities and protective measures that may be determined during IDT meeting.</p> <p>Observations for the implementation of plan as prescribed by Indiana Mentor Administrative staff will occur as follows: 5 days per week on week 1; 4 days a week on week 2; 3 days per week on week 3; 2 days per week on week 4; until we have reached 1 day observation. Assessment by the Area Director will occur at the end of each week to determine if further observation needs (sic).</p> <p>Home Manager and Program Director will complete observations 3 times per week to observe implementation of plan as prescribed above for 30 days. Ongoing, Home Manager and Program (sic) will complete observations once weekly.</p> <p>Area Director will review monthly all BDDS reports and complete analysis and make recommendations for trends/patterns or repeated incidents...."</p> <p>Observations were conducted in the group home on 07/29/13 from 11:11 AM until 12:15 PM. Client A had 1:1 staff. Client A was not observed to place any foreign bodies in his mouth during the observation time. Training scheduled in the home indicated all staff had been</p>		<p>3. Client A's supervision protocol was revised on 7/25/13. This protocol includes 1:1 staffing for Client A during waking hours and 15 minute visual check during the overnight hours and when Client A is napping. In addition, staff that are responsible for the 1:1 staffing are assigned by the Home Manager as noted on the "ER 1:1 assigned staff sheet" (see attachment). Staff have been trained that they are not to change who is assigned the 1:1 unless approved by the Home Manager. Staff that are providing the 1:1 staffing will have no other responsibilities other than to attend to Client A. Staff are to also complete an environmental checklist to scan for objects that Client A could possibly ingest. (see attachment) Staff are scanning the van prior to Client A getting on the van and checking Client A's pockets as well. When Client A is moving from room to room, staff will scan the room to check for objects that Client A could possibly ingest</p> <p>All Direct Care Staff were trained on this updated protocol prior to beginning their next shift of working with Client A. In addition, the Home Manager, On Call Supervisors, Program Director and any other staff that may assist with Administrative Observations were also trained on this updated protocol.</p>		

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	<p>trained on the 1:1 with client A prior to their working with him. Interviews conducted in the group home on 07/29/13 at 11:30 AM with staff #1, #8 and #9 indicated they had been trained on the 1:1 staffing with client A.</p> <p>The Immediate Jeopardy was removed on 07/29/13 at 12:45 PM, when through observation, interview and record reviews, it was determined the facility had implemented the plan of action to remove the Immediate Jeopardy and the steps taken removed the immediacy of the problem. Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at a Condition level (Client Protections) since the facility needed to continue to monitor the environment to evaluate the effectiveness of the plan.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to implement the facility's written policy and procedure to prevent neglect by failing to protect client A from ingesting foreign bodies. The facility neglected to ensure client A's safety and to provide adequate supervision to prevent him from ingesting foreign bodies which required examination x-rays. Please see W149. 		<p>Observations for the implementation of Client A's supervision protocol as prescribed by Indiana Mentor Administrative staff will occur as follows: 5 days per week on week 1; 4 days per week on week 2; 3 days per week on week 3; 2 days per week on week 4 until 1 day observation is reached. Assessment by the Area Director will occur at the end of each week to determine if further observation is needed. Notes from Administrative Observations will be recorded on the 1:1 Protocol Observation report. (see attachment) The Area Director will review the Observation reports at least weekly to determine if any further issues need to be addressed.</p> <p>Ongoing, after these 4 weeks of observations, the Home Manager and/or Program Director will complete observations a minimum of twice weekly to ensure implementation of plan is as prescribed.</p> <p>Responsible Staff: Home Manager, Program Director, Area Director, Quality Assurance Specialist, Behavior Consultant</p>				

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	<p>2. The facility failed for 26 of 26 allegations of abuse, neglect and/or injuries of unknown source reviewed, to conduct an investigation and/or conduct thorough investigations in regard to client neglect and injury of unknown sources, by failing to supervise client A to prevent him from ingesting foreign bodies and by failing to conduct a thorough investigation regarding client C's bruise of unknown origin. Please see W154.</p> <p>3. The facility failed for 25 of 26 allegations of abuse, neglect and/or injuries of unknown source reviewed, to initiate and document effective corrective action to prevent client neglect, by failing to supervise client (client A) to prevent him from ingesting foreign bodies. Please see W157.</p> <p>This federal tag relates to complaint #IN00132371.</p> <p>9-3-2(a)</p>				

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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.</p> <p>Based on observations, record review and interview for 2 of 3 BDDS (Bureau of Developmental Disabilities Services) reports, the facility neglected to implement the facility's policy and procedure prohibiting client neglect by neglecting to provide adequate supervision for 1 of 3 sampled clients (client A) who ingested foreign bodies and failed to investigate an injury of unknown source for client C.</p> <p>Findings include:</p> <p>1. Observations were conducted in the group home on 07/24/13 from 4:35 PM until 5:45 PM and staff #1, #2, #3 and #4 were on duty. During the entire observation client A was observed to walk around the house without constant staff supervision. He freely walked from the living room down the hallway and to his bedroom without staff accompanying him or following him. Staff failed to keep client A in a line of sight at all times.</p> <p>Observations were conducted in the group home on 07/25/13 from 4:45 PM until</p>	W000149	<p>1. All Direct Support staff, Home Manager and Program Director received retraining on exactly what PICA is, causes and symptoms of PICA and ways to prevent PICA by the Behavior Specialist. All Direct Care Staff were given a post-test to evaluate their knowledge of PICA.</p> <p>Client A's Behavior Support Plan was updated to include the increase in supervision levels and environmental checks. In addition, a separate behavior tracking sheet was developed for Client A to complete a structured ABC (antecedent-behavior-consequence) analysis of all of his targeted behaviors including his PICA. (see attachment) Staff received retraining on the updated behavior plan, updated behavior tracking sheet and the need to document on a narrative note any instances of PICA behaviors.</p> <p>Home Manager, Program Director, Area Director and any other staff assisting with Administrative Observations will review behavior tracking data and narrative notes to ensure that all are being completed as needed.</p> <p>Ongoing, after the initial 4 weeks</p>	08/29/2013	

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	<p>5:45 PM and staff #1, #5 and #6 were on duty. During the observation staff #5 followed client A around the house periodically. At 5:02 PM staff #5 turned her back to client A three times as she obtained items and attended to client D. At 5:07 PM client A walked down the hall and into his bedroom without staff and sat on his bed.</p> <p>An interview was conducted with staff #5 on 07/25/13 at 5:33 PM. Staff #5 indicated no one was assigned to client A. She indicated staff were assigned for client showers for that night.</p> <p>Observations were conducted in the group home on 07/25/13 from 10:30 AM until 11:45 AM and staff #1, #7 and #8 were on duty. At 10:42 AM, 10:44 AM and 10:49 AM staff #1 was observed to walk away from client A with her back turned to him. Client A was not in her line of sight. At 10:56 AM staff #1 indicated staff #7 was to monitor client A. During the observation time from 10:56 AM until 11:45 AM staff #7 turned her back and walked away from client A a total of 13 times. During the observation time staff #7 folded the laundry. Staff #7 failed to keep client A in her line of sight at all times.</p> <p>On 07/24/13 at 2:10 PM the facility's BDDS Reports, investigations and</p>		<p>of observations, the Home Manager and/or Program Director will complete observations a minimum of twice weekly to ensure implementation of plan is as prescribed and will review behavior tracking data and narrative notes to ensure that all are being completed as needed. In addition, the Behavior Consultant will review the behavior tracking data and narrative notes to ensure that all are being completed as needed a minimum of monthly when they are in the homes to collect data.</p> <p>2. The Program Director will receive retraining on investigation requirements to include what requires an investigation, what documents should be reviewed, who should be interviewed, when the investigation is to be completed, as well as how to write the report of findings. As soon as the retraining has been completed the Area Director and/or the Quality Assurance Specialist will complete a daily follow-up regarding any outstanding investigations to be completed by this Program Director.</p> <p>The Area Director will take corrective action if needed when investigation requirements have not been met. In addition the Area Director and/or the Quality Assurance Specialist will review all investigations completed by</p>		

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	<p>internal incident/accident reports were reviewed from 05/01/13 through 07/24/13 and indicated the following:</p> <p>1. A BDDS report submitted 07/05/13 for an incident dated 07/04/13 at 4:24 PM indicated, "[Client A] swallowed a paper clip. Nurse was notified and instructed staff to take [client A] to the ER (Emergency Room) [name]. Doctor found 6 paper pins and what looked like a key ring. [Client A] was sent home and Miralax (laxative) was increased to twice a day and [client A] will have a follow-up x-ray next week. [Client A] returned home and resumed his normal routine. Pica (eating non-food materials) is listed in [client A's] risk plan. Continue to monitor health and safety."</p> <p>Client A's records were reviewed on 07/25/13 at 10:25 AM. Client A's record contained the following dated documents:</p> <p>11/27/12: ISP (Individual Support Plan). The ISP indicated client A's diagnoses included but were not limited to: Severe Mental Retardation, Autism, Pica and Constipation.</p> <p>02/05/13: Inservice prior to Client A's move into the group home re: PICA.</p> <p>05/08/13: Admission to group home from</p>		<p>this Program Director and make recommendations as appropriate.</p> <p>3. Client A's supervision protocol was revised on 7/25/13. This protocol includes 1:1 staffing for Client A during waking hours and 15 minute visual check during the overnight hours and when Client A is napping. In addition, staff that are responsible for the 1:1 staffing are assigned by the Home Manager as noted on the "ER 1:1 assigned staff sheet" (see attachment). Staff have been trained that they are not to change who is assigned the 1:1 unless approved by the Home Manager. Staff that are providing the 1:1 staffing will have no other responsibilities other than to attend to Client A. Staff are to also complete an environmental checklist to scan for objects that Client A could possibly ingest. (see attachment) Staff are scanning the van prior to Client A getting on the van and checking Client A's pockets as well. When Client A is moving from room to room, staff will scan the room to check for objects that Client A could possibly ingest</p> <p>All Direct Care Staff were trained on this updated protocol prior to beginning their next shift of working with Client A. In addition, the Home Manager, On Call Supervisors, Program Director and any other staff that may assist with Administrative Observations were also trained</p>		

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	<p>another [same agency] group home.</p> <p>05/2013: BSP (Behavior Support Plan) indicated client A's behaviors include PICA and staff are to monitor the environment for any objects that he could ingest.</p> <p>06/2013: Behavior Data Records indicated PICA behavior occurred on the following dates and times in June 2013: 06/03/13 at 7:00 AM; 06/03/13 at 5:00 PM; 06/08/13 at 11:00 AM; 06/09/13 at 1:00 PM; 06/10/13 at 5:00 PM; 06/10/13 at 6:00 PM; 06/12/13 at 4:00 PM; 06/12/13 at 5:00 PM; 06/13/13 at 4:00 PM; 06/16/13 at 6:00 PM; 06/18/13 at 6:00 PM; 06/19/13 at 5:00 PM; 06/20/13 at 4:00 PM and 06/30/13 at 5:00 PM for a total of 14 occurrences in June. The data records did not indicate what he ingested.</p> <p>07/2013: Behavior Data Records indicated PICA behavior occurred on the following dates and times in July 2013: 07/02/13 at 8:00 AM; 07/03/13 at 6:00 PM; 07/04/13 at 3:30 PM (incident resulting in ER visit); 07/08/13 at 5:00 PM; 07/08/13 at 6:00 PM; 07/12/13 at 6:00 PM; 07/11/13 at 5:00 PM; 07/15/13 at 4:30 PM; 07/18/13 at 5:00 PM and 07/24/13 between 5:30 and 6:00 PM for a total of 10 occurrences in July to date. The data records did not indicate what he</p>		<p>on this updated protocol.</p> <p>Observations for the implementation of Client A's supervision protocol as prescribed by Indiana Mentor Administrative staff will occur as follows: 5 days per week on week 1; 4 days per week on week 2; 3 days per week on week 3; 2 days per week on week 4 until 1 day observation is reached. Assessment by the Area Director will occur at the end of each week to determine if further observation is needed. Notes from Administrative Observations will be recorded on the 1:1 Protocol Observation report. (see attachment) The Area Director will review the Observation reports at least weekly to determine if any further issues need to be addressed.</p> <p>Ongoing, after these 4 weeks of observations, the Home Manager and/or Program Director will complete observations a minimum of twice weekly to ensure implementation of plan is as prescribed.</p> <p>Responsible Staff: Home Manager, Program Director, Area Director, Quality Assurance Specialist, Behavior Consultant</p>	

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	<p>ingested.</p> <p>An interview was conducted with the House Manager on 07/25/13 at 1:30 PM. She indicated the "paper pin" client A ingested was a paper clip. She indicated the staff are to document on the data sheet if the behavior occurred by placing a "M" in the date and time column and they are to do a narrative note to describe the incident. The only narrative note on any of the June or July 2013 PICA incidents was on 07/04/13 when client A went to the ER. The HM was asked what kind of things client A has ingested in the past two months and she indicated small items like things on the ground, twigs, pen tops and paper. She indicated she did not know why the narrative notes were not completed. She also indicated there was not a specific staff assigned to him while he was awake; it was whoever was closest to follow him and keep him in sight.</p> <p>07/02/13: Group Home Inservice on various topics which included client A's "pica increase."</p> <p>07/04/13: Daily support record indicated client A was taken to ER after he swallowed a "paper pin" that was laying on the kitchen counter in the group home. "Called on call person and on call person called the nurse and the PD (Program</p>						

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	<p>Director). The on call person said he needs to go to there ER. So the van wasn't here, it had gone with another client. As soon as they came, [client A] was showered and brushed his teeth and changed clothes, he had two glasses of water then he had 100% of his food and he went to the ER with another staff."</p> <p>07/04/13: BPR (Behavior Problem Record) indicated, "[Client A] was sitting on couch and he wanted some juice...when he went to put the glass in the sink he picked up the paper pin which was lying on the kitchen counter on some papers clipped and he put it in his mouth. 2 of us staff tried to take it out of his mouth I felt (sic) my fingers but he had already swallowed it. Tried my best to open his mouth but he had already swallowed it. Then made him go to his room and relax in his bed and he lay down. Kept checking on him but he was ok till call came to take him to the ER."</p> <p>07/04/13: ER record indicated client A's arrival time in the ER was 6:34 PM. ER records indicated the discharge diagnosis was, "Multiple foreign bodies in GI (gastrointestinal) tract. Pica."</p> <p>07/12/13: Supervision Protocol for client A indicated: "This protocol will be effective 7/12/13 and remains in place</p>						

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	until changed by his Interdisciplinary Team. Staff will be scheduled during waking hours to ensure that a staff can provide line of sight supervision if needed. Line of sight supervision will begin when [client A] wakes up in the morning and remain in effect until he retires for the evening. Line of sight supervision will be defined as staff being in the same room with [client A] in eye sight. Staff may be engaged in other activities such as documentation, playing a game, washing dishes, etc as long as they can abandon those activities to immediately respond to [client A] if needed. Staff should check [client A's] pockets before he gets on the van and remove any no (sic) food items that he may ingest. When [client A] moves from one place to another, staff needs to accompany him and keep an eye out for any small non-edible objects on the floor, in the room etc. and remove them so he will not ingest them. When [client A] needs to use the restroom, staff will accompany him to the room and look through the room and on the floor to see if there are any non-edible objects that he may ingest. Staff will remain in the bathroom with him with the door closed for privacy or will remain in the doorway with the door cracked for privacy so that they are able to immediately intervene if [client A] tries to eat a non-edible object.			

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	<p>Staff are to complete the environmental checklist throughout the day to scan for any inedible objects that [client A] could possibly ingest. Staff should scan the van for any debris prior to [client A] getting on the van. Staff should check [client A's] pockets prior to him getting on the van. Overnight staff should check his lunch bag and backpack for any small, inedible objects he could ingest. Morning staff should check the kitchen, living room, bathroom, etc. prior to waking [client A] up."</p> <p>07/17/13: Follow-up physician examination indicated, "Normal exam. Continue to observe carefully."</p> <p>2. A BDDS report submitted 07/01/13 for an incident dated 06/30/13 at 8:06 AM indicated, "[Client C] has two bruises on the left side of his back near his spinal cord. The bruises are red and bigger than a quarter. Active Day and overnight staff did not see the bruise but evening staff saw it when giving [client C] a shower. Nurse was notified. Continue to monitor [client C] for health and safety." There was no investigation available for review of this incident.</p> <p>On 07/24/13 at 2:11 PM, a review of the facility's 04/2011 Policy of Quality and Risk Management indicated, "Indiana</p>				

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	<p>MENTOR promotes a high quality of service and seeks to protect individuals receiving Indian MENTOR services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluation and reducing risk to which individuals are exposed. Indiana MENTOR follows the BDDS Incident Reporting policy as outlined in the Provider Standards. An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS: 1. Alleged, suspected, or actual abuse, neglect, or exploitation of an individual...iii. Cause the individual to experience emotional distress...e. Failure to provide appropriate supervision, care or training...Indiana MENTOR is committed to ensuring the individuals we serve are provided with a safe and quality living environment...."</p> <p>On 07/25/13 at 12:30 PM an interview was conducted with the AD (Area Director). The AD indicated the staff failed to follow the policy/procedure on abuse/neglect. She indicated client A had a known history of Pica behavior and should not have gotten and consumed any of the metal objects he did. She indicated the staff had been trained on the 07/12/13 Supervision Protocol for client A. She</p>						

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	<p>indicated the protocol failed to specifically indicate which staff were to monitor him and she further indicated the staff could not be engaged in other activities if client A was to be in their line of sight supervision. She indicated the supervision plan was not adequate if he continued to have documented incidents of pica which occurred after the 07/12/13 protocol. The AD further indicated the agency failed to follow the policy, failed to investigate the incidents and provide sufficient effective corrective action for client A's pica or client C's injury of unknown origin.</p> <p>This federal tag relates to complaint #IN00132371.</p> <p>9-3-2(a)</p>				

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 3 BDDS (Bureau of Developmental Disabilities Services) reports regarding allegations of abuse, neglect and/or injuries of unknown source reviewed and 23 additional Behavior Data Records, the facility failed to conduct an investigation and/or conduct thorough investigations in regard to client neglect and injury of unknown source for clients A and C.</p> <p>Findings include:</p> <p>On 07/24/13 at 2:10 PM the facility's BDDS Reports, investigations and internal incident/accident reports were reviewed from 05/01/13 through 07/24/13 and indicated the following:</p> <p>1. A BDDS report submitted 07/05/13 for an incident dated 07/04/13 at 4:24 PM indicated, "[Client A] swallowed a paper clip. Nurse was notified and instructed staff to take [client A] to the ER (Emergency Room) [name]. Doctor found 6 paper pins and what looked like a key ring. [Client A] was sent home and Miralax (laxative) was increased to twice a day and [client A] will have a follow-up</p>	W000154	<p>The Program Director will receive retraining on investigation requirements to include what requires an investigation, what documents should be reviewed, who should be interviewed, when the investigation is to be completed, as well as how to write the report of findings. As soon as the retraining has been completed the Area Director and/or the Quality Assurance Specialist will complete a daily follow-up regarding any outstanding investigations to be completed by this Program Director.</p> <p>The Area Director will take corrective action if needed when investigation requirements have not been met. In addition the Area Director and/or the Quality Assurance Specialist will review all investigations completed by this Program Director and make recommendations as appropriate.</p> <p>Responsible Staff: Program Director, Area Director, Quality Assurance Specialist</p>	08/29/2013	

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	<p>x-ray next week. [Client A] returned home and resumed his normal routine. Pica (eating non-food materials) is listed in [client A's] risk plan. Continue to monitor health and safety." There was no investigation available for review of this incident.</p> <p>06/2013: Behavior Data Records indicated PICA behavior occurred on the following dates and times in June 2013: 06/03/13 at 7:00 AM; 06/03/13 at 5:00 PM; 06/08/13 at 11:00 AM; 06/09/13 at 1:00 PM; 06/10/13 at 5:00 PM; 06/10/13 at 6:00 PM; 06/12/13 at 4:00 PM; 06/12/13 at 5:00 PM; 06/13/13 at 4:00 PM; 06/16/13 at 6:00 PM; 06/18/13 at 6:00 PM; 06/19/13 at 5:00 PM; 06/20/13 at 4:00 PM and 06/30/13 at 5:00 PM for a total of 14 occurrences in June. The data records did not indicate what he ingested. There were no investigations available for review of these incidents.</p> <p>07/2013: Behavior Data Records indicated PICA behavior occurred on the following dates and times in July 2013: 07/02/13 at 8:00 AM; 07/03/13 at 6:00 PM; 07/04/13 at 3:30 PM (incident resulting in ER visit); 07/08/13 at 5:00 PM; 07/08/13 at 6:00 PM; 07/12/13 at 6:00 PM; 07/11/13 at 5:00 PM; 07/15/13 at 4:30 PM; 07/18/13 at 5:00 PM and 07/24/13 between 5:30 and 6:00 PM for a</p>			

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	<p>total of 10 occurrences in July to date. The data records did not indicate what he ingested. There were no investigations available for review of these incidents.</p> <p>2. A BDDS report submitted 07/01/13 for an incident dated 06/30/13 at 8:06 AM indicated, "[Client C] has two bruises on the left side of his back near his spinal cord. The bruises are red and bigger than a quarter. Active Day and overnight staff did not see the bruise but evening staff saw it when giving [client C] a shower. Nurse was notified. Continue to monitor [client C] for health and safety." There was no investigation available for review of this incident.</p> <p>On 07/25/13 at 12:30 PM an interview was conducted with the AD (Area Director). The AD indicated all incidents of abuse, neglect and injuries of unknown sources are to be investigated thoroughly. She indicated they failed to get the investigations conducted.</p> <p>This federal tag relates to complaint #IN00132371.</p> <p>9-3-2(a)</p>				

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 1 of 3 BDDS (Bureau of Developmental Disabilities Services) reports regarding allegations of abuse, neglect and/or injuries of unknown source reviewed and 23 additional Behavior Data Records, the facility failed to initiate and document effective corrective action to prevent client neglect, by failing to supervise client A to prevent him from ingesting foreign bodies.</p> <p>Findings include:</p> <p>On 07/24/13 at 2:10 PM the facility's BDDS Reports, investigations and internal incident/accident reports were reviewed from 05/01/13 through 07/24/13 and indicated the following:</p> <p>A BDDS report submitted 07/05/13 for an incident dated 07/04/13 at 4:24 PM indicated, "[Client A] swallowed a paper clip. Nurse was notified and instructed staff to take [client A] to the ER (Emergency Room) [name]. Doctor found 6 paper pins and what looked like a key ring. [Client A] was sent home and Miralax (laxative) was increased to twice a day and [client A] will have a follow-up</p>	W000157	<p>Client A's supervision protocol was revised on 7/25/13. This protocol includes 1:1 staffing for Client A during waking hours and 15 minute visual check during the overnight hours and when Client A is napping. In addition, staff that are responsible for the 1:1 staffing are assigned by the Home Manager as noted on the "ER 1:1 assigned staff sheet" (see attachment). Staff have been trained that they are not to change who is assigned the 1:1 unless approved by the Home Manager. Staff that are providing the 1:1 staffing will have no other responsibilities other than to attend to Client A. Staff are to also complete an environmental checklist to scan for objects that Client A could possibly ingest. (see attachment) Staff are scanning the van prior to Client A getting on the van and checking Client A's pockets as well. When Client A is moving from room to room, staff will scan the room to check for objects that Client A could possibly ingest</p> <p>All Direct Care Staff were trained on this updated protocol prior to beginning their next shift of working with Client A. In addition, the Home Manager, On Call Supervisors, Program Director and any other staff that may</p>	08/29/2013

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	<p>x-ray next week. [Client A] returned home and resumed his normal routine. Pica (eating non-food materials) is listed in [client A's] risk plan. Continue to monitor health and safety." No record of documented effective corrective action was available for review to prevent client A from repeating the behavior.</p> <p>Client A's records were reviewed on 07/25/13 at 10:25 AM. Client A's record contained the following dated documents:</p> <p>06/2013: Behavior Data Records indicated PICA behavior occurred on the following dates and times in June 2013: 06/03/13 at 7:00 AM; 06/03/13 at 5:00 PM; 06/08/13 at 11:00 AM; 06/09/13 at 1:00 PM; 06/10/13 at 5:00 PM; 06/10/13 at 6:00 PM; 06/12/13 at 4:00 PM; 06/12/13 at 5:00 PM; 06/13/13 at 4:00 PM; 06/16/13 at 6:00 PM; 06/18/13 at 6:00 PM; 06/19/13 at 5:00 PM; 06/20/13 at 4:00 PM and 06/30/13 at 5:00 PM for a total of 14 occurrences in June. The data records did not indicate what he ingested. No record of documented effective corrective action was available for review to prevent client A from repeating the behavior.</p> <p>07/2013: Behavior Data Records indicated PICA behavior occurred on the following dates and times in July 2013:</p>		<p>assist with Administrative Observations were also trained on this updated protocol.</p> <p>Observations for the implementation of Client A's supervision protocol as prescribed by Indiana Mentor Administrative staff will occur as follows: 5 days per week on week 1; 4 days per week on week 2; 3 days per week on week 3; 2 days per week on week 4 until 1 day observation is reached. Assessment by the Area Director will occur at the end of each week to determine if further observation is needed. Notes from Administrative Observations will be recorded on the 1:1 Protocol Observation report. (see attachment) The Area Director will review the Observation reports at least weekly to determine if any further issues need to be addressed.</p> <p>Ongoing, after these 4 weeks of observations, the Home Manager and/or Program Director will complete observations a minimum of twice weekly to ensure implementation of plan is as prescribed.</p> <p>Responsible Party: Home Manager, Program Director, Area Director</p>		

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	<p>07/02/13 at 8:00 AM; 07/03/13 at 6:00 PM; 07/04/13 at 3:30 PM (incident resulting in ER visit); 07/08/13 at 5:00 PM; 07/08/13 at 6:00 PM; 07/12/13 at 6:00 PM; 07/11/13 at 5:00 PM; 07/15/13 at 4:30 PM; 07/18/13 at 5:00 PM and 07/24/13 between 5:30 and 6:00 PM for a total of 10 occurrences in July to date. The data records did not indicate what he ingested. No record of documented effective corrective action was available for review to prevent client A from repeating the behavior after the 07/12/13 protocol was put in place.</p> <p>07/12/13: Supervision Protocol for client A indicated: "This protocol will be effective 7/12/13 and remains in place until changed by his Interdisciplinary Team. Staff will be scheduled during waking hours to ensure that a staff can provide line of sight supervision if needed. Line of sight supervision will begin when [client A] wakes up in the morning and remain in effect until he retires for the evening. Line of sight supervision will be defined as staff being in the same room with [client A] in eye sight. Staff may be engaged in other activities such as documentation, playing a game, washing dishes, etc as long as they can abandon those activities to immediately respond to [client A] if needed. Staff should check [client A's]</p>			

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	<p>pockets before he gets on the van and remove any no (sic) food items that he may ingest. When [client A] moves from one place to another, staff needs to accompany him and keep an eye out for any small non-edible objects on the floor, in the room etc. and remove them so he will not ingest them. When [client A] needs to use the restroom, staff will accompany him to the room and look through the room and on the floor to see if there are any non-edible objects that he may ingest. Staff will remain in the bathroom with him with the door closed for privacy or will remain in the doorway with the door cracked for privacy so that they are able to immediately intervene if [client A] tries to eat a non-edible object. Staff are to complete the environmental checklist throughout the day to scan for any inedible objects that [client A] could possibly ingest. Staff should scan the van for any debris prior to [client A] getting on the van. Staff should check [client A's] pockets prior to him getting on the van. Overnight staff should check his lunch bag and backpack for any small, inedible objects he could ingest. Morning staff should check the kitchen, living room, bathroom, etc. prior to waking [client A] up."</p> <p>On 07/25/13 at 12:30 PM an interview was conducted with the AD (Area</p>			

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	<p>Director). She indicated the staff had been trained on the 07/12/13 Supervision Protocol for client A. She indicated the protocol failed to specifically indicate which staff were to monitor him and she further indicated the staff could not be engaged in other activities if client A was to be in their line of sight supervision. She indicated the supervision plan was not adequate if he continued to have documented incidents of pica which occurred after the 07/12/13 protocol. She indicated the agency failed to implement and document effective corrective action for the incidents.</p> <p>This federal tag relates to complaint #IN00132371.</p> <p>9-3-2(a)</p>				

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W000249	<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, record review, and interview, the facility failed for 1 of 3 sampled clients (client A) to implement client A's Supervision Protocol as written.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 07/24/13 from 4:35 PM until 5:45 PM and staff #1, #2, #3 and #4 were on duty. During the entire observation client A was observed to walk around the house without constant staff supervision. He freely walked from the living room down the hallway and to his bedroom without staff accompanying him or following him. Staff failed to keep client A in a line of sight at all times.</p> <p>Observations were conducted in the group home on 07/25/13 from 4:45 PM until 5:45 PM and staff #1, #5 and #6 were on duty. During the observation staff #5 followed client A around the house periodically. At 5:02 PM staff #5 turned</p>	W000249	<p>Client A's supervision protocol was revised on 7/25/13. This protocol includes 1:1 staffing for Client A during waking hours and 15 minute visual check during the overnight hours and when Client A is napping. In addition, staff that are responsible for the 1:1 staffing are assigned by the Home Manager as noted on the "ER 1:1 assigned staff sheet" (see attachment). Staff have been trained that they are not to change who is assigned the 1:1 unless approved by the Home Manager. Staff that are providing the 1:1 staffing will have no other responsibilities other than to attend to Client A. Staff are to also complete an environmental checklist to scan for objects that Client A could possibly ingest. (see attachment) Staff are scanning the van prior to Client A getting on the van and checking Client A's pockets as well. When Client A is moving from room to room, staff will scan the room to check for objects that Client A could possibly ingest Add Direct Care Staff were trained on this updated protocol prior to</p>	08/29/2013

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	<p>her back to client A three times as she obtained items and attended to client D. At 5:07 PM client A walked down the hall and into his bedroom without staff and sat on his bed.</p> <p>An interview was conducted with staff #5 on 07/25/13 at 5:33 PM. Staff #5 indicated no one was assigned to client A. She indicated staff were assigned for client showers for that night.</p> <p>Observations were conducted in the group home on 07/25/13 from 10:30 AM until 11:45 AM and staff #1, #7 and #8 were on duty. At 10:42 AM, 10:44 AM and 10:49 AM staff #1 was observed to walk away from client A with her back turned to him. Client A was not in her line of sight. At 10:56 AM staff #1 indicated staff #7 was to monitor client A. During the observation time from 10:56 AM until 11:45 AM staff #7 turned her back and walked away from client A a total of 13 times. During the observation time staff #7 folded the laundry. Staff #7 failed to keep client A in her line of sight at all times.</p> <p>Client A's records were reviewed on 07/25/13 at 10:25 AM. Client A's record contained the following dated documents:</p> <p>07/12/13: Supervision Protocol for client</p>		<p>beginning their next shift of working with Client A. In addition, the Home Manager, On Call Supervisors, Program Director and any other staff that may assist with Administrative Observations were also trained on this updated protocol. Observations for the implementation of Client A's supervision protocol as prescribed by Indiana Mentor Administrative staff will occur as follows: 5 days per week on week 1; 4 days per week on week 2; 3 days per week on week 3; 2 days per week on week 4 until 1 day observation is reached. Assessment by the Area Director will occur at the end of each week to determine if further observation is needed. Notes from Administrative Observations will be recorded on the 1:1 Protocol Observation report. (see attachment) The Area Director will review the Observation reports at least weekly to determine if any further issues need to be addressed. Ongoing, after these 4 weeks of observations, the Home Manager and/or Program Director will complete observations a minimum of twice weekly to ensure implementation of plan is as prescribed. Responsible Party: Home Manager, Program Director, Area Director</p>		

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	A indicated: "This protocol will be effective 7/12/13 and remains in place until changed by his Interdisciplinary Team. Staff will be scheduled during waking hours to ensure that a staff can provide line of sight supervision if needed. Line of sight supervision will begin when [client A] wakes up in the morning and remain in effect until he retires for the evening. Line of sight supervision will be defined as staff being in the same room with [client A] in eye sight. Staff may be engaged in other activities such as documentation, playing a game, washing dishes, etc. as long as they can abandon those activities to immediately respond to [client A] if needed. Staff should check [client A's] pockets before he gets on the van and remove any no (sic) food items that he may ingest. When [client A] moves from one place to another, staff needs to accompany him and keep an eye out for any small non-edible objects on the floor, in the room etc. and remove them so he will not ingest them. When [client A] needs to use the restroom, staff will accompany him to the room and look through the room and on the floor to see if there are any non-edible objects that he may ingest. Staff will remain in the bathroom with him with the door closed for privacy or will remain in the doorway with the door cracked for privacy so that				

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	<p>they are able to immediately intervene if [client A] tries to eat a non-edible object. Staff are to complete the environmental checklist throughout the day to scan for any inedible objects that [client A] could possibly ingest. Staff should scan the van for any debris prior to [client A] getting on the van. Staff should check [client A's] pockets prior to him getting on the van. Overnight staff should check his lunch bag and backpack for any small, inedible objects he could ingest. Morning staff should check the kitchen, living room, bathroom, etc. prior to waking [client A] up."</p> <p>On 07/25/13 at 12:30 PM an interview was conducted with the AD (Area Director). The AD indicated the staff did not follow the Supervision Protocol as written and failed to implement it correctly with client A.</p> <p>This federal tag relates to complaint #IN00132371.</p> <p>9-3-4(a)</p>				

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W000252	<p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client A, the facility failed to document and/or collect data as outlined in the Behavior Support Plan.</p> <p>Findings include:</p> <p>Client A's records were reviewed on 07/25/13 at 10:25 AM. Client A's record contained the following dated documents:</p> <p>05/2013: BSP (Behavior Support Plan) indicated client A's behaviors include PICA and staff are to monitor the environment for any objects that he could ingest.</p> <p>06/2013: Behavior Data Records (BDR) indicated PICA behavior occurred on the following dates and times in June 2013: 06/03/13 at 7:00 AM; 06/03/13 at 5:00 PM; 06/08/13 at 11:00 AM; 06/09/13 at 1:00 PM; 06/10/13 at 5:00 PM; 06/10/13 at 6:00 PM; 06/12/13 at 4:00 PM; 06/12/13 at 5:00 PM; 06/13/13 at 4:00 PM; 06/16/13 at 6:00 PM; 06/18/13 at 6:00 PM; 06/19/13 at 5:00 PM; 06/20/13</p>	W000252	<p>All Direct Support staff, Home Manager and Program Director received retraining on exactly what PICA is, causes and symptoms of PICA and ways to prevent PICA by the Behavior Specialist. All Direct Care Staff were given a post-test to evaluate their knowledge of PICA.</p> <p>Client A's Behavior Support Plan was updated to include the increase in supervision levels and environmental checks. In addition, a separate behavior tracking sheet was developed for Client A to complete a structured ABC (antecedent-behavior-consequence) analysis of all of his targeted behaviors including his PICA. (see attachment) Staff received retraining on the updated behavior plan, updated behavior tracking sheet and the need to document on a narrative note any instances of PICA behaviors.</p> <p>Home Manager, Program Director, Area Director and any other staff assisting with Administrative Observations will review behavior tracking data and narrative notes to ensure that all are being completed as needed.</p>	08/29/2013			

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	<p>at 4:00 PM and 06/30/13 at 5:00 PM for a total of 14 occurrences in June. The data records did not indicate what he ingested. The BDRs indicated, "Document all incidents with BPR codes. Behaviors in the 'Code + Nar (narrative)' group must be coded and described on the BPR-NN (Behavior Problem Record - Narrative Note)." None of the 14 recorded pica incidents had a NN to describe the incident as required.</p> <p>07/2013: Behavior Data Records indicated PICA behavior occurred on the following dates and times in July 2013: 07/02/13 at 8:00 AM; 07/03/13 at 6:00 PM; 07/04/13 at 3:30 PM (incident resulting in ER visit); 07/08/13 at 5:00 PM; 07/08/13 at 6:00 PM; 07/12/13 at 6:00 PM; 07/11/13 at 5:00 PM; 07/15/13 at 4:30 PM; 07/18/13 at 5:00 PM and 07/24/13 between 5:30 and 6:00 PM for a total of 10 occurrences in July to date. The data records did not indicate what he ingested. The BDRs indicated, "Document all incidents with BPR codes. Behaviors in the 'Code + Nar (narrative)' group must be coded and described on the BPR-NN (Behavior Problem Record - Narrative Note)." Only 1 of the 10 recorded pica incidents had a NN to describe the incident as required and that was the ER visit of 07/04/13.</p>		<p>Ongoing, after the initial 4 weeks of observations, the Home Manager and/or Program Director will complete observations a minimum of twice weekly to ensure implementation of plan is as prescribed and will review behavior tracking data and narrative notes to ensure that all are being completed as needed. In addition, the Behavior Consultant will review the behavior tracking data and narrative notes to ensure that all are being completed as needed a minimum of monthly when they are in the homes to collect data.</p> <p>Responsible Party: Home Manager, Program Director, Area Director, Behavior Consultant</p>				

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	<p>On 07/25/13 at 12:30 PM an interview was conducted with the AD (Area Director). The AD indicated each of the recorded pica incidents should have had a narrative note to go along with the incident and it should have detailed what occurred.</p> <p>This federal tag relates to complaint #IN00132371.</p> <p>9-3-4(a)</p>				

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W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on record review and interview, the Condition of Participation of Health Care Services is not met for 1 of 3 sampled clients (client A), as the facility failed to assure client A received timely health care services after ingesting foreign bodies.</p> <p>Findings include:</p> <p>Please refer to W331 as the facility nursing services failed for 1 of 3 sampled clients (client A), by not ensuring the client received timely medical services according to his medical needs after ingesting foreign bodies.</p> <p>This federal tag relates to complaint #IN00132371.</p> <p>9-3-6(a)</p>	W000318	<p>The Facility Nurse has updated the PICA protocol for Client A to specify that the Facility Nurse (or On Call Nurse) is to be called any time Client A eats anything non-edible. The Facility Nurse (or On Call Nurse) will make the determination if Client A needs to be evaluated at the Emergency Room based on what he ate and how much he ingested. All Direct Support staff, Home Manager and Program Director have been retrained on the need to ensure that if they are directed to take a consumer to the Emergency Room for evaluation, they do it as immediately as possible and not wait for the group home van to be available, even if this means using their personal vehicles. If a vehicle is not immediately available they will contact the Home Manager to make alternative arrangements. Ongoing, the Home Manager and Program Director will ensure that staff are taking consumers to the ER as immediately as possible after they have been directed to do so. The Home Manager or On call supervisor will continue to contact staff at 10 minute intervals until the consumer is able to be transported to the Emergency Room. Responsible Staff: Facility Nurse, Home Manager, Program Director, Area</p>	08/29/2013	

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility nursing services failed for 1 of 3 sampled clients (client A), by not ensuring the client received timely medical services according to his medical needs after ingesting foreign bodies.</p> <p>Findings include:</p> <p>On 07/24/13 at 2:10 PM the facility's BDDS (Bureau of Developmental Disabilities Services) Reports, investigations and internal incident/accident reports were reviewed from 05/01/13 through 07/24/13 and indicated the following:</p> <p>A BDDS report submitted 07/05/13 for an incident dated 07/04/13 at 4:24 PM indicated, "[Client A] swallowed a paper clip. Nurse was notified and instructed staff to take [client A] to the ER (Emergency Room) [name]. Doctor found 6 paper pins and what looked like a key ring. [Client A] was sent home and Miralax (laxative) was increased to twice a day and [client A] will have a follow-up x-ray next week. [Client A] returned home and resumed his normal routine. Pica (eating non-food materials) is listed</p>	W000331	<p>The Facility Nurse has updated the PICA protocol for Client A to specify that the Facility Nurse (or On Call Nurse) is to be called any time Client A eats anything non-edible. The Facility Nurse (or On Call Nurse) will make the determination if Client A needs to be evaluated at the Emergency Room based on what he ate and how much he ingested. All Direct Support staff, Home Manager and Program Director have been retrained on the need to ensure that if they are directed to take a consumer to the Emergency Room for evaluation, they do it as immediately as possible and not wait for the group home van to be available, even if this means using their personal vehicles. If a vehicle is not immediately available they will contact the Home Manager to make alternative arrangements. Ongoing, the Home Manager and Program Director will ensure that staff are taking consumers to the ER as immediately as possible after they have been directed to do so. The Home Manager or on call supervisor will continue to contact staff at 10 minute intervals until the consumer is able to be transported to the Emergency Room. Responsible Staff: Facility Nurse, Home Manager, Program Director, Area</p>	08/29/2013			

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	<p>in [client A's] risk plan. Continue to monitor health and safety."</p> <p>Client A's records were reviewed on 07/25/13 at 10:25 AM. Client A's record contained the following dated documents:</p> <p>11/27/12: ISP (Individual Support Plan). The ISP indicated client A's diagnoses included but were not limited to: Severe Mental Retardation, Autism, Pica and Constipation.</p> <p>01/31/13: Choking Protocol indicated, "[Client A] has pica." The protocol indicated what to do if client A choked. The protocol did not address if client A had pica behavior and ingested a foreign body, but was not choking. It failed to indicate what staff were to do.</p> <p>02/05/13: Inservice prior to Client A's move into the group home re: PICA.</p> <p>05/08/13: Admission to group home from another [same agency] group home.</p> <p>05/2013: BSP (Behavior Support Plan) indicated client A's behaviors include PICA and staff are to monitor the environment for any objects that he could ingest.</p> <p>06/2013: Behavior Data Records</p>		Director.				

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	<p>indicated PICA behavior occurred on the following dates and times in June 2013: 06/03/13 at 7:00 AM; 06/03/13 at 5:00 PM; 06/08/13 at 11:00 AM; 06/09/13 at 1:00 PM; 06/10/13 at 5:00 PM; 06/10/13 at 6:00 PM; 06/12/13 at 4:00 PM; 06/12/13 at 5:00 PM; 06/13/13 at 4:00 PM; 06/16/13 at 6:00 PM; 06/18/13 at 6:00 PM; 06/19/13 at 5:00 PM; 06/20/13 at 4:00 PM and 06/30/13 at 5:00 PM for a total of 14 occurrences in June. The data records did not indicate what he ingested.</p> <p>07/2013: Behavior Data Records indicated PICA behavior occurred on the following dates and times in July 2013: 07/02/13 at 8:00 AM; 07/03/13 at 6:00 PM; 07/04/13 at 3:30 PM (incident resulting in ER visit); 07/08/13 at 5:00 PM; 07/08/13 at 6:00 PM; 07/12/13 at 6:00 PM; 07/11/13 at 5:00 PM; 07/15/13 at 4:30 PM; 07/18/13 at 5:00 PM and 07/24/13 between 5:30 and 6:00 PM for a total of 10 occurrences in July to date. The data records did not indicate what he ingested.</p> <p>An interview was conducted with the House Manager on 07/25/13 at 1:30 PM. She indicated the "paper pin" client A ingested was a paper clip. She indicated the staff are to document on the data sheet if the behavior occurred by placing a "M" in the date and time column and they are</p>			

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	<p>to do a narrative note to describe the incident. The only narrative note on any of the June or July 2013 PICA incidents was on 07/04/13 when client A went to the ER. The HM was asked what kind of things client A has ingested in the past two months and she indicated small items like things on the ground, twigs, pen tops and paper. She indicated she did not know why the narrative notes were not completed. She also indicated there was not a specific staff assigned to him while he was awake; it was whoever was closest to follow him and keep him in sight.</p> <p>07/02/13: Group Home Inservice on various topics which included client A's "pica increase."</p> <p>07/04/13: Daily support record indicated client A was taken to ER after he swallowed a "paper pin" that was laying on the kitchen counter in the group home. "Called on call person and on call person called the nurse and the PD (Program Director). The on call person said he needs to go to the ER. So the van wasn't here, it had gone with another client. As soon as they came, [client A] was showered and brushed his teeth and changed clothes, he had two glasses of water then he had 100% of his food and he went to the ER with another staff."</p>						

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	<p>07/04/13: BPR (Behavior Problem Record) indicated, "[Client A] was sitting on couch and he wanted some juice...when he went to put the glass in the sink he picked up the paper pin which was lying on the kitchen counter on some papers clipped and he put it in his mouth. 2 of us staff tried to take it out of his mouth I felt (sic) my fingers but he had already swallowed it. Tried my best to open his mouth but he had already swallowed it. Then made him go to his room and relax in his bed and he lay down. Kept checking on him but he was ok till call came to take him to the ER."</p> <p>07/04/13: ER record indicated client A's arrival time in the ER was 6:34 PM. ER records indicated the discharge diagnosis was, "Multiple foreign bodies in GI (gastrointestinal) tract. Pica."</p> <p>07/12/13: Supervision Protocol for client A indicated: "This protocol will be effective 7/12/13 and remains in place until changed by his Interdisciplinary Team. Staff will be scheduled during waking hours to ensure that a staff can provide line of sight supervision if needed. Line of sight supervision will begin when [client A] wakes up in the morning and remain in effect until he retires for the evening. Line of sight supervision will be defined as staff being</p>			

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	in the same room with [client A] in eye sight. Staff may be engaged in other activities such as documentation, playing a game, washing dishes, etc as long as they can abandon those activities to immediately respond to [client A] if needed. Staff should check [client A's] pockets before he gets on the van and remove any no (sic) food items that he may ingest. When [client A] moves from one place to another, staff needs to accompany him and keep an eye out for any small non-edible objects on the floor, in the room etc. and remove them so he will not ingest them. When [client A] needs to use the restroom, staff will accompany him to the room and look through the room and on the floor to see if there are any non-edible objects that he may ingest. Staff will remain in the bathroom with him with the door closed for privacy or will remain in the doorway with the door cracked for privacy so that they are able to immediately intervene if [client A] tries to eat a non-edible object. Staff are to complete the environmental checklist throughout the day to scan for any inedible objects that [client A] could possibly ingest. Staff should scan the van for any debris prior to [client A] getting on the van. Staff should check [client A's] pockets prior to him getting on the van. Overnight staff should check his lunch bag and backpack for any small,			

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	<p>inedible objects he could ingest. Morning staff should check the kitchen, living room, bathroom, etc. prior to waking [client A] up."</p> <p>07/17/13: Follow-up physician examination indicated, "Normal exam. Continue to observe carefully."</p> <p>On 07/25/13 at 12:30 PM an interview was conducted with the AD (Area Director). She indicated the nurse was currently on vacation and not available for interview. The AD indicated client A had a known history of Pica behavior and should not have gotten and consumed any of the metal objects he did. The AD further indicated when client A ingested the paper clip on 07/04/13 his ER evaluation and treatment should not have been delayed and staff failed to address his medical needs timely. She also indicated client A's record included a choking protocol but failed to contain a plan to indicate what staff were to do if client A ingested a foreign body and was not choking.</p> <p>This federal tag relates to complaint #IN00132371.</p> <p>9-3-6(a)</p>						

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