

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G117	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2015
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NAME OF PROVIDER OR SUPPLIER HOUSTON GROUP HOMES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 220 W MAIN ST CRAWFORDSVILLE, IN 47933
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	<p>This visit was for a recertification and state licensure survey.</p> <p>Survey Dates: May 11, 12, 13, 14, 15, 2015</p> <p>Facility Number: 000654 Aims Number: 100234270 Provider Number: 15G117</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0249 Bldg. 00	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (#2) to ensure client #2's shaving program was implemented when</p>	W 0249	HOUSTON GROUP HOMES, INC. PLAN OF CORRECTION 22 WEST MAIN STREET CRAWFORDSVILLE, IN 47933 TAG W-249 2015 SURVEY	06/05/2015

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

TITLE

(X6) DATE

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

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	<p>opportunities were present.</p> <p>Findings include:</p> <p>An observation was done on 5/11/15 from 3:58p.m. to 6:27p.m. at the facility group home. Client #2 was observed at 4:48p.m. to take his electric razor to the dining room. Client #2 plugged in his razor and began running it over his face while standing next to the dining room table. Client #2 had received a staff verbal prompt to go to the bathroom and to make sure he shaved all areas at 5:12p.m. The staff left the area and client #2 continued to run the razor over the area just under his chin.</p> <p>Record review for client #2 was done on 5/12/15 at 10:48a.m. Client #2 had an Individual Support Plan (ISP) on 9/7/14. The ISP indicated client #2 had a training program to "learn to shave face thoroughly." The program indicated client #2 was to receive staff supervision and prompts to pull his skin tight with one hand and shave with his other hand to get a smooth shave.</p> <p>Staff #2 was interviewed on 5/12/15 at 10:54a.m. Staff #2 indicated client #2 should be assisted by staff when he shaves and prompted to shave in the bathroom and to try to use a mirror.</p>				<p>Plan of Correction Houston Group Homes, Inc. 220 West Main Street June 2, 2015 The facility Executive Director had a conversation with the Residential Supervisor. The purpose of the conversation was to discuss the plan to correct deficiency tag number W-249 cited during the Indiana State Department of Health annual recertification survey completed on May 15, 2015. Ensure that client #2's shaving program was implemented when opportunities were present. The Executive Director instructed the Residential Supervisor to re-train all staff on client #2's shaving program (see attachment A)</p> <p>Incomplete</p> <ol style="list-style-type: none"> No other clients were affected. For client #2's shaving program, the program was written on 5/8/2015 and was to be run 2 times per week. On Monday 5/11/15 the first running of the program was the night that the surveyor was doing observation. <p>After the QIDP completes the monthly summary and changes are made, the Residential Trainer of the home will write</p>		

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	<p>Staff #1 was interviewed on 5/14/15 at 10:34a.m. Staff #1 indicated client #2's shaving program was a current training program and should have been implemented on 5/11/15.</p> <p>9-3-4(a)</p>		<p>anote to all staff telling them of any new program or changes.</p> <p>TheResidential Trainer will monitor the new programs along with the QIDP and the Residential Supervisor on amonthly basis. The Residential Trainerwill also monitor daily by checking the programs and reporting any concerns directlyto the QIDP and Residential Supervisor.</p> <p style="text-align: right;">Completion Date: 6/5/15 Completion Date: 6/5/15</p>	