

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G045	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/16/2011
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NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 829 EARL RD MICHIGAN CITY, IN46360
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: December 12, 13, 14, 15, and 16, 2011</p> <p>Facility number: 000601 Provider number: 15G045 AIM number: 100233480</p> <p>Surveyors: Christine Colon, Medical Surveyor III-Team Leader Tim Shebel, Medical Surveyor III</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/3/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the governing body failed for 6 of 6 clients (clients #1, #2, #3, #4, #5 and #6) living at the group home, to exercise general operating direction in a manner to ensure routine maintenance was completed.</p> <p>Findings include:</p>	W0104	In order for this deficiency to be corrected now and systemically, the maintenance issue of the toilet paper roll holder will be corrected on 1/11/12 and the hole behind the bathroom door has already been fixed. In order for this citation to be fixed now and systemically, the staff will write up maintenance orders when there	01/15/2012

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>A morning observation was conducted at the home of clients #1, #2, #3, #4, #5 and #6 on 12/12/11 from 5:50 A.M. until 8:00 A.M.. At 6:50 A.M., the bathroom located between clients #1, #4, #5 and #6's bedrooms was observed to have the toilet paper roll sitting on the back of the toilet seat. There was no toilet paper holder in the bathroom. The wall located behind the bathroom door was observed to have a hole measuring 4 inches by 3 inches in diameter.</p> <p>An interview with Direct Support Professional (DSP) #1 was conducted on 12/12/11 at 7:00 A.M.. DSP #1 indicated there was no toilet paper holder in the bathroom.</p> <p>An interview with the Qualified Mental Retardation Professional-Designee (QMRPD) was conducted on 12/13/11 at 11:25 A.M.. The QMRP-D indicated there should be a toilet paper holder in the bathroom and the hole behind the bathroom door needed repair. The QMRP-D further indicated he wasn't sure if there were any maintenance repair request forms for this group home. No further documentation was available for review to indicate when the repairs would be completed.</p>		are maintenance issues. The Residential Director does house observations and checks maintenance issues when at the homes. An environmental list is then prepared and sent to the maintenance supervisor to review and correct issues.(maintenance, direct care staff, Team Leader, Residential Director and Executive Director responsible)		

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W0126	<p>9-3-1(a)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on observation and interview, for 6 of 6 clients residing at the group home (clients #1, #2, #3, #4, #5 and #6), the facility failed to encourage and teach each client to access their personal finances.</p> <p>Findings include:</p> <p>A morning observation was conducted at the home of clients #1, #2, #3, #4, #5 and #6 on 12/12/11 from 5:50 A.M. until 8:00 A.M.. At 6:30 A.M., Direct Support Professional (DSP) #1 was asked if clients kept their personal funds. DSP #1 indicated the clients' personal funds were kept locked up. When asked if she could unlock the office so the clients could count their personal finances, DSP #1 indicated the group home leader was the only person who had access to the locked finances.</p> <p>An on grounds day program observation was conducted at the home of clients #1,</p>	W0126	In order for this citation to be met now and systemically, each consumer will have an immediate access to a certain amount of cash out of their personal budgets and placed in their specific spot in the medication cart for small impulse purchases. The money will be used by the consumers at the homes at any given time frame to allow consumers to work on goals in a natural setting and have choices. This will be a systemic practice for all consumers in group homes in the agency. The IDT will observe weekly to see if consumer money is available.(QMRP, Residential Coordinator, RN, Behavior Specialist, Team Leaders and Direct Care staff responsible)	01/15/2012	

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W0140	<p>#2, #3, #4, #5 and #6 on 12/12/11 from 10:30 A.M. until 12:00 P.M.. At 10:40 A.M., DSP #3 was asked if clients kept their personal funds. DSP #3 indicated the clients' personal funds were kept locked and further indicated only the group home leader had access to each clients personal funds.</p> <p>An interview with the Qualified Mental Retardation Professional-Designee (QMRPD) was conducted at the facility's administrative office on 12/13/11 at 11:25 A.M.. The QMRPD indicated the clients should have access to their personal funds and they should be available for their use. The QMRPD further indicated the group home leader was the only person with access to each client's personal funds.</p> <p>9-3-2(a)</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p> <p>Based on record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2, and #3) to ensure a system</p>	W0140	In order for this citation to be met now and systemically, the budget pack procedure has been revsied to eliminate errors that were made. From here forward, Team Leads responsible for completing	01/15/2012	

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	<p>was established for individual receipts to be maintained.</p> <p>Findings include:</p> <p>A record review of clients #1, #2, and #3's financial records was conducted on 12/13/11 at 12:45 P.M.. The receipts dated January 2011 through October 2011 failed to provide an individual accounting of which client had purchased the items on the receipt. Further review indicated meals in the community had not been reimbursed for the months of January 2011 through October 2011 for clients #1, #2, and #3.</p> <p>An interview with the Qualified Mental Retardation Professional Designee (QMRPD) was conducted on 12/13/11 at 11:25 A.M.. The QMRPD indicated the facility should pay for a meal if it replaces a meal at the home. The QMRPD also indicated there was only one receipt for multiple clients available for review and each receipt had multiple purchases on the receipts so there was no way of knowing how much each client would have spent or what they had bought.</p> <p>9-3-2(a)</p>		<p>budget packs were trained on consumers being reimbursed for meals if they do not choose to go out to eat. Consumers will be reimbursed if money is not available on a weekend if they want/need a hair cut, etc. Consumers will have individual receipts when at all possible. If not, appropriate tax will be figured in for each consumer so all are paying equally. All budget packs will be monitored on a monthly basis for accuracy, along with the normal month end checks. (Team Leaders, Residential Coordinator and Direct Care Staff responsible)</p>		

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W0249	<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 to implement written objectives during times of opportunity for 3 of 3 sampled clients (clients #1, #2, and #3).</p> <p>Findings include:</p> <p>Clients #1, #2, and #3 were observed during the group home observation period on 12/12/11 from 5:50 A.M. until 8:00 A.M.. At the morning meal at 5:50 A.M., client #1 was not observed to participate in meal preparation (help prepare meals with assistance as needed.) From 6:15 A.M. until 6:55 A.M., clients #1 and #2 sat in the living room without activity. At 6:55 A.M., client #3 did not identify what time she takes her medication during medication administration. During the noted time periods, Direct Support Professional (DSP) #1 and #2 would occasionally walk through and visually check on clients #1, #2 and #3 but did not offer meaningful active treatment activities or implement client objectives.</p>	W0249	The QMRP had a training with staff on 12/22/2012 addressing the need for continuous active treatment. See attachments of agendas that went over staff needing to interact and provider active treatment in a natural setting/environment involving ihps, chores, med administration, meal preparation, hygiene, etc. Staff were given a quiz on what active treatment is defined as, how to complete in a natural setting, why and when it should take place, etc. In order for this citation to be corrected now and systemically, the IDT goes over to the home at least once a week. IDT completes observation notes as to what they observe. If there are needed areas of training, IDT will train on those active treatment areas during that observation.(Team Leader, Residential Coordinator, QMRP, Behavior Specialist, RN, Direct Care staff responsible)	01/15/2012	

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	<p>From 6:55 A.M. until 8:00 A.M., client #1 walked around the facility and clients #2 and #3 sat in the family room. DSP #1 and #2 were not observed to provide the clients with meaningful active treatment activities or implement client objectives during the observation period.</p> <p>A review of client #1's records was conducted on 12/13/11 at 8:50 A.M.. A review of the client's 5/18/11 Individual Program Plan indicated the following objectives which could have been implemented during the 12/12/11 morning observation period: "Will practice his signing daily with the assistance of the prepared pictorial booklet for him...will learn to sign his name...follow a personal schedule to establish a routine...help prepare meals with assistance as needed."</p> <p>A review of client #2's records was conducted on 12/13/11 at 9:40 A.M.. A review of the client's 5/3/11 Individual Program Plan indicated the following objectives which could have been implemented during the 12/12/11 morning observation period: "Will improve communication skills with staff and peers...complete household tasks...develop skills to differentiate between coins."</p> <p>A review of client #3's records was</p>				

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	<p>conducted on 12/13/11 at 10:20 A.M.. A review of the client's 4/12/11 Individual Program Plan indicated the following objectives which could have been implemented during the 12/12/11 morning observation period: "Follow a daily routine/schedule...increase medication independence...will identify what time she takes her medication...demonstrate ability to call 911 in emergency...increase ability to sign name."</p> <p>The Qualified Mental Retardation Professional Designee (QMRPD) was interviewed on 12/13/11 at 11:25 A.M.. The QMRPD stated client objectives should be implemented "during times of opportunity." The QMRPD further indicated clients #1, #2, and #3 should have had been provided with meaningful active treatment activities during the 12/12/11 morning observation period.</p> <p>9-3-4(a)</p>				

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W0250	<p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>Based on record review and interview, the facility failed for 6 of 6 clients residing at the group home (clients #1, #2, #3, #4, #5 and #6) to have Active Treatment Schedules (ATS).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 12/13/11 at 8:50 A.M.. Client #1's record failed to have an ATS.</p> <p>Client #2's record was reviewed on 12/13/11 at 9:40 A.M.. Client #2's record failed to have an ATS.</p> <p>Client #3's record was reviewed on 12/13/11 at 10:20 A.M.. Client #3's record failed to have an ATS.</p> <p>Client #4's record was reviewed on 12/13/11 at 10:40 A.M.. Client #4's record failed to have an ATS.</p> <p>Client #5's record was reviewed on 12/13/11 at 10:50 A.M.. Client #5's record failed to have an ATS.</p> <p>Client #6's record was reviewed on 12/13/11 at 11:15 A.M.. Client #6's</p>	W0250	<p>In order for this citation to be met now and systemically, the QMRP is updating each consumer active treatment schedule. There were already active treatment schedules in place, with no times attached to them. Please see attachments giving examples of consumers' a.m. and p.m. schedules. Also included is an example of a day activities schedule for these consumers. The time frames are to provide staff with a general idea as to when and what consumers could be doing during the course of the day to involve them in active treatment. This is only a general schedule which allows consumers time for down time and free choice. The IDT will observe on a weekly basis to see that continuous active treatment is occurring. If IDT sees a lag of time where consumers are sitting, IDT will redirect staff to get consumers involved. This active treatment training occurred on 12/22/11.(Team Leaders, Residential Coordinator, QMRP, Behavior Specialist, RNs, and direct care staff responsible)</p>	01/15/2012	

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W0323	<p>record failed to have an ATS.</p> <p>An interview with the Qualified Mental Retardation Professional Designee (QMRPD) was conducted on 12/13/11 at 11:25 A.M.. The QMRPD indicated clients #1, #2, #3, #4, #5 and #6 should have active treatment schedules. No documentation was available for review to indicate each client had an ATS.</p> <p>9-3-4(a)</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2 and #3) to provide annual hearing evaluations/assessments.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 12/13/11 at 8:50 A.M.. Client #1's record indicated a most current hearing evaluation dated 4/30/09. The record further indicated a most current physical dated 8/29/11 which failed to</p>	W0323	<p>This citation was corrected by a simple revision to our Annual Physical form (attachment included) for our consumers. The form was changed to include lines for vision test and hearing test (which weren't included before). This form will be filled out by the attending physician on an annual basis, along with the consumers going to see the ear and eye doctors within the allotted Medicaid timeframes. If the primary doctor sees a problem with these two areas at the annual physical, the RN will contact the necessary physicians to get appointments made for the</p>	01/15/2012	

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	<p>indicate the physician had completed a hearing evaluation/assessment. Client #1's record did not contain evidence of an annual hearing evaluation.</p> <p>A review of client #2's record was conducted on 12/13/11 at 9:40 A.M.. Client #2's record indicated a most current hearing evaluation dated 8/24/10. The record further indicated a most current physical dated 9/12/11 which failed to indicate a hearing evaluation/assessment had been completed. Client #2's record did not contain evidence of an annual hearing evaluation.</p> <p>A review of client #3's record was conducted on 12/13/11 at 10:20 A.M.. Client #3's record indicated a most current hearing evaluation dated 11/10/09. Client #3's record did not contain evidence of an annual hearing evaluation.</p> <p>The Registered Nurse (RN) was interviewed on 12/13/11 at 11:56 A.M.. The RN indicated there was no evidence of annual evaluations of client #1, #2 and #3's hearing.</p> <p>9-3-6(a)</p>		Medicaid allotted times.(RN, medical support responsible)		

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W0383	<p>Only authorized persons may have access to the keys to the drug storage area.</p> <p>Based on observation and interview, the facility failed for 5 of 6 clients residing at the group home (clients #1, #2, #3, #4 and #5), to ensure only authorized persons had access to the keys to the medication office.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 12/12/11 from 5:50 A.M. until 8:00 A.M.. At 6:55 A.M., a medication administration for clients #3 and #5 was observed. At 6:50 A.M. Direct Support Professional (DSP) #1 was observed to put a set of keys into the office door and enter into the office leaving the keys hanging from the outside of the door where clients #1, #2 and #4 sat. DSP #1 closed the office door with the keys hanging on the outside of the door, then retrieved the medication keys hanging on the wall above the medication cart. DSP #1 unlocked the medication cart, administered client #3 her medications, locked the cart, and hung the keys back on the wall. At 7:05 A.M. DSP #1 again took the keys from the wall and unlocked the medication cart. After passing medications to client #5, DSP #1</p>	W0383	<p>In order for this citation to be corrected now and sytemically, the PAF QMRP and RN have retrained staff on 12/22/11 at a staff meeting on the madndate to always have the medication cart locked up at all times, with the exception of administering medications. At that time, the medication cart keys will be kept with the authorized staff person. If that person steps out of the room where medications are being passed, the staff will lock up the medication cart, keeping the keys with an authorized person or location, and shutting the office door. During a med pass, the keys must be on a secured staff. IDT makes weekly observations atr the homes. IDT will check to make sure staff are maintaining compliance with this. (QMRP, RN, Team Leader, Direct Care Staff, Residential Coordinator and Behavior Specialist responsible)</p>	01/15/2012	

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W0484	<p>hung the keys back on the wall where anyone could have access to them. The office door was observed to be unlocked throughout the morning observation.</p> <p>An interview with the Registered Nurse (RN) was conducted on 12/13/11 at 12:15 P.M.. The RN indicated the keys should only be available to authorized persons, not hanging on the wall or from the door where anyone would have access to them.</p> <p>9-3-6(a)</p> <p>The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview, the facility failed for 3 of 3 clients observed during meal time (clients #1, #2 and #4) to provide condiments at the dining table.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 12/12/11 from 5:50 A.M. until 8:00 A.M.. At 5:55 A.M., client #4 was eating breakfast which consisted of a bowl of unsweetened cereal, 2 slices of toast, orange juice and milk. At 6:15 A.M., clients #1 and #2 were observed eating breakfast which consisted of unsweetened cereal, 2 slices</p>	W0484	In order for this citation to be met now and systemically, staff were informed on 12/22/11 that all meals should have condiments readily available to the consumers, such as jelly, butter, salt and pepper. IDT will monitor to make sure the condiments are being placed on the table during meal time.(QMRP, Team Leader, dietician, Direct Care Staff, RN, Behavior Specialist and Residential Coordinator responsible)	01/15/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G045	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 829 EARL RD MICHIGAN CITY, IN46360		
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W0488	<p>of toast and orange juice. The table was observed to have no butter, jelly or sugar/sugar substitute available for use.</p> <p>An interview with the Qualified Mental Retardation-Designee (QMRPD) was conducted on 12/13/11 at 11:25 A.M.. The QMRPD indicated condiments should be put on the table for the clients to use at all meals.</p> <p>9-3-8(a)</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, record review and interview, the facility failed to assure 3 of 3 clients observed during meal time (clients #1, #2 and #4) were involved in meal preparation.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group on 12/12/11 from 5:50 A.M. until 8:00 A.M.. At 5:55 A.M., Direct Support Professional (DSP) #1 poured cereal into a bowl and placed it on the table in front of client #4. DSP #1 then retrieved two slices of toast out of the</p>	W0488	<p>In order for this citation to be corrected now and systemically, the QMRP had a training on 12/22/11 addressing the need for continuous active treatment (see agendas attached). This included meal preparation, along with all other aspects of active treatment. IDT goes to the group home at least once a week. IDT completes observation notes as to what they observe. If IDT sees a consumers is not being included in meat time preparation IDT will stop staff immediately and have consumers help. If this continues to be a recurring issues, disciplinary action may occur. Staff were trained that</p>	01/15/2012	

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	<p>toaster and placed them on a plate and placed the plate on the table in front of client #4. Client #4 ate his breakfast independently. At 6:15 A.M., DSP #1 poured cereal into bowls and placed them on the table in front of clients #1 and #2. DSP #1 then retrieved four slices of toast out of the toaster and placed them on plates and placed the plates on the table in front of clients #1 and #2. Clients #1 and #2 ate their breakfast independently. Clients #1, #2 and #4 did not assist in meal preparation.</p> <p>A review of client #1's record was conducted on 12/13/11 at 8:50 A.M.. Review of client #1's Individual Program Plan (IPP) dated 5/18/11 indicated: "Will participate in meal prep...Help prepare meals with staff assistance as needed."</p> <p>An interview with the Qualified Mental Retardation Professional-Designee (QMRPD) was conducted at the facility's administrative office on 12/13/11 at 11:25 A.M.. The QMRPD indicated clients were capable of assisting in meal preparation and further indicated they should be assisting in meal preparation at meal times.</p> <p>9-3-8(a)</p>		<p>consumers must learn to complete ihps in a natural setting. It is understood consumers may not be able to complete the entire meal independently, but can be involved in some steps of the meal preparation.(QMRP, Team Leaders, Direct Care staff responsible)</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	<input checked="" type="checkbox"/> X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G045	<input checked="" type="checkbox"/> X2) MULTIPLE CONSTRUCTION A. BUILDING 00 _____ B. WING _____	<input checked="" type="checkbox"/> X3) DATE SURVEY COMPLETED 12/16/2011
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