

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G489	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/10/2014
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: October 27, 28, 29, 30, 31, and November 10, 2014</p> <p>Provider Number: 15G489 AIM Number: 100235260 Facility Number: 001003</p> <p>Surveyors: Glenn David, RN-TC Paula Eastmond, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/24/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview of</p>	W000125	The QIDP is responsible to	12/10/2014

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>1 of 4 sampled clients (#2), the facility failed to ensure the client had access to funds held by the facility without review and approval of the Human Rights Committee.</p> <p>Findings include:</p> <p>Client #2's financial records were reviewed on 10/30/14 at 10:30 AM. Client #2's Resident Financial Management System (RFMS) account held by the facility from 1/2/14 through 10/24/14 indicated the following (not all inclusive):</p> <p>On 7/8/14 there was a withdrawal in the amount of \$15 for personal needs items.</p> <p>There was not another withdrawal for personal needs items until 10/15/14.</p> <p>Record review of the group home's petty cash accounting log on 10/28/14 at 7:40 PM indicated a balance of \$0.26 available on hand for client #2. Client #2's accounting log indicated she had not received any petty cash for personal expenditures since 7/8/14.</p> <p>Interview with staff #1 (Home Manager) on 10/28/14 at 7:40 PM stated client #2's money "had been frozen" due to her stealing from other clients in the group</p>		<p>insure that all the needs of each individual is addressed in the Individual program plan and addressed formally as recommended by the IDT. The QIDP is responsible to provide information to the Residential Manager and staff as to the formal objectives that they must initiate to meet each individuals needs and assist them toward independence. The Residential Manager and the QIDP will monitor and audit the client personal funds on at least a quarterly basis. The Program Manager or designee will also complete an audit on at least a quarterly basis to ensure that all client funds are being handled appropriately. The Residential Manager and the QIDP will complete daily home visits to ensure that all client's have access to funds. The Program Manager will on at least a quarterly basis, conduct a review of each ISP to insure that specific individual needs are being addressed by programming and that all individuals are being afforded the right to manage their own personal funds either as part of a formal program or a more general, informal series of activities that are geared to the individual's functioning level.</p>	

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W000153	<p>home and having to pay back restitution. She also indicated client #2's guardian had agreed to the monetary freeze of funds.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 10/30/14 at 11:25 AM indicated client #2's money had been frozen for 3 to 4 months. The QIDP also indicated the freeze of client #2's financial spending had not been reviewed and approved by the Human Rights Committee (HRC).</p> <p>Interview with client #2's guardian on 10/30/14 at 11:10 AM indicated she had agreed to a monetary freeze of client #2's spending money due to her stealing from staff and other clients.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p>				

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	<p>Based on record review and interview, the facility failed to ensure staff immediately reported allegations of abuse to the administrator involving 1 of 13 incidents reviewed in accordance with state law involving client #4.</p> <p>Findings include:</p> <p>During client #4's record review on 10/29/14 at 2:20 PM, a progress health note from client #4's therapist dated 4/8/14 indicated client #4's ex boyfriend "had been picking on her at the day service." The report also indicated client #4 had advised the therapist her ex boyfriend "calls (to the group home) and makes threats of harm" to her.</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 10/28/14 at 10:15 AM. No incident report was found to indicate the allegation of abuse referenced above was reported to BDDS.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 10/30/14 at 11:25 AM indicated she was not aware of the allegation of abuse against client #4 as noted in the 4/8/14 Progress Health Note from the therapist.</p>	W000153	<p>The facility has developed and will consistently implement written policies that prohibit mistreatment, neglect or abuse of the client and that outline the procedures for reporting suspected abuse immediately to the administrator or other officials in accordance with State law through established procedures.</p> <p>The facility has policies and procedures that outline the definition of abuse, neglect, and mistreatment; reporting requirements for allegation of such incidents; the obligation and responsibility of reporting abuse; and the process for reporting and appropriate follow up to any such allegations reported.</p> <p>The agency is very adamant that no person served by the facility is subject to abuse and neglect at any time. All staff are trained and show competency in the Abuse, Neglect and Mistreatment Policies and Procedures upon hire and at least annually thereafter. All allegations of abuse are to reported and investigated according to the written policies of the facility. Normal Life of Indiana has a "zero-tolerance" policy for abuse, neglect or mistreatment of individuals served. Normal Life of Indiana will actively and aggressively investigate all</p>	12/10/2014			

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	<p>Interview with AS (administrative staff) #1 (Executive Director) on 10/31/14 at 10:15 AM indicated she had not been informed of client #4's allegation of abuse as reported to the therapist in the 4/8/14 Progress Health Note by client #4.</p> <p>9-3-2(a)</p>		<p>allegations of Abuse, Neglect and/or Mistreatment. All incidents are to be reported immediately according to the facility procedures. The policy states that failure to report can be cause for corrective actions, up to and including termination of employment.</p> <p>All staff will receive retraining on the agency policies and procedures that outline their responsibilities in the immediate reporting of suspected abuse and neglect. The Residential manager is responsible to insure staff receives training on the agency policy and procedures concerning the prohibition of abuse, neglect and mistreatment; reporting requirements for allegations of such incidents; the obligation and responsibility of reporting abuse; the process for reporting and appropriate follow-up to any such allegations reporting. Training will be documented in each staff person's training file.</p> <p>Home and Nursing Staff will also receive training on their responsibilities to review follow-up documentation from any outside professional to insure that if allegations or issues have been identified, they are followed-up and reported immediately. The Program Manager will be responsible for implementing this training.</p>		

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W000189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	W000189	NOTE: It was the facility's understanding that this incident was noted in an Independent Therapist Progress Note on 4-8-14, just one occasion, that Client #4 had stated this during the session. Client #4 is currently seeing a Therapist because of behaviors related to making up stories concerning "boyfriends" and people threatening her. At the time that this note was written by the Therapist concerning the boyfriend calling and threatening her, the male that she was accusing had passed away. Client #4 has had no incidents of abusive or threatening interactions that have been reported. The facility feels that this finding should be more focused on our follow-up to address Client #4's behavioral needs and supervision concerning her incidents of making accusation's and feeling threatened by others. The IDT is aware of these actions and her specific needs in this area. All employees complete an orientation period that includes	12/10/2014	

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	<p>Based on record review and interview, the facility failed to ensure all staff were trained in regards to the weekly Una Boot application for 1 of 4 sampled clients (#2).</p> <p>Findings include:</p> <p>During interview with the home manager on 10/29/14 at 7:55 am, when asked about adaptive devices for client #2, she indicated client #2 was supposed to be wearing an Una Boot at that time, but client #2 was not wearing it. She stated the physician ordered Una Boot should be worn "all the time" and changed by staff every Thursday.</p> <p>During morning observations at 8:15 am on 10/29/14, client #2 was not seen wearing the physician ordered Una Boot.</p> <p>The Interdisciplinary Team Meeting note dated 9/19/14 was reviewed on 10/29/14 at 12:50 PM. It indicated client #2's "health was doing well, Una Boot working with picking...."</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 10/30/14 at 11:25 AM stated as far as she knew "staff had been trained" regarding the application of client #2's Una Boot.</p>		<p>classroom and on-the-job training that provided the training and experience needed to perform their duties. Training is also provided on at least a monthly basis by the Residential Manager, QIDP or other person as needed to insure that the employee has the current and best information in order to complete their job duties and specific individual needs. The Clinical Supervisor, Residential Manager and/ or the QIPD is responsible for ensuring that training and instruction is provided if staff requires additional training in order to prevent reoccurrence of any incident or client need. All training is to be documented and maintained in each employees training file. All staff in the home will receive training on the Una boot application for Client #2. Training will be documented and maintained in the employees training file. The Clinical Supervisor will be responsible for coordinating and for providing the training. Addendum (added 1-10-15): Following staff training, the scheduled day/ time that the Una boot is to be applied was added to the Monthly Treatment Sheet where staff will document when it was changed and who completed the application. This record will also include documentation by each shift that the Una Boot is checked and is applied correctly. This record is monitored by the Residential</p>		

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	<p>Interview with the RN on 10/30/14 at 11:25 AM indicated she could not locate the inservice training for the group home staff regarding the weekly application/changing of client #2's Una Boot.</p> <p>9-3-3(a)</p>		<p>Manager, Nurse and QIDP on at least a weekly basis.</p>				
W000247	<p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. Based on observation and interview for 3 of 4 sampled clients (#2, #3 and #4) and for 3 additional clients (#5, #6 and #8), the facility failed to ensure the clients had a choice in the amount of sugar packets they received.</p> <p>Findings include:</p>	W000247	<p>Staff will also receive training on client rights in regards to making choices. All staff will be trained on client rights. The Residential Manager/QIDP will be responsible for providing this training.</p>	12/10/2014			

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	<p>During the 10/29/14 observation period between 5:50 AM and 8:00 AM, at the group home, staff #4 placed one packet of sweetener at each setting at the table for clients #1, #2, #3, #4, #5, #6, #7 and #8. Clients #1, #2, #3, #4, #5, #6, #7 and #8 had scrambled eggs, a choice of cold cereal, coffee and/or hot tea for breakfast. When the clients were sitting at the dining table getting ready to eat, client #1 was told she could only have black coffee as she had to have fasting labs done. Client #6 looked for her sugar packet on the table and it was gone. Staff #4 asked client #5 if she took client #6's sugar packet as she knew the client would take the sugar packets for extra sugar to place in her coffee. Client #5 told staff #4 she did not take client #6's sugar packet. Client #5 then stated she would like to have 2 sugar packets. Staff #4 stated "You know you all only get one packet for our coffee." Client #7 indicated she did not want any sugar for her tea.</p> <p>Interview with staff #4 on 10/29/14 at 6:35 AM when asked why clients were only allowed to have 1 sugar packet, staff #4 stated "They can only have one. I was told when I was hired." When staff #4 asked how many (clients) want another sugar packet for their coffee, clients #2, #3, #4, #5, #6 and #8 raised their hands</p>		<p>All staff will receive training on active treatment and family style dining expectations to incorporate client involvement to the highest level of their independence during meal preparation and dining. The QIDP is responsible for providing this training.</p> <p>The QIDP and/Residential Manager will complete daily observations at the home for 30days at various meals times to assure staff are meeting expectations with family style dining and active treatment during meal preparation and dining. Additional training will be provided immediately in instances where staff are observed not to be meeting these expectations.</p>	

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W000262	<p>for yes. Staff #4 returned to the kitchen and brought clients #2, #3, #4, #5 and #6 an extra sugar packet to place in their coffee.</p> <p>Interview with staff #1 on 10/29/14 at 7:50 AM when asked why clients were allowed to have only 1 sugar packet, staff #1 stated "They should not be restricted." Staff #1 indicated the clients should choose how many sugar packets they wanted to put in their coffee and/or tea.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview, the Human Rights Committee (HRC) failed to review and approve a restrictive device (Una Boot) for 1 of 4 sampled clients (#2) that have restrictive measures as indicated by their Individual Support Plan (ISP) and/or Behavior Support Plan (BSP). The HRC failed to address client #2's self injurious behavior of picking as well as reactive strategies to implement regarding this behavior and the use of the</p>	W000262	<p>The QIDP is responsible for ensuring that informed consent is provided and approvals are obtained from the client and/ or their guardian prior to presenting the program to the Human Rights Committee for their review and approval. The facility has a written policy and process in which the QIDP is to follow when reviewing information and obtaining these approvals. The facility encourages active participation of</p>	12/10/2014

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	<p>Una Boot.</p> <p>Findings include:</p> <p>An Interdisciplinary Team Meeting note dated 9/19/14 was reviewed on 10/29/14 at 12:50 PM. It indicated client #2's "health was doing well, Una Boot working with picking...Staff are to check [client #2's] room every night - continue with 5 minutes tracking."</p> <p>Review of client #2's records on 10/29/14 at 12:50 PM indicated there was no HRC review and approval for the restrictive use of the Una Boot.</p> <p>Interview with Qualified Intellectual Disabilities Professional (QIDP) on 10/30/14 at 11:25 AM indicated the client's BSP dated 9/19/14 had not been revised to include the restrictive use of the Una Boot. The QIDP stated "I did not know that the Una Boot was considered a restrictive device." The use of the Una Boot as a restrictive measure for client #2 and had not been reviewed and/or approved by the HRC.</p> <p>9-3-4(a)</p>		<p>family and guardian on the IDT when discussion and reviews takes place. If the guardian is not able attend the meeting, the QIDP is responsible for contacting the guardian by phone or scheduling a meeting with them to discuss plans or issues, and then follow up the discussion in writing in order to obtain a signature of the approval.</p> <p>The QIDP will review the ISP and the BSP for client #2 with the guardian to insure that informed consent is obtained and will review the plan with the HRC for approval. The QIDP will also check to ensure that all clients ISP's and Behavior and Restrictive plans have proper approvals and signatures.</p> <p>The QIDP will receive training concerning their responsibilities in reviewing and obtaining proper approvals from the Human Rights Committee. The Program Manager will insure that the training is complete and is documented.</p> <p>The Clinical Supervisor is responsible for reviewing plans on a quarterly basis. The Clinical Supervisor and/or Program Manager will review ISP/BSP and plans that may include restrictions to ensure</p>		

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W000312	<p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 1 of 4 sampled clients (#1), on behavior controlling medications, the facility failed to ensure the client had an active treatment program in the Behavior Support Plan (BSP) for Depression.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 10/29/14 at 11:50 AM.. Client #1's 10/1/14 physician's orders indicated client #1's diagnosis included, but was not limited to, depression. Client #1's physician's orders indicated client #1 received Mirtazapine (Remeron) 45</p>	W000312	<p>proper approvals have been obtained prior to the implementation of the plan.</p> <p>The BSP for all individuals in the home, as well as Client # 1 have been reviewed to insure that a medication reduction plan is in place and are current.</p> <p>The QIDP is responsible to monitor the progress of behavior support goals and report the progress of lack of progress to the physician that monitors the individual's behavior medications. The QIDP reports this progress to the physician and to the team on at least a quarterly basis for review. The QIDP will assure that a medication reduction plan is included</p>	12/10/2014	

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W000331	<p>milligrams at bedtime for depression.</p> <p>Client #1's 9/19/14 Behavior Support Plan (BSP) indicated client #1 demonstrated the targeted behavior of disturbing interpersonal behaviors. Client #1's 9/19/14 BSP did not define client #1's depression and/or specifically include an active treatment program which addressed the behaviors for which the client received Remeron.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 10/30/14 at 11:25 AM indicated when asked how client #1 demonstrated Depression, she stated "isolating in room, don't talk a lot." The QIDP indicated client #1's BSP did not clearly define client #1's depression and/or include an active treatment program which addressed the client's behaviors for which the client received the Remeron.</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview,</p>	W000331	<p>in each individual Behavior Support Plan and that a medication reduction is initiated on at least an annual basis. Each QIDP will receive training on their responsibilities for monitoring and reporting progress to the IDT and physician.</p> <p>The Program Manager and/or designee is responsible for reviewing each individual client record on at least a quarterly basis.</p> <p>A physicians order has been obtained for the use of the Una</p>	12/10/2014

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	<p>the facility nursing services failed to ensure for 1 of 4 sampled clients (client #2), to provide a physician's order for the use of an Una Boot for client #2.</p> <p>Findings include:</p> <p>Client #2's January through October 2014 physician's orders were reviewed on 10/29/14 at 12:50 PM. No physician's order for an Una Boot for client #2 was located.</p> <p>The Interdisciplinary Team Meeting note dated 9/19/14 was reviewed on 10/29/14 at 12:50 PM. It indicated client #2's "health was doing well, Una Boot working with picking...."</p> <p>Interview with the Administrative Staff AS #3 (Nurse), at 10/30/14 on 11:25 AM indicated client #2 had been prescribed an Una Boot by the physician to reduce open sores caused by client #2's picking behavior. AS #3 indicated she was unable to locate a physician's order for the Una Boot for client #2.</p> <p>9-3-6(a)</p>		<p>Boot for client #3. Client #3 had previously had a physician's order for the bot, however it had expired. When the IDT determined that the Una boot would be beneficial in assisting in the prevention of ongoing issues with the client's leg wound, the nurse mistakenly did not renew the order for the continuation of the treatment. It is the responsibility of the nurse to review physicians orders for changes and initiate the process of receiving physician orders as needed when individuals needs change. The nurse then reports needs, changes and progress to the IDT on a Quarterly or as needed basis to discuss changes and needs in the individual's health care. The team discusses and agrees upon recommendations from other health care disciplines that are involved. All current nurses will complete training on their expectations with this process and for insuring that a physician's order is obtained for all treatments and medications. The Director of Health Services is responsible for completing this training. An audit of the current client charts will be conducted by the Nurse and the Director of Health Services to review all treatments to insure that all orders are current. The Home nurse will continue to review physician's orders and treatments with the IDT on at least a</p>		

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W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and for 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure clients were involved in all aspects of the meal preparation and serving/family style.</p> <p>Findings include:</p> <p>During the 10/28/14 observation period between 3:50 PM and 7:25 PM, at the group home, staff #3 cut up green peppers and onions while client #4 stood in the kitchen and watched. Staff #3 rolled the hamburger up into large balls</p>	W000488	<p>quarterly basis to insure that orders are current. Addendum (added 1-10-15): Following staff training, the scheduled day/ time that the Una boot is to be applied was added to the Monthly Treatment Sheet where staff will document when it was changed and who completed the application. This record will also include documentation by each shift that the Una Boot is checked and is applied correctly. This record is monitored by the Residential Manager, Nurse and QIDP on at least a weekly basis.</p> <p>All staff will receive training on active treatment and family style dining expectations to incorporate client involvement to the highest level of their independence during meal preparation and dining. The QIDP is responsible for providing this training. The QIDP and/Residential Manager will complete daily observations at the home for 30days at various meals times to assure staff are meeting expectations with family style dining and active treatment during meal preparation and dining. Additional training will be provided immediately in instances where staff are observed not to be meeting these expectations.</p>	12/10/2014

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	<p>and placed them into a baking dish. Clients #3 and #6 interchangeably assisted with cooking the dinner meal. The clients retrieved pots out of the cabinet, stirred the spinach on the stove, assisted in washing the potatoes to bake, and placed rolls on a cookie sheet. Client #4 also set the table in the dining room with verbal and physical prompts. Staff #3 placed the Salisbury steak/balls, spinach and rolls into the oven without involving client #6, who was in the kitchen. Once the food was done, staff #3 removed the food from the oven and carried the food to the table without involving clients #1, #2, #3, #4, #5, #6, #7 and #8 who sat in the living room areas watching TV/waiting to eat. Staff #4 carried the cookie sheet of rolls around to each client without teaching and/or encouraging the clients to pass the rolls to each other. Staff #3 placed spinach onto client #1, #3, #4, #5, #6 and #7's plates without involving and/or encouraging the clients to serve themselves. Staff #2 then placed a Salisbury steak patty/ball onto clients #1, #2, #3, #4, #5, #6, #7 and #8's plate without involving the clients. Staff #1 poured milk into each cup/glass of clients #1, #2, #3, #4, #5, #6, #7 and #8's cups without involving the clients. At one point while staff was passing food around and serving the clients, staff #1 indicated</p>			
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	<p>to clients #1, #2, #3, #4, #5, #6, #7 and #8 they should slow down in eating as the clients would be done before staff could sit down and eat with them. Staff #1, #2 and #3 were serving the clients at the time. Client #4 asked if she could go get the sour cream for her potato. Staff #1 told client #4 she (staff #1) would go to the kitchen and get the sour cream.</p> <p>During the 10/29/14 observation period between 5:50 AM and 8:00 AM, at the group home, staff #4 poured coffee for clients #1, #2, #3, #4, #5, #6 and #8 as clients #1, #2, #3, #4, #5, #6 and #8 sat at the table waiting to eat their breakfast. Staff #4 did not ask and/or provide hand over hand training for the clients to pour their own coffee, and/or provide training on how to handle hot items. Staff #4 asked client #4 if she wanted help pouring her milk into a cup/glass. Client #4 stated "help me." Staff #4 picked up the client's cup/glass and poured the milk without assisting client #4 to pour her own milk. During the above mentioned 10/29/14 breakfast meal, clients #1, #2, #3, #4, #5, #6 and #8 were able to serve themselves/placed eggs on their own plates, and poured cereal into their bowls independently.</p> <p>Interview with staff #1 on 10/29/14 at 7:50 AM stated facility staff did not do</p>						

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W009999	<p>the "family style dining right." Staff #1 indicated clients should have been encouraged to pass the food items and to serve themselves. Staff #1 indicated she spoke to facility staff about family style dining after the surveyors left.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 10/30/14 at 11:25 AM indicated staff should involve clients #1, #2, #3, #4, #5, #6, #7 and #8 in all aspects of the meal preparation. The QIDP indicated clients #1, #2, #, #4, #5, #6, #7 and #8 should eat family style dining. The QIDP indicated she was aware family style dining was an issue at the group home.</p> <p>9-3-8(a)</p> <p>STATE FINDINGS</p> <p>The following Community Residential Facilities For Persons With Developmental Disabilities rules were not met.</p> <p>1. 460 IAC 9-3-1 Governing Body Section 1.(b) The residential provider shall report the following circumstances to the division by telephone no later than</p>	W009999	<p>1.460 IAC 9-3-1 Governing Body: Alleged, suspected or actual neglect (which must also be reported to Adult Protective Services) which includes but is not limited to: b. "failure to provide a safe, clean and sanitary environment.</p> <p>The facility does not feel that it was neglectful in providing a safe, clean and sanitary environment as cited by the surveyors. The</p>	12/10/2014			

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	<p>the first business day followed by written summaries as requested by the division.</p> <p>"Incidents to be reported to BQIS (Bureau of Quality Improvement Services) included any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual including but not limited to:</p> <p>2. Alleged, suspected or actual neglect (which must also be reported to Adult Protective Services) which includes but is not limited to:</p> <p>b. failure to provide a safe, clean and sanitary environment."</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to provide a safe, clean and sanitary environment for 1 of 4 sampled clients (#2).</p> <p>Findings include:</p> <p>Record review of Client #2 was completed on 10/29/14 at 12:50 PM. The Individual Nursing Note dated 9/3/14 indicated client #2 "...was seen at the hair</p>		<p>individual was noted to have possible evidence of lice while receiving a haircut, although no live or evidence lice was found when examined at home. As a precaution, the facility immediately obtained treatment for all persons involved as a precautionary measure, thus providing a safe, clean and sanitary environment. Client #2 had been in several other environments other than her home in which she could have contracted the possibility of lice. The facility did not report this incident as neglect as it was not recognized to meet the definition at that time. However, the facility in the future will report circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division including any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual including but not limited to alleged, suspected or actual neglect (which will also be reported to Adult Protective Services) which includes but is not limited to failure to provide a safe, clean and sanitary environment. The Clinical Supervisor is responsible for completing and submitting reportable incidents to BDDS, BQIS, APS, ISDH and others as indicated. They will complete</p>	

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	<p>salon and found to have head lice. New orders received per primary care physician [doctor's name] indicated client #2 should begin taking 'Permethrin Shampoo' use as directed - repeat 10 days after first application."</p> <p>Interview with the facility RN on 10/30/14 at 11:25 AM indicated client #2 had gone to the hair salon on 9/3/14 and was noted as having head lice per her cosmetologist. The RN stated "all of the other clients at the group home were also treated for head lice as well."</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 10/30/14 at 11:25 AM indicated the incident of head lice for client #2 had not been reported to BQIS.</p> <p>9-3-1(b)</p> <p>2. 460 IAC 9-3-2 Resident Protections</p> <p>Section 2(c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as</p>		<p>additional training on the expectations of the Community Residential Facilities for Persons with DD for reporting incidents of alleged, suspected or actual neglect. The Executive Director will insure that this training is completed. The Program Manager is responsible to insure that all reportable incidents are submitted by the Clinical Supervisors in a timely and appropriate fashion as required.</p> <p>2. 460 IAC 9-3-2 Resident Protections - Section 2(c) – (Employment Practices)</p> <p>The facility maintains strict policy and procedures on conducting bureau of motor vehicles record checks, a criminal history check, a wide variety of background checks and obtaining three references PRIOR to offering a position to any employee. All of these records are maintained in the employee personnel file. The Human Resource Specialist is responsible for obtaining and maintaining these records. The facility has not been able to find an employee file that was missing a reference form as identified in the survey. The Human Resources Specialist is fully aware of the policies and expectations of obtaining references for employees. The Executive Director has recently discussed her responsibility to insure understanding and compliance. The Human</p>	

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	<p>authorized in IC-5-3-5-5, and three references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 10 personnel records reviewed, the facility failed to provide documentation of a completed reference check for DSP (Direct Support Professional) #3.</p> <p>Findings include:</p> <p>DSP #3's employee file was reviewed on 10/28/14 at 3:30 PM. DSP #3's employee file did not indicate documentation of completed reference checks.</p> <p>Interview with Administrative Staff-AS #2 (Human Resources Manager) on 10/28/14 at 12:45 pm stated "The company [name of facility] only requires 2 reference checks on all new employees."</p> <p>9-3-2(c)(3)</p>		Resource Specialist completes a checklist upon hire to insure that all required information is obtained. Additionally, the Hiring Software and Payroll program that the facility uses has a quality assurance section that asks for each item to be checked off as it is completed. On a quarterly basis, the facility conducts a random check of at least 10 employee files during an agency audit. One of the checkpoints is to insure that at least 3 references are completed for each employee. Any issues noted at that time are resolved immediately. The Executive Director is responsible for the initiation of and follow-up to the quarterly audit.		

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

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