

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G720		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/26/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 82 BENNY LN NORTH VERNON, IN 47265			
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: February 24, 25 and 26, 2014</p> <p>Facility number: 004396 Provider number: 15G720 AIM number: 200511360</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/4/14 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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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 1 of 2 clients in the sample (#1), the governing body failed to ensure client #1 did not pay for his own haircut.</p> <p>Findings include:</p> <p>A review of the client's finances was conducted on 2/24/14 at 3:33 PM. Client #1's Cash on Hand Record, dated 5/17/13 to 10/12/13 indicated client #1 paid \$10.00 for a haircut on 7/6/13. There was no documentation indicating the facility reimbursed client #1 the \$10.00 he paid for his haircut.</p> <p>On 2/24/14 at 3:33 PM, the Program Director indicated the facility should pay for the client's haircut.</p> <p>On 2/26/14 at 1:38 PM, the Area Director indicated the facility should pay for the client's haircut.</p> <p>9-3-1(a)</p>	W000104	Client will be reimbursed by Indiana Mentor. AD will retrain PD and HM on client expenses and Agency responsibilities. What's covered under per diem rate and what clients are responsible for paying for with their personal funds. PD will review finances for all clients and determine if there were any other clients affected by this deficient practice. If any other clients were affected then those clients will be reimbursed by Indiana Mentor for those items that Indiana Mentor is responsible to pay. PD will retrain all staff on policy. HM will review finances weekly to ensure policy is being implemented. PD will review policy monthly to ensure policy is being implemented. AD will review monthly for 3 months to ensure policy is being implemented. Following 3 months AD will complete routine quarterly audits to ensure that policy is being implemented correctly.	03/28/2014			

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W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</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. Based on record review and interview for 2 of 2 non-sampled clients (#2 and #3), the facility failed to keep an accurate accounting of the clients' finances.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 2/24/14 at 3:33 PM and indicated the following:</p> <p>Client #2's February 2014 Cash on Hand ledger indicated client #2 should have \$11.92. Upon counting the money, the Program Director (PD) indicated client #2 had \$22.22. There was no documentation accounting for the discrepancy between the ledger and actual cash on hand.</p> <p>Client #3's February 2014 Cash on Hand ledger indicated client #3 should have \$39.83. Upon counting the money, the PD indicated client #3 had \$39.92. There was no documentation accounting for the discrepancy between the ledger and actual cash on hand.</p> <p>On 2/25/14 at 9:56 AM, the Home</p>	W000140	<p>After review of all client finances it was determined that no other clients were affected by this deficient practice. Area Director will retrain PD and HM on client finances, including balancing and counting petty cash. HM will check petty cash weekly and balance to ledger to ensure accuracy. PD will check petty cash monthly and balance to ledger to ensure accuracy. AD will check petty cash 1x a month for 3 months to ensure that correct procedures are being completed. Following 3 month period, AD will complete routine quarterly audits to ensure that policy continues to be implemented correctly.</p>	03/28/2014			

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	<p>Manager (HM) indicated the facility should account for the clients' finances to the penny.</p> <p>On 2/25/14 at 9:56 AM, the PD indicated the facility should account for the clients' finances to the penny.</p> <p>On 2/26/14 at 1:38 PM, the Area Director indicated the facility should account for the clients' finances to the penny.</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. Based on record review and interview for 3 of 7 incident/investigative reports reviewed affecting clients #1, #2 and #4, the facility neglected to implement its policies and procedures for conducting an investigation of client #1's fractured ankle and reporting incidents of unknown injuries to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/24/14 at 1:23 PM and indicated the following:</p> <p>1) On 5/2/13 at 5:30 PM, the Mentor Network - Incident Report indicated, in part, "Follow-up with MD (medical doctor) on swollen ankle. Ankle (right) found to be fractured. MD ordered boot & (and) will consult orthopedist for appointment." The Bureau of Developmental Disabilities Services (BDDS) report, dated 5/3/13, indicated, "[Client #1] diagnosed with a fractured right ankle. [Client #1] hit the wall in his powerchair at the Day Services on</p>	W000149	Per initial review of incident reports no other clients are found to be affected by this deficient practice. AD will retrain PD on investigation policy and procedures including those incidents that require investigations to be completed, including abuse, neglect and exploitation. PD will ensure that all incidents requiring an investigation are completed within 5 days and submitted to AD for review. AD will review incidents and investigations weekly to ensure policy is being implemented.	03/28/2014			

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	<p>4/17/13. RN (Registered Nurse) looked at foot several times that day and had ice applied and elevation. Before going home bruise had faded and [client #1] did not complain of pain. Foot noted as bruised along the other edge on 4/18 and that [client #1] did not want to bear weight. On 4/18/13 [client #1] hit the corner of the wall with his right foot/ankle at his home while driving his powerchair again. Staff asked if he was ok or in pain and he indicated he was fine. On 4/19/13 in the evening staff noted his right ankle was swollen so RN was consulted. She instructed he be seen so sent to Urgent Care due to time of day. MD instructed staff to elevate his leg, apply heat for 20 mins (minutes) 4x (four times) a day over the weekend, use ibuprofen every 6 hours as needed for pain, and no follow-up instructed unless symptoms worsen. RN talked with Home Manager on 4/22 and ankle was not swollen and [client #1] was denying pain. Staff noted foot to continue to be bruised in various stages. RN examined ankle area on 4/25. [Client #1] denied pain and according to staff, had been using leg/foot for some time at times to re-position self but had limited weight bearing on it. 5/1/13 RN examined again, per staff request, his ankle/foot area this time. Big toe and 2nd toe noted as bruised and tender and some swelling noted of ankle</p>			
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	<p>and top of foot. [Client #1] communicated he had run into a chair again at Day Services that day while in his powerchair. Appointment scheduled for 5/2/13 with MD in PCP (primary care physician) practice. X-rays revealed fractured ankle. MD ordered boot to be applied when obtained from pharmacy on 5/3/13, keep leg/foot elevated, no weight bearing on right leg. Lortab prescribed for pain as needed, and MD office will set up consult with Orthopedist for Monday or as soon as possible." There was no documentation the facility conducted an investigation into the fracture. There was no documentation of client #1 or the staff at the group home and facility-operated day program being interviewed. There was no documentation in the BDDS report indicating client #1's wheelchair did not have the proper footrests at the time of the incident.</p> <p>A review of client #1's record was conducted on 2/25/14 at 8:37 AM. An email, dated 5/3/13, from the Program Director (PD), to the wheelchair repair company employee indicated, in part, "Where are we in the process of getting the proper footrests for [client #1's] chair? [Client #1] now has a fractured ankle - not really in part from the footrests but because he is running into</p>			
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	<p>things, but having the right footrests would surely offer a little more 'protection' (lack of a better word) for his feet/ankles. If you can just let me know where we stand in the process."</p> <p>On 2/25/14 at 9:56 AM, the Program Director (PD) indicated she was not able to find a full investigation into client #1's fractured ankle. The PD indicated an investigation was not conducted. The PD indicated she had notes regarding the situation but did not document them in an investigation. The PD indicated there were witnesses of client #1 hitting his foot/ankle on items while driving his wheelchair and she felt the information she submitted in the BDDS report was sufficient for the incident.</p> <p>On 2/24/14 at 1:38 PM, the Area Director (AD) indicated an investigation should have been conducted into client #1's fractured ankle. On 2/26/14 at 1:38 PM, the AD indicated she contacted the PD and the Quality Assurance Specialist and neither had conducted an investigation. The AD indicated an investigation should have been conducted.</p> <p>2) On 11/16/13 at 10:45 AM (reported to BDDS on 11/18/13), client #2 was found to have a bruise on her foot of an unknown origin. The BDDS report,</p>						

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	<p>dated 11/18/13, indicated, in part, "Staff, [staff #5], reported that she discovered a bruise of significant size on the top (of her foot) of consumer, [client #2]. [Client #2] was asked if she had hit her foot on anything or bumped into anything while in her chair and she could not remember anything happening."</p> <p>On 2/24/14 at 1:38 PM, the Area Director (AD) indicated the timeframe for reporting incidents to BDDS was 24 hours.</p> <p>3) On 10/8/13 at 11:00 AM, while transferring client #4 to change her Depends, staff found a purple bruise, one inch long by 1/4 inch wide, on her left upper arm on the inside of an unknown origin. The facility reported the incident to BDDS on 10/10/13.</p> <p>On 2/24/14 at 1:38 PM, the Area Director (AD) indicated the timeframe for reporting incidents to BDDS was 24 hours.</p> <p>A review of the facility's abuse and neglect policy, dated April 2011, was conducted on 2/24/14 at 11:57 AM. The policy indicated the following, "Any allegation of abuse or human rights violation is thoroughly investigated by the Area Director in consultation with</p>						

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	<p>Human Resources Department and/or Quality Assurance/Risk Management Department." The policy indicated, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e. Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment... o. The following actions are prohibited by employees of Indiana MENTOR: 1) abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds. 2) violation of an individual's rights." The policy indicated, "Indiana MENTOR is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. 1. Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident."</p> <p>9-3-2(a)</p>				

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 of 7 incident reports reviewed affecting clients #2 and #4, the facility failed to submit incident reports (unknown injuries) to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/24/14 at 1:23 PM and indicated the following:</p> <p>1) On 11/16/13 at 10:45 AM (reported to BDDS on 11/18/13), client #2 was found to have a bruise on her foot of an unknown origin. The BDDS report, dated 11/18/13, indicated, in part, "Staff, [staff #5], reported that she discovered a bruise of significant size on the top (of her foot) of consumer, [client #2]. [Client #2] was asked if she had hit her foot on anything or bumped into anything while in her chair and she could not remember anything happening."</p>	W000153	Per initial review, no other clients were found to be affected by deficient practice. Area Director will retrain PD on incident reporting, including the BDDS definition of a reportable incident. PD will retrain Home Manager and all staff on BDDS reportable incidents, including abuse, neglect and exploitation. Home Manager will review daily support logs daily to ensure that all incidents that meet the BDDS definition have been reported per Indiana Mentor policy to the Program Director. PD will review daily support records weekly to ensure that all incidents that meet the BDDS definition of reportable incidents have been reported to BDDS. PD will ensure that all incidents that meet the BDDS definition of reportable incidents are reported to BDDS within 24 hours. Area Director will review daily support logs monthly to ensure that all incidents meeting the BDDS definition of reportable incidents have been reported to BDDS.	03/28/2014
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	<p>2) On 10/8/13 at 11:00 AM, while transferring client #4 to change her Depends, staff found a purple bruise, one inch long by 1/4 inch wide, on her left upper arm on the inside of an unknown origin. The facility reported the incident to BDDS on 10/10/13.</p> <p>On 2/24/14 at 1:38 PM, the Area Director (AD) indicated the timeframe for reporting incidents to BDDS was 24 hours.</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 1 of 7 incident/investigative reports reviewed affecting client #1, the facility failed to conduct an investigation of client #1's fractured ankle.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/24/14 at 1:23 PM and indicated the following: On 5/2/13 at 5:30 PM, the Mentor Network - Incident Report indicated, in part, "Follow-up with MD (medical doctor) on swollen ankle. Ankle (right) found to be fractured. MD ordered boot & (and) will consult orthopedist for appointment." The Bureau of Developmental Disabilities Services report, dated 5/3/13, indicated, "[Client #1] diagnosed with a fractured right ankle. [Client #1] hit the wall in his powerchair at the Day Services on 4/17/13. RN (Registered Nurse) looked at foot several times that day and had ice applied and elevation. Before going home bruise had faded and [client #1] did not complain of pain. Foot noted as bruised along the other edge on 4/18 and that [client #1] did not want to bear</p>	W000154	Per initial review of incident reports no other clients are found to be affected by this deficient practice. AD will retrain PD on investigation policy and procedures including those incidents that require investigations to be completed, including abuse, neglect and exploitation. PD will ensure that all incidents requiring an investigation are completed within 5 days and submitted to AD for review. AD will review incidents and investigations weekly to ensure policy is being implemented.	03/28/2014
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	<p>weight. On 4/18/13 [client #1] hit the corner of the wall with his right foot/ankle at his home while driving his powerchair again. Staff asked if he was ok or in pain and he indicated he was fine. On 4/19/13 in the evening staff noted his right ankle was swollen so RN was consulted. She instructed he be seen so sent to Urgent Care due to time of day. MD instructed staff to elevate his leg, apply heat for 20 mins (minutes) 4x (four times) a day over the weekend, use ibuprofen every 6 hours as needed for pain, and no follow-up instructed unless symptoms worsen. RN talked with Home Manager on 4/22 and ankle was not swollen and [client #1] was denying pain. Staff noted foot to continue to be bruised in various stages. RN examined ankle area on 4/25. [Client #1] denied pain and according to staff, had been using leg/foot for some time at times to re-position self but had limited weight bearing on it. 5/1/13 RN examined again, per staff request, his ankle/foot area this time. Big toe and 2nd toe noted as bruised and tender and some swelling noted of ankle and top of foot. [Client #1] communicated he had run into a chair again at Day Services that day while in his powerchair. Appointment scheduled for 5/2/13 with MD in PCP (primary care physician) practice. X-rays revealed fractured ankle. MD ordered boot to be</p>			
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	<p>applied when obtained from pharmacy on 5/3/13, keep leg/foot elevated, no weight bearing on right leg. Lortab prescribed for pain as needed, and MD office will set up consult with Orthopedist for Monday or as soon as possible." There was no documentation the facility conducted an investigation into the fracture. There was no documentation of client #1 or the staff at the group home and facility-operated day program being interviewed. There was no documentation in the BDDS report indicating client #1's wheelchair did not have the proper footrests at the time of the incident.</p> <p>A review of client #1's record was conducted on 2/25/14 at 8:37 AM. An email, dated 5/3/13, from the Program Director (PD), to the wheelchair repair company employee indicated, in part, "Where are we in the process of getting the proper footrests for [client #1's] chair? [Client #1] now has a fractured ankle - not really in part from the footrests but because he is running into things, but having the right footrests would surely offer a little more 'protection' (lack of a better word) for his feet/ankles. If you can just let me know where we stand in the process."</p> <p>On 2/25/14 at 9:56 AM, the Program</p>			
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	<p>Director (PD) indicated she was not able to find a full investigation into client #1's fractured ankle. The PD indicated an investigation was not conducted. The PD indicated she had notes regarding the situation but did not document them in an investigation. The PD indicated there were witnesses of client #1 hitting his foot/ankle on items while driving his wheelchair and she felt the information she submitted in the BDDS report was sufficient for the incident.</p> <p>On 2/24/14 at 1:38 PM, the Area Director (AD) indicated an investigation should have been conducted into client #1's fractured ankle. On 2/26/14 at 1:38 PM, the AD indicated she contacted the PD and the Quality Assurance Specialist and neither had conducted an investigation. The AD indicated an investigation should have been conducted.</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 for 2 of 4 clients living in the group home (#1 and #3), the facility failed to ensure the staff implemented the clients' program plans as written.</p> <p>Findings include:</p> <p>1) An observation was conducted at the facility-operated day program on 2/24/14 from 12:30 PM to 1:17 PM. During the observations at the day program, client #1 did not have and was not prompted to use a communication device. Observations were conducted at the group home on 2/24/14 from 3:33 PM to 6:08 PM and 2/25/14 from 6:03 AM to 7:59 AM. On 2/24/14 at 3:48 PM, client #1's communication device (Dynavox) was on a desk in the living room at the group home. The device was present at the group home prior to client #1 returning to the group home from the facility-operated day program. On 2/25/14 at 7:59 AM when client #1 was leaving the group home to go to the day program, his</p>	W000249	<p>PD will retrain staff on all goals and objectives for all 4 clients including, client #1 communication objective and client # 3 mealtime objectives. Supervisory staff will complete observations 3x a week for 4 weeks to ensure that objectives are being completed properly. Following 4 weeks, supervisory staff will complete monthly observations on an ongoing basis to ensure goals and objectives are being implemented.</p>	03/28/2014			

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	<p>communication device was on the desk in the living room.</p> <p>On 2/25/14 at 8:37 AM, client #1's record review was conducted. Client #1's Individual Support Plan (ISP), dated 1/10/14, indicated he had a training objective to increase his ability to express who he is and his choices using his Dynavox.</p> <p>On 2/25/14 at 7:50 AM, staff #4 indicated client #1 did not take his communication device to the day program. Staff #4 stated, "Don't want (communication device) out of the house until he can use it better."</p> <p>On 2/25/14 at 9:56 AM, the Home Manager (HM) indicated the facility did not send client #1's communication device to the day program. The HM stated, "We just haven't started sending. We should, I guess."</p> <p>On 2/26/14 at 1:38 PM, the Area Director (AD) indicated client #1's training objective should be implemented across settings. The AD indicated client #1 used to take his communication device to the day program and she was not sure why he stopped taking it to the day program.</p> <p>2) Observations were conducted at the</p>						

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	<p>group home on 2/24/14 from 3:33 PM to 6:08 PM and 2/25/14 from 6:03 AM to 7:59 AM. On 2/24/14 at 5:58 PM, client #3 started eating. Staff #8 was not observed to ask client #3 if she was ready for a drink, prompt client #3 to pick up her cup or hold her cup. Staff #8 poured client #3's drink, held the cup to client #3's mouth and staff put the cup on the table. On 2/25/14 at 6:56 AM, client #3 was observed eating her breakfast with assistance from staff #2. Staff #2 was not observed to ask client #3 if she was ready for a drink, prompt client #3 to pick up her cup or hold her cup. Staff #2 poured client #3's drink, held the cup to client #3's mouth and staff put the cup on the table.</p> <p>On 2/25/14 at 10:02 AM, a focused review of client #3's record was conducted. Client #3's ISP, dated 1/22/14, indicated she had a mealtime training objective to hand her cup back to staff after drinking. The steps included staff asking client #3 if she was ready for a drink, staff filling the cup with 5 milliliters of fluid, client #3 picking up the cup, client #3 holding the cup, client #3 tipping her head and cup to drink, and staff to ask her for the cup back.</p> <p>On 2/25/14 at 9:56 AM, the HM indicated client #3's mealtime training</p>				

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	<p>objective should be implemented at every meal.</p> <p>On 2/26/14 at 1:38 PM, the Area Director (AD) indicated client #3's training objective should be implemented at every meal. The AD indicated client #3 needed numerous prompts to pick up her cup.</p> <p>9-3-4(a)</p>			
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W000340	<p>483.460(c)(5)(i) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. Based on observation and interview for 2 of 4 clients living at the group home (#3 and #4), the facility failed to ensure the staff cleaned the clients' pill crushers in between uses.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 2/25/14 from 6:03 AM to 7:57 AM. On 2/25/14 at 6:34 AM, client #4 received her medications from staff #4. Client #4's pill crusher had a white film and pill residue in the pill crusher prior to staff #4 crushing client #4's pills. At 7:08 AM, client #3's pill crusher was observed prior to client #3 receiving her medications from staff #4. Client #3's pill crusher had a white film on the inside of the container with pill residue on the bottom of the crusher.</p> <p>On 2/25/14 at 6:34 AM, staff #4 indicated the pill crushers should be washed after each use.</p> <p>On 2/25/14 at 9:56 AM, the Home</p>	W000340	<p>PD will retrain staff on cleaning pill crushers after each use for all 4 clients as each client has been affected by this deficient practice..Supervisory staff will complete observations 3x a week for 4 weeks to ensure that staff are properly cleaning pill crushers after each use.Following 4 weeks supervisory staff will complete monthly observations to ensure staff continue to clean pill crushers after each use.</p>	03/28/2014
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	<p>Manager (HM) indicated the clients' pill crushers should be washed after each use.</p> <p>On 2/26/14 at 1:38 PM, the Area Director indicated the clients' pill crushers should be washed after each use.</p> <p>9-3-6(a)</p>			
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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review for 1 of 2 non-sampled clients (#3), the facility failed to ensure client #3's wheelchair was in good repair.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/24/14 from 3:33 PM to 6:08 PM and 2/25/14 from 6:03 AM to 7:59 AM. During the observations, client #3's manual wheelchair had tears and cracks on both armrests covered with duct tape. Client #3's right brake was not working. On 2/25/14 at 7:47 AM, client #3 was rolling around in circles in the living room. The left brake on her wheelchair was engaged causing her to roll in circles.</p> <p>On 2/25/14 at 6:17 AM, staff #2 indicated client #3's wheelchair brake on the right side did not function correctly. Staff #2 indicated the right brake was broken and unable to be engaged.</p> <p>On 2/25/14 at 9:56 AM, the Home Manager (HM) indicated she was aware</p>	W000436	AD will contact pharmacy to have adaptive equipment added to the treatment sheet for all clients prompting staff to check that all adaptive equipment is present and in good condition. PD will retrain staff on use of treatment sheet to check adaptive equipment and notification process if something is not in good condition. HM will check adaptive equipment weekly to ensure working properly. PD will check adaptive equipment monthly to ensure working properly. Any issues with adaptive equipment will be reported to Program Director within 24 hours and all necessary steps will be taken to repair or replace adaptive equipment in a timely manner.	03/28/2014

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	<p>of the issues with client #3's wheelchair and an appointment was scheduled to address the repairs needed.</p> <p>On 2/25/14 at 9:56 AM, the Program Director (PD) indicated she was aware of client #3's wheelchair issues and scheduled an appointment in April 2014 to have client #3's wheelchair repaired.</p> <p>On 2/26/14 at 1:38 PM, the Area Director (AD) indicated she was aware client #3's wheelchair needed repairs. The AD indicated the facility should ensure client #3's wheelchair remained in good repair.</p> <p>9-3-7(a)</p>			
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W000440	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to ensure an evacuation drill was conducted quarterly for each shift.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 2/24/14 at 3:12 PM. The facility did not conduct an evacuation drill during the night shift (11:00 PM to 7:00 AM) from 9/7/13 to 2/24/14. The facility was unable to provide documentation a night shift drill had been conducted since 9/7/13. This affected clients #1, #2, #3 and #4.</p> <p>On 2/24/14 at 3:29 PM, the Program Director (PD) indicated the facility should conduct one drill per shift per quarter.</p> <p>On 2/25/14 at 9:56 AM, the Home Manager (HM) indicated the facility should conduct one drill per shift per quarter.</p> <p>On 2/26/14 at 1:38 PM, the Area Director (AD) the facility should conduct quarterly evacuation drills for each shift.</p>	W000440	<p>PD will retrain staff on evacuation drills and scheduleHM will review drills upon completion to ensure that staff are following schedule rotation. PD will review drills upon completion to ensure staff are following schedulelf drills were not completed per schedule then another drill will be completed that meets schedule requirements within that month period.</p>	03/28/2014			

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W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(a) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division:</p> <p>11. An emergency intervention for the individual resulting from: a. a physical symptom. 15. A fall resulting in injury, regardless of the severity of the injury.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 7 incident reports reviewed affecting clients #1 and #2, the facility failed to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was</p>	W009999	Per initial review, no other clients were found to be affected by deficient practice. Area Director will retrain PD on incident reporting, including the BDDS definition of a reportable incident. PD will retrain Home Manager and all staff on BDDS reportable incidents, including abuse, neglect and exploitation. Home Manager will review daily support logs daily to ensure that all incidents that meet the BDDS definition have been reported per Indiana Mentor policy to the Program Director. PD will review daily support records weekly to ensure that all incidents that meet the BDDS definition of reportable incidents have been reported to BDDS. PD will ensure that all incidents that meet the BDDS definition of reportable incidents are reported to BDDS within 24 hours. Area Director will review daily support logs monthly to ensure that all incidents meeting the BDDS definition of reportable incidents have been reported to BDDS.	03/28/2014			

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	<p>conducted on 2/24/14 at 1:23 PM and indicated the following:</p> <p>1) On 11/3/13 at 7:30 PM, client #2 was congested, coughing and running a fever of 101 degrees Fahrenheit. RN (Registered Nurse) contacted and sent her to the emergency room for an evaluation. The incident was reported to BDDS on 11/5/13.</p> <p>2) On 4/21/13 at 12:55 PM, client #1 was sitting on the toilet. Client #1 would not sit up properly on the toilet and allowed himself to fall over sideways resulting in him landing on the floor. The Mentor Network - Incident Report, dated 4/21/13, indicated, "Client/Individual Injury By: fall (checked)." The incident report indicated, "While sitting on the toilet [client #1] would not sit up properly, allowing himself to fall over sideways and break gait belt resulting in him landing on the floor." There was no documentation of a description of the injury. There was no documentation the fall with injury was reported to BDDS.</p> <p>On 2/24/14 at 1:38 PM, the Area Director (AD) indicated the timeframe for reporting incidents to BDDS was 24 hours. The AD indicated a fall with an injury should be reported to BDDS.</p>						

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