

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G296	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/12/2014
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 417 W WALNUT ST KOKOMO, IN 46901
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 8/26, 8/27, 8/28, 9/4, 9/11, and 9/12/2014.</p> <p>Facility Number: 000815 Provider Number: 15G296 AIM Number: 100249080</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed September 25, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on observation, interview, and record review, for 1 of 4 sampled clients (client #4), and three additional clients (clients #5, #6, and #7) who attended day services in the classroom at workshop, the facility failed to ensure the contracted workshop implemented individual</p>	W000120	The IDT meet annually to determine goals and objectives for the clients. Goals are tracked and reviewed and the IDT meets at workshop monthly to review individual progress. Additionally members of management do checks on the clients while attending workshop. Indiana	10/10/2014

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>support plan (ISP) objectives and provided active treatment during formal and informal opportunities for client interaction and money skills training.</p> <p>Findings include:</p> <p>Observations were completed on 8/27/14 from 9:15am until 10:35am at the workshop for clients #4, #5, #6, and #7 in the classroom. At 9:50am, Workshop Staff (WKS) #1 retrieved a box of brown plastic disks, silver plastic disks, lime green paper with \$1.00, \$5.00, and \$10.00 of non United States Currency items. Client #6 was prompted to identify a quarter. Client #6 shook her head "no" and WKS #1 held up a large silver plastic disk and indicated it was a quarter. Clients #5, #6, and #7 did not respond when offered plastic disks as coins. WKS #1 indicated clients #4, #5, #6, and #7's ISP (Individual Support Plan) goals/objectives were not run with the use of United States Currency. WKS #1 stated the "play money" did not have the same texture, weight, or visual identification of United States Currency.</p> <p>From 9:15am until 10:35am, client #4 was provided boxes of simulated work and stayed on task to complete. No interaction with facility staff was observed and no encouragement to</p>		<p>Mentor met immediately with the classroom staff and had the fake money pulled from the program and ensured resources were in place for them to use the real money. Management did a quality check to ensure staff were engaged with the consumers. Mentor is continuing monthly meetings with workshop. On going Indiana Mentor is doing at least 2 checks on a month at the workshop with at least one of them being an unannounced visit. During these checks we will check on active treatment and ensure proper currency is in place. Additionally Indiana Mentor will continue its monthly meetings with Bona Vista staff. Responsible Party: QMRP/House Manager Complete Date: 10/10/14</p>				

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	<p>participate in other activities was encouraged.</p> <p>From 9:15am until 10:35am, client #6 sat in rain soaked wet slacks at a table and was not offered the opportunity to change her clothing.</p> <p>From 9:15am until 10:15am, clients #5 and #7 sat in the classroom. Client #5 slept upright in a chair inside the classroom and no interaction or activity was observed offered. Client #7 sat upright in a chair inside the classroom, paced back and forth across the room, no interaction or activity was offered.</p> <p>Client #4's record was reviewed on 8/28/14 at 11:40am. Client #4's 2/18/14 ISP (Individual Support Plan) indicated an objective for client #4 to pick out four quarters to equal one dollar of United States Currency.</p> <p>An interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted on 8/28/14 at 12:00 pm. The PD/QIDP indicated United States Currency should have been used for clients #4, #5, #6, and #7 during formal and informal opportunities to teach clients about currency and to identify coins and dollar bills. The PD/QIDP indicated play</p>			

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W000125	<p>money should not have been used. The PD/QIDP indicated each program should have been implemented with United States Currency. The PD/QIDP stated clients #4, #5, and #7 should have been interacted with by the workshop staff "at least every 15 minutes" and offered an activity for participation. The PD/QIDP indicated client #6 should have been offered a change of clothing for her rain soaked slacks.</p> <p>9-3-2(a)</p> <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 observation, record review, and interview, for 7 of 7 clients (clients #1, #2, #3, #4, #5, #6, and #7) who resided in the home, the facility failed to allow and encourage access to the facility's food supply which was kept in the basement area of the group home.</p> <p>Findings include: On 8/26/14 from 3:24pm until 5:25pm</p>	W000125	Indiana Mentor has policies and procedures in place in regards to restrictions that are placed in the home for consumer safety and protection. These restrictions go through a HRC review prior to implementation. The QMRP has gotten all approvals for the food restrictions and placements within the group home and these approvals have been filed. On going management will obtain HRC approvals prior to any restrictions being put in place.	10/10/2014

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	and on 8/27/14 from 5:50am until 8:00am, clients #1, #2, #3, #4, #5, #6, and #7's observations and interviews were completed at the group home. The facility's food supply was kept in the basement. During both observation periods, facility staff went up and down the wooden steps into the basement to retrieve menu items to cook in the kitchen for the supper, snack, lunch box items, and the morning meal. On 8/26/14 at 3:40pm, Group Home Staff (GHS) #1 went into the basement, retrieved snack items for clients #1, #2, #3, #4, #5, #6, and #7, and set each individual snack on the counter in the kitchen. From 3:40pm until 4:05pm, GHS #4 and the Program Director (PD) both indicated the refrigerator's freezer was empty except for one dish of pre dipped ice cream and one dish of pre dipped sherbet with spoons in each dish. The PD stated the "ice cream dishes" were dipped by the staff for client #7 for his evening snack. When asked why the frozen items were not kept in the freezer and why frozen snacks were pre dipped. The PD stated "it's a space issue" and indicated the frozen foods and refrigerated items were kept in the basement. At 4:05pm, the kitchen cabinets were reviewed for contents with the PD. A note on the outside of the kitchen cabinet indicated "Put Cocoa + (and) PB (Peanut Butter)		These will be reviewed by the Area Director on a case by case basis to ensure proper compliance. Responsible Party: QMRPComplete Date: 10/10/2014	

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	<p>downstairs. Do Not have in cabinet." When asked why the sign. The PD indicated "We've always done that for space" reasons. Inside the twelve kitchen cabinets was one box of cereal, one box of pink sugar substitute, and one box of tea bags. Inside the refrigerator compartment of the refrigerator was one partial gallon of milk, ketchup, mustard, mayonnaise, and salad dressing. The basement was observed to have a week's worth of food supply, a refrigerator held multiple gallons of milk, frozen foods, cold meat, cold cheese, eggs, and soft drink products. The basement had a freezer filled with frozen food items. The basement had multiple tables set up with canned goods of fruit, vegetables, meats, snack items, bottled water, chips, bread, and soft drinks. When asked why the bread and multiple other snack items were kept in the basement and not accessible by clients. The PD stated "it's a space issue." The PD indicated the basement food supply was not available to clients #1, #2, #3, #4, #5, #6, and #7. The PD indicated the facility staff obtained food for each meal and snacks.</p> <p>On 8/27/14 at 12:20pm, client #1's record was reviewed and did not identify the need for the restriction of food to be kept secure in the basement.</p>			

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W000126	<p>On 8/28/14 at 11:10am, client #2's record was reviewed and did not identify the need for the restriction of food to be kept secure in the basement.</p> <p>On 8/28/14 at 10:40am, client #3's record was reviewed and did not identify the need for the restriction of food to be kept secure in the basement.</p> <p>On 8/28/14 at 11:40am, client #4's record was reviewed and did not identify the need for the restriction of food to be kept secure in the basement.</p> <p>On 8/28/14 at 8:40am, an interview with the PD was conducted. The PD indicated clients #1, #2, #3, #4, #5, #6, and #7 had not been assessed for the restriction to keep the facility food supply in the basement away from client access.</p> <p>Confidential Interview (CI) #1 stated "the food was all taken downstairs (to the basement) so [client #1] won't take it. [Client #1] steals it."</p> <p>9-3-2(a)</p> <p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial</p>						

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	<p>affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on observation, interview, and record review, for 1 of 4 sampled client (client #4) and three additional clients (clients #5, #6, and #7) who attended day services in the classroom at workshop, the facility failed to use United States Currency to implement individual support plan (ISP) recommendations and objectives for money skills training.</p> <p>Findings include:</p> <p>Observations were completed on 8/27/14 from 9:15am until 10:35am, at the workshop for clients #4, #5, #6, and #7 in the classroom. At 9:50am, Workshop Staff (WKS) #1 retrieved a box of brown plastic disks, silver plastic disks, lime green paper with \$1.00, \$5.00, and \$10.00 of non United States Currency items. Client #6 was prompted to identify a quarter. Client #6 shook her head no and WKS #1 held up a large silver plastic disk and indicated it was a quarter. Clients #5, #6, and #7 did not respond when offered plastic disks as coins. WKS #1 indicated clients #4, #5, #6, and #7's ISP (Individual Support Plan) goals/objectives were not run with the use of United States Currency. WKS #1 stated the "play money" did not have the same texture, weight, or visual</p>	W000126	<p>The IDT meet annually to determine goals and objectives for the clients. Goals are tracked and reviewed and the IDT meets at workshop monthly to review individual progress. Additionally memembers of management do checks on the clients while attending workshop. Indiana Mentor met immediately with the classroom staff and had the fake money pulled from the program and ensured resources were in place for them to use the real money. Management did a quality check to ensure staff were engaged with the consumers. Mentor is continuing monthly meetings with workshop. On going Indiana Mentor is doing at least 2 checks on a month at the workshop with at least one of them being an unannounced visit. During these checks we will check on active treatment and ensure proper currency is in place. Additionally Indiana Mentor will continue its monthly meetings with Bona Vista staff. Responsible Party: QMRP/House Manager Complete Date: 10/10/14</p>	10/10/2014

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W000149	<p>identification as United States Currency.</p> <p>Client #4's record was reviewed on 8/28/14 at 11:40am. Client #4's 2/18/14 ISP (Individual Support Plan) indicated an objective for client #4 to pick out four quarters to equal one dollar of United States Currency.</p> <p>An interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted on 8/28/14 at 12:00 pm. The PD/QIDP indicated United States Currency should have been used for clients #4, #5, #6, and #7 during formal and informal opportunities to teach clients about currency and to identify coins and dollar bills. The PD/QIDP indicated play money should not have been used. The QIDP indicated each program should have been implemented with United States Currency.</p> <p>9-3-2(a)</p> <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 2 of 2 allegations of neglect (for</p>	W000149	Indiana Mentor has policies and procedures in place in regards to abuse and neglect and	10/10/2014			

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	<p>clients #1, #4, and #6), the facility neglected to implement their Abuse/Neglect/Mistreatment policy to complete a thorough investigation, implement sufficient corrective action, and to ensure staff provided supervision at the group home for clients #1 and #6 when they engaged in inappropriate sexual behavior and for client #4 when he was left alone in the van with the ignition on.</p> <p>Findings include:</p> <p>On 8/26/14 at 9:32pm and on 8/27/14 at 12:11pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 08/01/2013 through 08/19/2014 and indicated the following:</p> <p>1. An 10/6/13 BDDS report for an incident on 10/6/13 at 9:20am, which indicated "Staff located [client #1] in [client #6's] bed under the covers with [client #6]. Staff observed that [client #6's] nightgown was pulled up over her breasts and [client #1] was fondling [client #6's] breasts. Staff immediately separated [clients #1 and #6] and placed [client #1] on sight supervision...During waking hours staff will have sight supervision of [client #1] at all times to ensure safety of individuals." The report</p>		<p>investigations of allegations and incidents where abuse or neglect has occurred. Each staff has trained on these policies upon hire and annually there after. For clients 1 and 6 new alarms where put in place after the investigated had concluded and HRC approval had been obtained. Staff were retrained on their plans and on the abuse and neglect policies. For client #4 the staff was terminated and further retraining was done with the remaining house staff. For the next 3 house meeting the house manager is doing in services on abuse and neglect. Management will conduct at least 4 observations a month to ensure mentors policies and procedures are followed. The Area Director retrained the trained investigators on investigations as well. Complete Date: 10/10/2014 Responsible Party: QMRP, House Manager, Area Director</p>				

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	<p>indicated door alarms have been put in place on the upstairs bedroom doors and the bathroom linking the two bedrooms to ensure client movement at night was monitored.</p> <p>-The facility's 10/7/13 investigation into clients #1 and #6's 10/6/13 incident indicated client #1 had "a past history of inappropriate sexual behaviors, [client #1] has that as a target behavior in her BSP (Behavior Support Plan)...." The investigation indicated staff went upstairs to check on client #6 and when staff entered client #6's bedroom client #1 was "under the covers with [client #6]." The investigation did not include written witness statements, the questions which were asked during the interviews by the investigator, and no client interviews were documented.</p> <p>On 8/27/14 at 12:20pm and on 8/27/14 at 9:00am, client #1's 5/2014 BSP (Behavior Support Plan) and client #1's 2/4/14 ISP (Individual Support Plan) were reviewed.</p> <p>Client #1's targeted behaviors included, but were not limited to, physical assault, Stealing, Resistance, and Inappropriate Sexual Behavior. Client #1's plan indicated she "required" staff supervision during "all" awake hours because of client #1's behaviors.</p>						

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	<p>2. A 1/14/14 BDDS report for an incident on 1/13/14 at 9:00am, which indicated client #4 "was alone in the car with the ignition on while [staff] took the other consumers into [Name of Workshop] building at 9:00am. [Client #4] requires staff to be with him at all times in the community...."</p> <p>-The facility's 1/21/14 investigation into client #4's 1/13/14 incident indicated client #4 was left alone inside an unattended facility van outside the day services building. The investigation indicated client #4 "requires 24/7 (twenty-four hour, seven days per week) awake supervision." The investigation indicated client #4 "could not respond to questions asked." The investigation indicated client #4 was "left alone" with the ignition on and the van running without staff present on 1/13/14. The investigation indicated the length of time was between three to five minutes. No corrective measures were available for review.</p> <p>On 8/28/14 at 11:40am, client #4's record was reviewed. Client #4's 2/18/14 ISP and 9/2013 BSP both indicated staff were to be present and "within direct supervision" of client #4 because of his behaviors of ripping clothing, spitting,</p>						

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	<p>and incontinence. Client #4's ISP and BSP both indicated client #4 did not recognize dangers around him or in the community. Client #4's ISP and BSP both included client #4 "requires 24/7 supervision" by the facility staff.</p> <p>On 8/28/14 at 12:00 pm, an interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted. The PD/QIDP indicated the facility followed the BDDS reporting policy and procedure which included investigations. The PD/QIDP indicated staff should have known where clients #1 and #6 were at 9:20am in the morning. The PD/QIDP indicated the investigations did not include questions asked, responses, or witness statements. The PD/QIDP indicated the investigation did not include corrective measures employed after client #4's 1/13/14 incident. The PD/QIDP indicated clients #1, #4, and #6 were not supervised according to their identified needs which resulted in the incidents occurring. The PD/QIDP indicated neglect was the failure to provide services, supports, and/or supervision when clients needed it.</p> <p>On 8/27/14 at 2:45pm, a record review of the 6/11/2002 BDDS "Incident Reporting" policy and procedure</p>						

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W000154	<p>indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...."</p> <p>On 8/27/14 at 2:45pm, a record review of the facility's 1/1/2011 policy and procedure "Suspected Abuse, Neglect, & Exploitation Reporting" was conducted. The policy and procedure indicated the agency prohibited abuse, neglect, and/or mistreatment and all employees were responsible to immediately report incidents of abuse, neglect, and/or mistreatment. The policy and procedure indicated "Neglect: the failure to provide the proper care for a resident/consumer, in a timely manner, causing the resident/consumer undue physical or emotional stress or injury; unreasonable delays in providing appropriate services...."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview,</p>	W000154	Indiana Mentor has policies and procedures in place in regards to	10/10/2014

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	<p>for 2 of 2 allegations of neglect (for clients #1, #4, and #6), the facility failed to implement their Abuse/Neglect/Mistreatment policy to complete a thorough investigation for clients #1 and #6 when they engaged in inappropriate sexual behavior and for client #4 when he was left alone in the van with the ignition on.</p> <p>Findings include:</p> <p>On 8/26/14 at 9:32pm and on 8/27/14 at 12:11pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 08/01/2013 through 08/19/2014 and indicated the following:</p> <p>1. An 10/6/13 BDDS report for an incident on 10/6/13 at 9:20am, which indicated "Staff located [client #1] in [client #6's] bed under the covers with [client #6]. Staff observed that [client #6's] nightgown was pulled up over her breasts and [client #1] was fondling [client #6's] breasts. Staff immediately separated [clients #1 and #6] and placed [client #1] on sight supervision...During waking hours staff will have sight supervision of [client #1] at all times to ensure safety of individuals."</p> <p>-The facility's 10/7/13 investigation into</p>		<p>abuse and neglect and investigations of allegations and incidents where abuse or neglect has occurred. Each staff has trained on these policies upon hire and annually there after. For clients 1 and 6 new alarms where put in place after the investigated had concluded and HRC approval had been obtained. Staff were retrained on their plans and on the abuse and neglect policies. For client #4 the staff was terminated and further retraining was done with the remaining house staff. For the next 3 house meeting the house manager is doing in services on abuse and neglect. Management will conduct at least 4 observations a month to ensure mentors policies and procedures are followed. The Area Director retrained the trained investigators on investigations as well. Complete Date: 10/10/2014 Responsible Party: QMRP, House Manager, Area Director</p>				

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	<p>client #1 and #6's 10/6/13 incident indicated client #1 had "a past history of inappropriate sexual behaviors, [client #1] has that as a target behavior in her BSP (Behavior Support Plan)...." The investigation indicated staff went upstairs to check on client #6 and when staff entered client #6's bedroom client #1 was "under the covers with [client #6]." The investigation did not include written witness statements, the questions which were asked during the interviews by the investigator, and no client interviews were documented.</p> <p>2. A 1/14/14 BDDS report for an incident on 1/13/14 at 9:00am, which indicated client #4 "was alone in the car with the ignition on while [staff] took the other consumers into [Name of Workshop] building at 9:00am. [Client #4] requires staff to be with him at all times in the community...."</p> <p>-The facility's 1/21/14 investigation into client #4's 1/13/14 incident indicated client #4 was left alone inside an unattended facility van outside the day services building. The investigation indicated client #4 "requires 24/7 (twenty-four hour, seven days per week) awake supervision." The investigation indicated client #4 "could not respond to questions asked." The investigation</p>			

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W000249	<p>indicated client #4 was "left alone" with the ignition on and the van running without staff present on 1/13/14. The investigation indicated the length of time was between three to five minutes. The investigation did not include the questions asked or the outcomes from the investigation.</p> <p>On 8/28/14 at 12:00 pm, an interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted. The PD/QIDP indicated the facility followed the BDDS reporting policy and procedure which included investigations. The PD/QIDP indicated staff should have known where clients #1 and #6 were at 9:20am in the morning. The PD/QIDP indicated the investigations did not include questions asked, responses, or witness statements. The PD/QIDP indicated the investigation did not include corrective measures employed after client #4's 1/13/14 incident.</p> <p>9-3-2(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan,</p>			

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	<p>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 record review and interview, for 2 of 4 sampled clients (clients #1 and #4) and 1 additional client (client #6), the facility failed to ensure staff provided supervision based on each clients' identified need at the group home for clients #1 and #6 when they engaged in inappropriate sexual behavior and for client #4 when he was left alone in a car with the ignition on.</p> <p>Findings include:</p> <p>On 8/26/14 at 9:32pm and on 8/27/14 at 12:11pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 08/01/2013 through 08/19/2014 and indicated the following:</p> <p>1. A 10/6/13 BDDS report for an incident on 10/6/13 at 9:20am, which indicated "Staff located [client #1] in [client #6's] bed under the covers with [client #6]. Staff observed that [client #6's] nightgown was pulled up over her breasts and [client #1] was fondling [client #6's] breasts. Staff immediately separated [clients #1 and #6] and placed</p>	W000249	<p>Indiana Mentor has policies and procedures in place in regards to abuse and neglect and investigations of allegations and incidents where abuse or neglect has occurred. Each staff has trained on these policies upon hire and annually there after. For clients 1 and 6 new alarms where put in place after the investigated had concluded and HRC approval had been obtained. Staff were retrained on their plans and on the abuse and neglect policies. For client #4 the staff was terminated and further retraining was done with the remaining house staff. Staff have been retrained on the supervision levels for the clients in the group home. For the next 3 house meeting the house manager is doing in services on abuse and neglect. Management will conduct at least 4 observations a month to ensure mentors policies and procedures are followed and that proper supervision levels are followed. The Area Director retrained the trained investigators on investigations as well.</p> <p>Complete Date: 10/10/2014 Responsible Party: QMRP, House Manager, Area Director</p>	10/10/2014			

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	<p>[client #1] on sight supervision...During waking hours staff will have sight supervision of [client #1] at all times to ensure safety of individuals." The report indicated door alarms have been put in place on the upstairs bedroom doors and the bathroom linking the two bedrooms to ensure client movement at night is monitored.</p> <p>-The facility's 10/7/13 investigation into client #1 and #6's 10/6/13 incident indicated client #1 had "a past history of inappropriate sexual behaviors, [client #1] has that as a target behavior in her BSP (Behavior Support Plan)...." The investigation indicated staff went upstairs to check on client #6 and when staff enter client #6's bedroom client #1 was "under the covers with [client #6]."</p> <p>On 8/27/14 at 12:20pm and on 8/27/14 at 9:00am, client #1's 5/2014 BSP (Behavior Support Plan) and client #1's 2/4/14 ISP (Individual Support Plan) targeted behaviors included but were not limited to physical assault, Stealing, Resistance, and Inappropriate Sexual Behavior. Client #1's plan indicated she "required" staff supervision during "all" awake hours because of client #1's behaviors.</p> <p>2. A 1/14/14 BDDS report for an</p>			

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	<p>incident on 1/14/14 at 9:00am, which indicated client #4 "was alone in the car with the ignition on while [staff] took the other consumers into [Name of Workshop] building at 9:00am. [Client #4] requires staff to be with him at all times in the community...."</p> <p>-The facility's 1/21/14 investigation into client #4's 1/13/14 incident indicated client #4 was left alone inside an unattended facility van outside the day services building. The investigation indicated client #4 "requires 24/7 (twenty-four hour, seven days per week) awake supervision." The investigation indicated client #4 "could not respond to questions asked." The investigation indicated client #4 was "left alone" with the ignition on and the van running without staff present on 1/13/14.</p> <p>On 8/28/14 at 11:40am, client #4's record was reviewed. Client #4's 2/18/14 ISP and 9/2013 BSP both indicated staff were to be present and "within direct supervision" of client #4 because of his behaviors of ripping clothing, spitting, and incontinence. Client #4's ISP and BSP both indicated client #4 did not recognize dangers around him or in the community. Client #4's ISP and BSP both included client #4 "requires 24/7 supervision" by the facility staff.</p>						

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W000317	<p>On 8/28/14 at 12:00 pm, an interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted. The PD/QIDP indicated the facility failed to provide supervision of clients #1, #4, and #6 when opportunities existed. The PD/QIDP indicated staff should have known where clients #1 and #6 were at 9:20am in the morning. The PD/QIDP indicated clients #1, #4, and #6 were not supervised according to their identified needs which resulted in the incidents occurring.</p> <p>9-3-4(a)</p> <p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. Based on record review and interview, for 2 of 3 sampled clients (clients #1 and #2) who received psychotropic medications, the facility failed to evaluate client #1 and #2's status for an annual decrease or contraindication for decrease of psychotropic medication.</p>	W000317	Indiana Mentor has policies and procedures in place in regards to the wellness and medical care of the consumers. The agency has a nurse on staff who aids in monitoring and setup of appointments and reviews any orders. The agency has contacted the psychiatrist for	10/10/2014

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	<p>Findings include:</p> <p>1. Client #1's record was reviewed on 8/27/14 at 12:20pm. Client #1's 2/4/14 ISP (Individual Support Plan) and client #1's 5/2014 BSP (Behavior Support Plan) indicated the targeted behaviors of Physical Assault, Spitting, Resistance, Stealing, Inappropriate Sexual Behavior, and False Accusations. Client #1's plans indicated the use of Abilify 15mg (milligrams) for Schizophrenia, Tegretol 700mg for behaviors, and Remeron 30mg for sleep. Client #1's 5/7/14, 1/30/14, and 6/19/13 "Psych Medication Reviews" did not indicate a change in client #1's psychiatric medications or a contraindication. Client #1's 6/25/2014 "Physician's Order" indicated client #1's Psychiatric medications were started: Abilify was 1/2008, Tegretol was 12/23/2008, and Remeron was 1/29/2013. Client #1's record did not indicate the last psychotropic medication change or contraindication. No behavior data was provided for review.</p> <p>Interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted on 8/28/14 at 12:00 pm. The PD/QIDP indicated client #1's psychiatric medication had not been changed in over</p>		<p>clients 1 and 2 and the behavioralist in regards to the contraindication and any possible reduction in the medication. A new appointment has been set for the medication review and review for the contraindication. Indiana Mentor will continue to monitor the health and well being of all consumers in care and will continue to ensure clients are on the minimal effective dose and have routine appointments with psychiatrist and other certified specialist to ensure optimal care. The agency nurse will review future appointment forms to ensure they have properly been filled out. Completion Date: 10/10/2014 Responsible Party: Nurse, QMRP</p>				

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	<p>a year and no contraindication for client #1's psychiatric medication had been documented. The PD/QIDP indicated client #1 had no documented evidence that a medication change had been considered or a medication reduction.</p> <p>2. Client #2's record was reviewed on 8/28/14 at 11:10am. Client #2's 1/2014 ISP (Individual Support Plan) and client #2's 9/2013 BSP (Behavior Support Plan) indicated the targeted behaviors of temper tantrums, extreme irritability, and physical aggression. Client #2's plans indicated the use of Zoloft 150mg for behaviors, Geodon 160mg for behaviors, and Depakote ER 1000mg for behaviors and seizures. Client #2's 5/7/14 and 1/30/14 "Psych Medication Reviews" did not indicate a change in client #2's psychiatric medications or a contraindication. Client #2's 7/2014 "Physician's Order" indicated client #2's Psychiatric medications were started: Geodon on 7/15/2002, Depakote ER was 6/25/2013, and Zoloft was 8/29/2009. Client #2's record did not indicate the last psychotropic medication change or contraindication. No behavior data was provided for review.</p> <p>Interview with the PD/QIDP was conducted on 8/28/14 at 12noon. The PD/QIDP indicated client #2's psychiatric</p>			

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W000369	<p>medication had not been changed in over a year and no contraindication for client #2's psychiatric medication had been documented. The PD/QIDP indicated client #2 had no documented evidence that a medication change had been considered or a medication reduction.</p> <p>9-3-5(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview for 1 of 3 doses of medication administered (client #2) at the evening medication administration and for 1 of 10 doses of medications (client #1) administered at the morning medication administration, the facility failed to administer medications without error.</p> <p>Findings include:</p> <p>1. On 8/26/14 at 4:15pm, GHS (Group Home Staff) #3 asked client #2 to come to the medication room. GHS #3 selected client #2's bottle of liquid and read the label: "Lactulose 10mg (milligrams)/15ml (milliliters), take 30ml or 2 tablespoons three times a day" for</p>	W000369	<p>Indiana Mentor has policies and procedures in place in regards to the administration of medications for the consumers. All staff must pass Core A and B prior to being allowed to pass medications in the programs. They are retrained on medication annually thereafter. Indiana Mentor contacted the nurse for clients 1 and 2 for the medication errors. The consumers were observed for side effects and no ill side effects were noted. The staff involved were retrained to ensure they were competent in the med procedure by a trained observer, and the rest of the house was trained on proper medication administration. The staff whom made the error was observed by a member of management who has been trained in the</p>	10/10/2014

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	<p>constipation. GHS #3 measured out 15ml into a clear medication measuring cup, handed the medication to client #2, and client #2 consumed the medication. At 4:20pm, Client #2's 8/2014 MAR (Medication Administration Record) was reviewed and indicated "Lactulose 10mg (milligrams)/15ml (milliliters), take 30ml or 2 tablespoons three times a day" for constipation.</p> <p>On 8/28/14 at 11:10am, client #2's record was reviewed. Client #2's 7/2014 "Physician's Order" indicated "Lactulose 10mg (milligrams)/15ml (milliliters), take 30ml or 2 tablespoons three times a day" for constipation.</p> <p>2. On 8/27/14 at 6:42am, GHS #2 asked client #1 to come to the medication room. GHS #2 selected client #1's bottle of liquid and read the label: "Lactulose 10mg (milligrams)/15ml (milliliters), take 30ml or 2 tablespoons once daily" for constipation. GHS #2 measured 15ml into a clear medication measuring cup, handed the medication to client #1, and client #1 consumed the medication. At 6:50am, client #1's 8/2014 MAR (Medication Administration Record) was reviewed and indicated "Lactulose 10mg (milligrams)/15ml (milliliters), take 30ml or 2 tablespoons once daily" for constipation.</p>		<p>medication administrative procedures but was not a nurse. The house manager is adding medication administration to the next 3 house meetings. Additionally management will conduct at least 4med observations on month on staff to ensure compliance with policies and procedures. For any additional medication errors staff will be retrained and have an observation conducted on med pass prior to giving out any medications. The Program director will also conduct a review of the MARs and send in the documentation to the Area Director for review.Respnsorable Party: House Manager, QMRPComplete Date: 11/04/2014</p>				

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W000383	<p>On 8/27/14 at 12:20pm, client #1's record was reviewed. Client #1's 6/25/14 "Physician's Order" indicated "Lactulose 10mg (milligrams)/15ml (milliliters), take 30ml or 2 tablespoons once daily" for constipation.</p> <p>On 8/28/14 at 8:40am, an interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted. The PD/QIDP indicated clients #1 and #2 were not administered their medications according to physician's orders if clients #1 and #2 did not receive the correct dose of medication. The PD/QIDP indicated client #1 and #2's physician's orders should be followed.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation, record review, and interview, the facility failed to secure the medication cabinet keys for 4 of 4 sample clients (#1, #2, #3, and #4), and three additional clients (clients #5, #6, and #7) who resided in the home.</p> <p>Findings include:</p>	W000383	Indiana Mentor has policies and procedures in place in regards to safety and precautions in the home. Among these are policies in regards to medication safety and keeping keys to locked meds on the staff. This is trained upon in orientation and annually thereafter. The house manager retrained the house staff on this	10/10/2014

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	<p>On 8/26/14 from 3pm until 5:25pm, and on 8/27/14 from 5:50am until 8:00am, observations were conducted and clients #1, #2, #3, #4, #5, #6, and #7 walked and/or accessed each room throughout the group home independently. During both observation periods, the medication administration office door was open and/or not locked with the medication cabinet keys laying at eye level on the table in the room. During both observation periods, Group Home Staff (GHS) #1, #2, #3, the Residential Manager (RM), and the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) were present. During both observation periods when the medication cabinet keys were moved from the table inside the medication room the keys were laid unsecured on top of the activity table in the living room area of the facility. On 8/27/14 at 7:50am, the RM indicated the facility kept the keys either on the activity table or on the table inside the medication room. The RM indicated the medication cabinet keys should be secure and the staff should know where the keys were kept.</p> <p>An interview was conducted on 8/27/14 at 11:10am with the agency RN (Registered Nurse). The RN indicated</p>		<p>policy and did an observation to ensure this was being followed. The management will conduct at least 4 observation per month to ensure these policies are being followed in the home. Responsible Party: House Manager/QMRP Complete Date: 10/10/2014</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G296	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/12/2014
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W000391	<p>the medication keys should be kept secured when medications were not administered and the keys were not secured. The RN indicated clients #1, #2, #3, #4, #5, #6, and #7 had access to the medication keys to the medication cabinet. The RN indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 8/27/14 at 11:10am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medication cabinet keys should be kept secure.</p> <p>9-3-6(a)</p> <p>483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #3), the facility failed to remove from use the medication containers without labels and/or illegible labels from the supply on 8/26/14.</p>	W000391	<p>Indiana Mentor has policies and procedures in place in regards to medications administration and management with medications. All staff are trained in Core A and B prior to working in the homes and annually do a medication review thereafter. The label for client #3 was corrected that same</p>	10/10/2014

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	<p>Findings include:</p> <p>On 8/26/14 at 4:13pm, GHS (Group Home Staff) #3 selected client #3's Tegretol 200mg/milligrams (for seizures) and no directions for its use were written on the label. GHS #3 administered client #3's Tegretol 200mg tablet and client #3 took the medication. At 4:20pm, client #3's 8/2014 MAR (Medication Administration Record) indicated "Tegretol 200mg, give 1 tablet by mouth 3 times a day for seizures."</p> <p>On 8/28/14 at 10:40am, client #3's 6/25/14 "Physician's Order" indicated "Tegretol 200mg, give 1 tablet by mouth 3 times a day for seizures."</p> <p>On 8/27/14 at 11:10am, an interview with the agency's Registered Nurse (RN) was conducted. The RN stated "all" medications administered by the group home staff to clients living in the group home should have a "legible pharmacy label." The RN indicated the label should include the client name and directions for the medication's use. The RN indicated the facility followed the Core A/Core B training for medication administration and the facility's policy and procedure for medication administration.</p>		<p>day and staff have been retrained on the medication management including ensuring labels match and are in good condition. Management is including medication training at next 3 staff meeting and is conducting at least 2 medication observations per month which will include a label check. Responsible Party: House Manager/QMRP Complete Date: 10/10/2014</p>		

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	On 8/27/14 at 11:10am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be labeled. 9-3-6(a)				