

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G432	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2014
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3606 HIGHWOODS DR N INDIANAPOLIS, IN 46222
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 7/14/14, 7/15/14 and 7/16/14.</p> <p>Facility Number: 000946 Provider Number: 15G432 AIMS Number: 100244570</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/24/14 by Ruth Shackelford, QIDP.</p>	W000000		
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 2 of 4 sampled clients (#2 and #4), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients #2 and</p>	W000104	The Program Director and Home Manager will be retrained on Client Finances, including ensuring that the client is not over resources at any time. All financial transactions are monitored by the Home	08/15/2014

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>#4's personal finances were not in excess of the predetermined maximum amount allowed by Medicaid.</p> <p>Findings include:</p> <p>1. Client #2's financial record was reviewed on 7/15/14 at 12:20 PM. Client #2's facility based cluster account dated 4/1/14 through 7/15/14 indicated an ending balance of \$1,581.48. Client #2's personal community based checking account ledger dated July 2014 indicated an ending balance of \$751.45. The review indicated client #2's personal finances/resources exceeded \$2,000.00.</p> <p>2. Client #4's financial record was reviewed on 7/15/14 at 12:25 PM. Client #4's facility based cluster account dated 4/1/14 through 7/15/14 indicated an ending balance of \$3,903.50. Client #4's personal community based checking account ledger dated July 2014 indicated an ending balance of \$273.64. The review indicated client #4's personal finances/resources exceeded \$2,000.00.</p> <p>AD (Area Director) #1 was interviewed on 7/15/14 at 1:30 PM. AD #1 indicated the maximum amount predetermined by Medicaid for client finances/resources was \$2,000.00.</p>		<p>Manager, reconciled on a monthly basis by the Program Director, and then reviewed by the Client Finance Specialist at the completion of each month. Once a month the Client Finance Specialist will notify the Area Director of all clients, if any, that are over resources, so that the Area Director can follow up on the plan of correction. Ongoing, the Area Director will complete quarterly reviews of a random sample of client finances to ensure that all is completely accurately and correctly. Responsible Party: Home Manager, Program Director, Client Finance Specialist, and Area Director.</p>	

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W000125	<p>9-3-1(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 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to ensure clients #1, #2, #3 and #4's individual rights were not violated by the facility's practice of locking knives and cleaning chemicals, having the group home's doors and windows equipped with alarms and by restricting the clients from soda in the group home without due process and/or consent.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/14/14 from 4:27 PM through 6:08 PM. At 4:27 PM, upon entering the group home's front entry door an audible alarm was heard as the door opened. Each time the front entry door was opened an audible alarm sounded in the home. At 5:15 PM, HM</p>	W000125	The Program Director will be retrained on convening the IDT to discuss the specific needs for the restrictions before implementing them. The Program Director will be retrained on completing guardian and HRC approvals before restrictions are put into place. The Program Director, in conjunction with the Interdisciplinary Team, will assess the needs of the sharp items to be locked up. If the teams decide that this is necessary, the Program Director will get the appropriate approvals from each guardian and HRC and this will remain in place. The Program Director, in conjunction with the Interdisciplinary Team, will assess the needs of the restriction on soda in the group home. If the teams decide that this is necessary, the Program Director will get the appropriate approvals from each guardian and HRC and this will remain in place. The Program Director, in conjunction	08/15/2014	

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	<p>(Home Manager) #1 picked up a set of keys from the medication administration table. HM #1 utilized the keys to open a cabinet located in the kitchen which had an external padlock on the door. The cabinet was utilized to store cleaning chemicals. HM #1 utilized the scissors, returned the scissors to the cabinet and locked the door with the external padlock. The group home did not have soda available for clients.</p> <p>Observations were conducted at the group home on 7/15/14 from 6:15 AM through 7:45 AM. At 6:15 AM, upon entering the group home's front entry door an audible alarm was heard as the door opened. Each time the front entry door was opened an audible alarm sounded in the home. The group home did not have soda available for clients.</p> <p>Client #5 was interviewed on 7/14/14 at 4:50 PM. Client #5 stated, "[HM #1] won't buy pop for us. She says because we drink it too much, we can't have any in the house. I don't think it's right. She can't do that."</p> <p>HM #1 was interviewed on 7/15/14 at 2:00 PM. HM #1 indicated the entry/exit doors and the windows in the group home have alarms. HM #1 indicated scissors and knives and cleaning</p>		<p>with the Interdisciplinary Team, will assess the needs of the cleaning materials to be locked up. If the teams decide that this is necessary, the Program Director will get the appropriate approvals from each guardian and HRC and this will remain in place. The alarms on the doors are not for restrictions on the clients, but are due to the previous/historical break-ins that have occurred in this home while no one was present. The Program Director will meet to discuss this with the teams and get approval from guardians and HRC to ensure that this is still appropriate for the clients. If it is known to be too restrictive or causing some concerns with the clients, Indiana MENTOR will work to have the alarms removed.</p>	

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	<p>chemicals are kept locked in the kitchen cabinet. When asked if the clients can have soda, HM #1 stated, "They can get it on outings on weekends." When asked if the clients can have soda in the group home, HM #1 stated, "No...."</p> <p>1. Client #1's record was reviewed on 7/15/14 at 10:19 AM. Client #1's BSP (Behavior Support Plan) dated 10/9/13 did not indicate client #1 required the use of door and window alarms, should be restricted from access to knives, scissors, cleaning chemicals and/or soda. Client #1's POF (Physician Orders Form) dated 6/24/14 indicated client #1 could have sugar free beverages. Client #1's ISP (Individual Support Plan) dated 11/19/13 indicated client #1 had a legal guardian. Client #1's record did not indicate documentation of written informed consent regarding the facility's use of door/window alarms, restriction of access to knives, scissors, cleaning agents and soda.</p> <p>2. Client #2's record was reviewed on 7/15/14 at 11:59 AM. Client #2's BSP dated 5/10/13 did not indicate client #2 required the use of door and window alarms, should be restricted from access to knives, scissors, cleaning chemicals and/or soda. Client #2's POF dated 6/24/14 indicated client #2 could have</p>			

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	<p>sugar free beverages. Client #2's ISP dated 11/15/13 indicated client #2 had a legal guardian. Client #2's record did not indicate documentation of written informed consent regarding the facility's use of door/window alarms, restriction of access to knives, scissors, cleaning agents and soda.</p> <p>3. Client #3's record was reviewed on 7/15/14 at 12:42 PM. Client #3's BSP dated 8/14/13 did not indicate client #3 required the use of door and window alarms, should be restricted from access to knives, scissors, cleaning chemicals and/or soda. Client #3's POF dated 6/24/14 indicated client #3 could have sugar free beverages. Client #3's ISP dated 10/21/13 indicated client #3 had a HCR (Health Care Representative). Client #3's record did not indicate documentation of client #3's written informed consent or her HCR's consent regarding the use of door/window alarms, restriction of access to knives, scissors, cleaning agents and soda.</p> <p>4. Client #4's record was reviewed on 7/15/14 at 9:08 AM. Client #4's BSP dated 5/18/13 did not indicate client #4 should be restricted from access to knives, scissors, cleaning chemicals and/or soda. Client #4's POF dated 6/24/14 indicated did not indicate client</p>			

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	<p>#4 should be restricted from soda consumption. Client #4's ISP dated 11/14/13 indicated client #4 had a legal guardian. Client #4's record did not indicate documentation of written informed consent of client #4's guardian regarding the use of door/window alarms, restriction of access to knives, scissors, cleaning agents and soda.</p> <p>PD (Program Director) #1 was interviewed on 7/15/14 at 1:50 PM. PD #1 indicated client #5's diet did not restrict him from consuming soda. PD #1 indicated clients in the home should have access to soda or diet/sugar free soda. PD #1 indicated the doors and windows in the home had alarms. PD #1 indicated restrictive practices should be implemented when indicated by assessment of need and described in each client's BSP. HM #1 indicated there was not additional documentation of HRC review or approval for the restrictions of door/window alarms, knives, scissors, cleaning chemicals and soda.</p> <p>PD (Program Director) #1 was interviewed on 7/15/14 at 1:50 PM. PD #1 indicated written informed consent was needed for restrictive practices.</p> <p>9-3-2(a)</p>						

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) plus 4 additional clients (#5, #6, #7 and #8), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients #1, #2, #3, #4, #5, #6, #7 and #8's active treatment programs. The QIDP failed to ensure clients #1, #2, #3 and #4's individual rights were not violated by the facility's practice of locking knives and cleaning chemicals, having the group home's doors and windows equipped with alarms and by restricting the clients from soda in the group home without due process, to ensure client #1's ISP (Individual Support Plan) included training through formal or informal learning objectives to address drooling, ensure clients #1, #2 and #4's CFAs (Comprehensive Functional Assessments) were reviewed/updated annually, to ensure the facility's HRC (Human Rights Committee) reviewed, approved and monitored the facility's practice of locking knives and cleaning chemicals, having the group home's doors</p>	W000159	<p>Please see W125 The Program Director will be retrained on convening the IDT to discuss the specific needs for the restrictions before implementing them. The Program Director will be retrained on completing guardian and HRC approvals before restrictions are put into place. The Program Director, in conjunction with the Interdisciplinary Team, will assess the needs of the sharp items to be locked up. If the teams decide that this is necessary, the Program Director will get the appropriate approvals from each guardian and HRC and this will remain in place. The Program Director, in conjunction with the Interdisciplinary Team, will assess the needs of the restriction on soda in the group home. If the teams decide that this is necessary, the Program Director will get the appropriate approvals from each guardian and HRC and this will remain in place. The Program Director, in conjunction with the Interdisciplinary Team, will assess the needs of the cleaning materials to be locked up. If the teams decide that this is necessary, the Program</p>	08/15/2014
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	<p>and windows equipped with alarms, to ensure client #1's clothing and drooling management promoted his dignity and to monitor clients #1 and #3's behavior programs to ensure gradual withdrawals of drugs used for control of inappropriate behavior were attempted, ensure clients #1, #2, #3, #4, #5, #6, #7 and #8 were given the opportunity to express their individual preference/choice regarding menu items and to ensure client #5 was offered alternative food choices during meal time.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The QIDP failed to ensure clients #1, #2, #3 and #4's individual rights were not violated by the facility's practice of locking knives and cleaning chemicals, having the group home's doors and windows equipped with alarms and by restricting the clients from soda in the group home without due process. Please see W125. 2. The QIDP failed to ensure client #1's ISP included training through formal or informal learning objectives to address drooling. Please see W227. 3. The QIDP failed to ensure clients #1, #2 and #4's CFAs were reviewed/updated annually. Please see W259. 		<p>Director will get the appropriate approvals from each guardian and HRC and this will remain in place. The alarms on the doors are not for restrictions on the clients, but are due to the previous/historical break-ins that have occurred in this home while no one was present. The Program Director will meet to discuss this with the teams and get approval from guardians and HRC to ensure that this is still appropriate for the clients. If it is known to be too restrictive or causing some concerns with the clients, Indiana MENTOR will work to have the alarms removed. Please see W227 The Program Director will be retrained on writing client goals and objectives based on their individual needs. The Program Director will be retrained on including the client goals in the Individualized Support Plan. The Program Director, in conjunction with the Interdisciplinary teams, will create a goal surrounding a concern of drooling for client 1. The staff will be retrained on client dignity. After the retraining occurs, the Home Manager and/or Program Director will complete two (2) weekly observations to ensure that the goals are being completed according to Indiana MENTOR policy and procedures for four (4) weeks. These will then be reviewed by the Program Director ensuring that there are no further</p>		

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	<p>4. The QIDP failed to ensure the facility's HRC reviewed, approved and monitored the facility's practice of locking knives and cleaning chemicals, having the group home's doors and windows equipped with alarms and by restricting the clients (#1, #2, #3, #4) from soda in the group home. Please see W264.</p> <p>5. The QIDP failed to ensure client #1's clothing and drooling management promoted his dignity. Please see W268.</p> <p>6. The QIDP failed to monitor clients #1 and #3's behavior programs to ensure gradual withdrawals of drugs used for control of inappropriate behavior were attempted. Please see W317.</p> <p>7. The QIDP failed to ensure client #5 was offered alternative food choices during meal time. Please see W460.</p> <p>8. The QIDP failed to ensure clients #1, #2, #3, #4, #5, #6, #7 and #8 were given the opportunity to express their individual preference/choice regarding menu items. Please see W478.</p> <p>9-3-3(a)</p>		<p>training needs. After the initial four (4) weeks, the Home Manager and/or Program Director will complete weekly observations ongoing, and will ensure that all needed future retrainings will be completed. Ongoing each DSP will complete Medication Administration as expected by Indiana MENTOR's policy and procedures. Ongoing, the Program Director will work with the interdisciplinary teams to ensure that each client has training goal to identify their specific areas of need. Ongoing, all Individualized Support Plans will be reviewed by the Area Director and/or Quality Assurance Manager, to ensure accuracy and to ensure that all areas of need are met for each client. Responsible Party: Program Director, Area Director, and Quality Assurance Manager. Please see W259 The Program Director and Home Manager will be retrained on the importance of completing and reviewing each client's annual CFA's within an appropriate time frame of no more than 365 days. The Home Manager will review the current CFA's for each client and ensure that all are brought up to date, including clients 1, 2, and 4. Ongoing, the Program Director will review each CFA no less than annually to ensure accuracy and completion at the time of the annual review. Responsible Party: Program Director and</p>	

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			<p>Home Manager Please see W264 The Program Director will be retrained on convening the IDT to discuss the specific needs for the restrictions before implementing them. The Program Director will be retrained on completing guardian and HRC approvals before restrictions are put into place. The Program Director, in conjunction with the Interdisciplinary Team, will assess the needs of the sharp items to be locked up. If the teams decide that this is necessary, the Program Director will get the appropriate approvals from each guardian and HRC and this will remain in place. The Program Director, in conjunction with the Interdisciplinary Team, will assess the needs of the restriction on soda in the group home. If the teams decide that this is necessary, the Program Director will get the appropriate approvals from each guardian and HRC and this will remain in place. The Program Director, in conjunction with the Interdisciplinary Team, will assess the needs of the cleaning materials to be locked up. If the teams decide that this is necessary, the Program Director will get the appropriate approvals from each guardian and HRC and this will remain in place. The alarms on the doors are not for restrictions on the clients, but are due to the previous/historical break-ins that have occurred in this home while</p>		

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			no one was present. The Program Director will meet to discuss this with the teams and get approval from guardians and HRC to ensure that this is still appropriate for the clients. If it is known to be too restrictive or causing some concerns with the clients, Indiana MENTOR will work to have the alarms removed. Please see W268 The staff will be retrained on client dignity. After the retraining occurs, the Home Manager and/or Program Director will complete two (2) weekly observations to ensure that dignity is respected for all clients according to Indiana MENTOR policy and procedures for four (4) weeks. These will then be reviewed by the Program Director ensuring that there are no further training needs. After the initial four (4) weeks, the Home Manager and/or Program Director will complete weekly observations ongoing, and will ensure that all needed future retrainings will be completed. Ongoing each DSP will ensure dignity for each client as expected by Indiana MENTOR's policy and procedures. Ongoing, the Program Director will work with the interdisciplinary teams to ensure that each client has training goal to identify their specific areas of need. Ongoing, all Individualized Support Plans will be reviewed by the Area Director and/or Quality		

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			<p>Assurance Manager, to ensure accuracy and to ensure that all areas of need are met for each client. Responsible Party: Program Director, Area Director, and Quality Assurance Manager.</p> <p>Please see W317 The Program Director will convene the IDT to review the titration plan for client 1, to discuss the possibility of titrating some medications based on the lack of behavioral incidents. The Program Director will convene the IDT to review the titration plan for client 3, to discuss the possibility of titrating some medications based on the lack of behavioral incidents. The Program Director will be retrained on convening the IDT to discuss each client's programmatic changes, or lack thereof no less than quarterly for each client applicable. The staff will be retrained on completing and documenting behavior data for each client on a daily basis. The Program Director will be retrained on sharing the collected data with the IDT to discuss if any programmatic changes are needed based on the monthly/quarterly reviews.</p> <p>Please see W323 Due to a change over in administration at this group home, client 2's two year visual follow up examination was missed. The Home Manager or Program Nurse scheduled a vision exam for 8/30/2014. The Program Nurse reviews all appointments recommendations</p>	

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			and followup with the Home Manager regarding each appointment needing scheduled. The Program Nurse will review all appointments for clients at this hometo ensure no other appointments are outstanding. Ongoing the Area Director will complete random quarterly audits of theappointments forms to ensure that no other appointments are missed in thefuture. Responsible Party: Home Manager, Program Nurse, and Area Director Please see W331 The Program Nurse will follow up on scheduling an appointment forClient 1 to address the lethargic state that staff have reported him to be in. The Program Nurse will also follow up with the PCP for an assessment onPT to assist with the possible slouching/back pain client 1 seems to be in. If he is cleared medically, the Program Director will follow up withthe IDT to address adding in an exercise goal to assist with Client 1's energylevels. The Home Manager will be retrained on addressing all medical concernswith the Program Nurse and Program Director as they are noticed. Ongoing, the Program Nurse will complete 1 monthly observation on eachclient to ensure that no medical needs require attention. Responsible Party: Home Manager, Program Nurse, Program Director Please see W460 The Direct Care Staff will	

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			<p>be retrained on offering substitutions at each meal. The Home Manager will be retrained on ensuring that reasonable substitutions are available for the staff to over to each client based on the menus created by the dietician. After the retraining occurs, the Home Manager and/or Program Director will complete two (2) weekly observations to ensure that family style dining is completed correctly, and substitutions are offered for all clients according to Indiana MENTOR policy and procedures for four (4) weeks. These will then be reviewed by the Program Director ensuring that there are no further training needs. After the initial four (4) weeks, the Home Manager and/or Program Director will complete weekly observations ongoing, and will ensure that all needed future retrainings will be completed. Ongoing each DSP will ensure dignity for each client as expected by Indiana MENTOR's policy and procedures. Responsible Party: Home Manager and Program Director Please see W478 The Direct Care Staff will be retrained on offering substitutions at each meal. The Home Manager will be retrained on ensuring that reasonable substitutions are available for the staff to over to each client based on the menus created by the dietician. After the retraining occurs, the Home Manager and/or Program Director</p>	

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1's ISP (Individual Support Plan) included training through formal or informal learning objectives to address drooling.</p> <p>Findings include:</p> <p>Observations were conducted at client</p>	W000227	<p>willcomplete two (2) weekly observations to ensure that family style dining iscompleted correctly, and substitutions are offered for all clients according toIndiana MENTOR policy and procedures for four (4) weeks. These will then bereviewed by the Program Director ensuring that there are no further trainingneeds. After the initial four (4) weeks, the Home Manager and/or Program Directorwill complete weekly observations ongoing, and will ensure that all neededfuture retrainings will be completed. Ongoing each DSP will ensure dignity for each client as expected byIndiana MENTOR's policy and procedures. Responsible Party: Home Manager and Program Director</p> <p>The Program Director will be retrained on writing client goals and objectives based on their individual needs. The Program Director will be retrained on including the client goals in the Individualized Support Plan. The Program Director, in conjunction with the Interdisciplinary teams,will create a goal surrounding a concern of drooling for client 1. The staff will be</p>	08/15/2014

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	<p>#1's day services facility on 7/14/14 from 11:30 AM through 12:20 PM. Client #1 was observed throughout the observation period. Client #1 had saliva dripping from his mouth onto the front of his shirt throughout the observation period.</p> <p>DSS (Day Service Staff) #1 was interviewed on 7/14/14 at 12:00 PM. DSS #1 indicated client #1 drooled on a daily basis.</p> <p>Observations were conducted at the group home on 7/14/14 from 4:27 PM through 6:08 PM. At 4:40 PM, client #1 was seated on the group home's living room couch. Client #1 had saliva dripping from his mouth to the front of his shirt. Client #1 drooled on himself while seated on the couch until 4:50 PM when he was prompted to take his evening medications.</p> <p>Client #1's record was reviewed on 7/15/14 at 10:19 AM. Client #1's QNA (Quarterly Nursing Assessment) narrative note dated 10/7/13 indicated "Drooling noted. Atrovent for drooling." Client #1's HCCMR (Health Care Coordination Monthly Review) narrative note dated 5/31/14 indicated, "Drooling has improved since increasing Cogentin (tardive dyskinesia) to twice a day." Client #1's ISP dated 11/19/13 did not</p>		<p>retrained on client dignity. After the retraining occurs, the Home Manager and/or Program Director will complete two (2) weekly observations to ensure that the goals are being completed according to Indiana MENTOR policy and procedures for four (4) weeks. These will then be reviewed by the Program Director ensuring that there are no further training needs. After the initial four (4) weeks, the Home Manager and/or Program Director will complete weekly observations ongoing, and will ensure that all needed future retrainings will be completed. Ongoing each DSP will complete Medication Administration as expected by Indiana MENTOR's policy and procedures. Ongoing, the Program Director will work with the interdisciplinary teams to ensure that each client has training goal to identify their specific areas of need. Ongoing, all Individualized Support Plans will be reviewed by the Area Director and/or Quality Assurance Manager, to ensure accuracy and to ensure that all areas of need are met for each client. Responsible Party: Program Director, Area Director, and Quality Assurance Manager.</p>		

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W000259	<p>indicate training to assist client #1 to wipe his mouth or address his drooling.</p> <p>HM (Home Manager) #1 was interviewed on 7/15/14 at 2:00 PM. HM #1 indicated client #1 drooled on a daily basis. HM #1 indicated client #1 was prescribed Atrovent and his Cogentin dosage had been increased to address his drooling. HM #1 indicated no formal training or supports had been developed to address client #1's drooling.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 3 of 4 sampled clients (#1, #2 and #4), the facility failed to ensure clients #1, #2 and #4's CFAs (Comprehensive Functional Assessments) were reviewed/updated annually.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 7/15/14 at 10:19 AM. Client #1's CFA was dated 6/3/13. Client #1's record did</p>	W000259	<p>The Program Director and Home Manager will be retrained on the importance of completing and reviewing each client's annual CFA's within an appropriate time frame of no more than 365 days. The Home Manager will review the current CFA's for each client and ensure that all are brought up to date, including clients 1, 2, and 4. Ongoing, the Program Director will review each CFA no less than annually to ensure accuracy and completion at the time of the annual review. Responsible Party: Program Director and</p>	08/15/2014			

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W000264	<p>not indicate documentation of annual review/update of client #1's 6/3/13 CFA.</p> <p>2. Client #2's record was reviewed on 7/15/14 at 11:59 AM. Client #2's CFA was dated 6/23/13. Client #2's record did not indicate documentation of annual review/update of client #2's 6/23/13 CFA.</p> <p>3. Client #4's record was reviewed on 7/15/14 at 9:08 AM. Client #4's record did not indicate documentation of a CFA.</p> <p>PD (Program Director) #1 was interviewed on 7/15/14 at 1:50 PM. PD #1 indicated clients #1 and #2's CFAs should be reviewed/updated on an annually basis. PD #1 indicated there was not additional documentation available for review regarding client #4's CFA.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any</p>		Home Manager				

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	<p>other areas that the committee believes need to be addressed.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility's HRC (Human Rights Committee) failed to review, approve and monitor the facility's practice of locking knives and cleaning chemicals, having the group home's doors and windows equipped with alarms and by restricting the clients from soda in the group home.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/14/14 from 4:27 PM through 6:08 PM. At 4:27 PM, upon entering the group home's front entry door an audible alarm was heard as the door opened. Each time the front entry door was opened an audible alarm sounded in the home. At 5:15 PM, HM (Home Manager) #1 picked up a set of keys from the medication administration table. HM #1 utilized the keys to open a cabinet located in the kitchen which had an external padlock on the door. HM #1 opened the cabinet and retrieved a pair of scissors. HM #1 utilized the scissors, returned the scissors to the cabinet and locked the door with the external padlock. The cabinet was utilized to store cleaning chemicals. HM #1 utilized the</p>	W000264	<p>The Program Director will be retrained on convening the IDT to discuss the specific needs for the restrictions before implementing them.</p> <p>The Program Director will be retrained on completing guardian and HRC approvals before restrictions are put into place.</p> <p>The Program Director, in conjunction with the Interdisciplinary Team, will assess the needs of the sharp items to be locked up. If the teams decide that this is necessary, the Program Director will get the appropriate approvals from each guardian and HRC and this will remain in place.</p> <p>The Program Director, in conjunction with the Interdisciplinary Team, will assess the needs of the restriction on soda in the group home. If the teams decide that this is necessary, the Program Director will get the appropriate approvals from each guardian and HRC and this will remain in place.</p> <p>The Program Director, in conjunction with the Interdisciplinary Team, will assess the needs of the cleaning materials to be locked up. If the teams decide that this is necessary, the Program Director will get the appropriate approvals from each guardian and HRC and this will remain in place.</p> <p>The alarms on the doors are not</p>	08/15/2014

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	<p>scissors, returned the scissors to the cabinet and locked the door with the external padlock. The group home did not have soda available for clients.</p> <p>Observations were conducted at the group home on 7/15/14 from 6:15 AM through 7:45 AM. At 6:15 AM, upon entering the group home's front entry door an audible alarm was heard as the door opened. Each time the front entry door was opened an audible alarm sounded in the home.</p> <p>Client #5 was interviewed on 7/14/14 at 4:50 PM. Client #5 stated, "[HM #1] won't buy pop for us. She says because we drink it too much, we can't have any in the house. I don't think it's right. She can't do that."</p> <p>1. Client #1's record was reviewed on 7/15/14 at 10:19 AM. Client #1's BSP (Behavior Support Plan) dated 10/9/13 did not indicate client #1 required the use of door and window alarms, should be restricted from access to knives, scissors, cleaning chemicals and/or soda. Client #1's POF (Physician Orders Form) dated 6/24/14 indicated client #1 could have sugar free beverages. Client #1's record did not indicate documentation of HRC review or approval regarding the use of door/window alarms, restriction of access</p>		<p>for restrictions on the clients, butare due to the previous/historical break-ins that have occurred in this homewhile no one was present. The Program Director will meet to discuss this withthe teams and get approval from guardians and HRC to ensure that this is stillappropriate for the clients. If it is known to be too restrictive or causingsome concerns with the clients, Indiana MENTOR will work to have the alarmsremoved.</p>	

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	<p>to knives, scissors, cleaning agents and soda.</p> <p>2. Client #2's record was reviewed on 7/15/14 at 11:59 AM. Client #2's BSP dated 5/10/13 did not indicate client #2 required the use of door and window alarms, should be restricted from access to knives, scissors, cleaning chemicals and/or soda. Client #2's POF dated 6/24/14 indicated client #2 could have sugar free beverages. Client #2's record did not indicate documentation of HRC review or approval regarding the use of door/window alarms, restriction of access to knives, scissors, cleaning agents and soda.</p> <p>3. Client #3's record was reviewed on 7/15/14 at 12:42 PM. Client #3's BSP dated 8/14/13 did not indicate client #3 required the use of door and window alarms, should be restricted from access to knives, scissors, cleaning chemicals and/or soda. Client #3's POF dated 6/24/14 indicated client #3 could have sugar free beverages. Client #3's record did not indicate documentation of HRC review or approval regarding the use of door/window alarms, restriction of access to knives, scissors, cleaning agents and soda.</p> <p>4. Client #4's record was reviewed on</p>						

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	<p>7/15/14 at 9:08 AM. Client #4's BSP dated 5/18/13 did not indicate client #4 should be restricted from access to knives, scissors, cleaning chemicals and/or soda. Client #4's POF dated 6/24/14 indicated did not indicate client #4 should be restricted from soda consumption. Client #4's record did not indicate documentation of HRC review or approval regarding the use of door/window alarms, restriction of access to knives, scissors, cleaning agents and soda.</p> <p>HM #1 was interviewed on 7/15/14 at 2:00 PM. HM #1 indicated the entry/exit doors and the windows in the group home have alarms. HM #1 indicated scissors and knives and cleaning chemicals are kept locked in the kitchen cabinet. When asked if the clients can have soda, HM #1 stated, "They can get it on outings on weekends." When asked if the clients can have soda in the group home, HM #1 stated, "No...." HM #1 indicated there was not additional documentation of HRC review or approval for the restrictions of door/window alarms, knives, scissors, cleaning chemicals and soda.</p> <p>PD (Program Director) #1 was interviewed on 7/15/14 at 1:50 PM. PD #1 indicated HRC review and approval</p>						

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W000268	<p>was needed for restrictive practices.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1's clothing and drooling management promoted his dignity.</p> <p>Findings include:</p> <p>Observations were conducted at client #1's day services facility on 7/14/14 from 11:30 AM through 12:20 PM. Client #1 was observed throughout the observation period. Client #1 had saliva dripping from his mouth onto the front of his shirt throughout the observation period. Client #1 wore a sweat shirt with athletic wind breaker style elastic pants. Client #1's pants were on backwards and sagging in the back area exposing the upper portion of client #1's buttocks. Client #1's appearance was unkempt.</p> <p>DSS (Day Service Staff) #1 was interviewed on 7/14/14 at 12:00 PM.</p>	W000268	<p>The staff will be retrained on client dignity. After the retraining occurs, the Home Manager and/or Program Director will complete two (2) weekly observations to ensure that dignity is respected for all clients according to Indiana MENTOR policy and procedures for four (4)weeks. These will then be reviewed by the Program Director ensuring that there are no further training needs. After the initial four (4) weeks, the Home Manager and/or Program Director will complete weekly observations ongoing, and will ensure that all needed future retrainings will be completed. Ongoing each DSP will ensure dignity for each client as expected by Indiana MENTOR's policy and procedures. Ongoing, the Program Director will work with the interdisciplinary teams to ensure that each client has training goal to identify their specific areas of need. Ongoing, all Individualized Support Plans</p>	08/15/2014

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W000317	<p>When asked if client #1's pants were on backwards, DSS #1 stated, "Hmm, well yes. It looks like they are. I hadn't noticed but the pockets are on the wrong side and facing the wrong direction."</p> <p>Observations were conducted at the group home on 7/14/14 from 4:27 PM through 6:08 PM. At 4:40 PM, client #1 was seated on the group home's living room couch. Client #1 had saliva dripping from his mouth to the front of his shirt. Client #1 drooled on himself while seated on the couch until 4:50 PM when he was prompted to take his evening medications. Client #1 wore a sweat shirt with athletic wind breaker style elastic waist pants with a pair of suspenders. Client #1's appearance was unkempt.</p> <p>PD (Program Director) #1 was interviewed on 7/15/14 at 1:50 PM. PD #1 indicated client #1 should be encouraged to wipe his mouth, wear his pants correctly and not wear suspenders with athletic style pants.</p> <p>9-3-5(a)</p> <p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate</p>		<p>will be reviewed by the Area Director and/or Quality Assurance Manager, to ensure accuracy and to ensure that all areas of need are met for each client.</p> <p>Responsible Party: Program Director, Area Director, and Quality Assurance Manager.</p>		

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	<p>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 4 sampled clients (#1 and #3), the facility failed to monitor clients #1 and #3's behavior programs to ensure gradual withdrawals of drugs used for control of inappropriate behavior were attempted.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 7/15/14 at 10:19 AM. Client #1's BSP (Behavior Support Plan) dated 10/9/13 indicated the following:</p> <p>"Target behaviors for reduction: -"Delusional Talk (DT). Complete inaccuracy of an event, frequently paranoid. Examples would include, but not be limited to, 'I killed my parents', 'Did you see the accident outside where people died.' Current Baseline/date: 0/month. August/Sept 2013. Objective: Maintain baseline within 3 months of implementation of BSP." -"Extreme Irritability (EI). Acts fretful, angry, or annoyed in an overly-reactive manner to an extent that it interferes with social functioning and/or upsets other in the environment. Current Baseline/date.</p>	W000317	<p>The Program Director will convene the IDT to review the titration plan for client 1, to discuss the possibility of titrating some medications based on the lack of behavioral incidents. The Program Director will convene the IDT to review the titration plan for client 3, to discuss the possibility of titrating some medications based on the lack of behavioral incidents. The Program Director will be retrained on convening the IDT to discuss each client's programmatic changes, or lack thereof no less than quarterly for each client applicable. The staff will be retrained on completing and documenting behavior data for each client on a daily basis. The Program Director will be retrained on sharing the collected data with the IDT to discuss if any programmatic changes are needed based on the monthly/quarterly reviews.</p>	08/15/2014

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	<p>0/month. August/September 2013. Objective: Maintain baseline within 3 months of implementation of BSP."</p> <p>- "Physical Assault (PA). attempted and/or actual purposeful attacks directed at others. May include hitting, kicking, pulling hair/clothing and biting. Current Baseline/date. 0/month. August/September 2013. Objective: Maintain baseline within 3 months of implementation of BSP."</p> <p>- "Verbal Abuse (VA). Hostile language used to threaten or intimidate. Current Baseline/date. 0/month. August/September 2013. Objective: Maintain baseline within 3 months of implementation of BSP."</p> <p>- "Resistance. Refusing to follow through with requests to cease and/or initiate a specific behavior. Current Baseline/date. 0/month. August/September 2013. Objective: Maintain baseline within 3 months of implementation of BSP."</p> <p>- "Demanding. Insisting that any non-emergency requests he has be met immediately. Current Baseline/date. 0/month. August/September 2013. Objective: Maintain baseline within 3 months of implementation of BSP."</p>			

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	<p>"Current Medications: -Fluoxetine 10 milligrams for depression. -Clozapine 100 milligrams for schizophrenia."</p> <p>"Medication Review: -Medication reduction plan was reviewed at this time and the plan shows insufficient data to recommend a medication reduction. The IST (Individual Support Team) should consider a reduction in the total daily dosage of medications that [client #1] receives after collecting data on frequency and intensity based on the updated BSP. Incident should be documented on the BPR (Behavior Problem Record). During review, if there are fewer incident occurring, the team might want to consult [client #1's] psychiatrist in regards to a reduction in his medications."</p> <p>"Titration Criteria: -Recommendations for medication review will be based upon data collected through program data forms. Recommendations will be based on data indicating significant, sustained reduction in behavior (example: at least 75% improvement in rate, duration or intensity of behaviors to decrease lasting no less than 6 consecutive months unless otherwise indicated by prescribing</p>						

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	<p>physician), that effect health, safety and ability to cope. In the event of no significant changes in behavior (example: increase or decrease of 10% or less) 12 months following prescription change, medication review will also be recommended."</p> <p>"Review periods: -Review periods will occur quarterly beginning: January 2013. Baselines on target behaviors will be reviewed and recommendations presented to IST at that time."</p> <p>"Reduction recommendations, order of reductions, size of reductions and medication increases: -During each review period, IST members will review behavioral data and progress which will be communicated with the prescribing physician. The prescribing physician will then indicate their recommendations using the form on page 2. Based on this form, IST will follow the prescribing psychiatrist/physician's recommendations regarding order of reduction, size of reductions, or medication increases. A history of all medicine changes will be maintained by the nurse."</p> <p>Client #1's BPRs indicated the following:</p>						

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	<p>-January 2014: no recorded/documented incidents of DT, EI, PA, VA, resistance and demanding behaviors.</p> <p>-February 2014: no recorded/documented incidents of DT, EI, PA, VA, resistance and demanding behaviors.</p> <p>-March 2014: no recorded/documented incidents of DT, EI, PA, VA, resistance and demanding behaviors.</p> <p>-April 2014: no recorded/documented incidents of DT, EI, PA, VA, resistance and demanding behaviors.</p> <p>-May 2014: no recorded/documented incidents of DT, EI, PA, VA, resistance and demanding behaviors.</p> <p>-June 2014: no recorded/documented incidents of DT, EI, PA, VA, resistance and demanding behaviors.</p> <p>-July 1 through review (7/15/14): no recorded/documented incidents of DT, EI, PA, VA, resistance and demanding behaviors.</p> <p>Client #1's POF (Physician's Order Form) dated 6/24/14 indicated client #1 had a physician's order dated 9/15/04 for Fluoxetine 10 milligram capsule, take one capsule by mouth every night at</p>			

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	<p>bedtime for schizophrenia and depression. Client #1's POF dated 6/24/14 indicated client #1 had a physician's order dated 7/19/12 for Clozapine 100 milligram tablet, take one tablet by mouth once daily at 9:00 PM for schizophrenia.</p> <p>Client #1's record did not indicate documentation of IST/IDT (Interdisciplinary Team) monitoring and/or recommendations regarding behavioral data progress/regression. Client #1's record did not indicate documentation of communication between the IST/IDT and the prescribing physician/psychiatrist and completion of the psychiatrist recommendations form regarding order of reduction, size of reductions, or medication increases. Client #1's record did not indicate documentation of reduction attempts for client #1's Fluoxetine and or Clozapine.</p> <p>2. Client #3's record was reviewed on 7/15/14 at 12:42 PM. Client #3's BSP dated 8/14/13 indicated the following:</p> <p>"Target behaviors for reduction: -"Type 2 resistance. Refusal to comply with an incidental staff member's request to cease/initiate a behavior. Current Baseline/Date: 0/month. June/July 2013. Objective: 10% reduction from baseline</p>			

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	<p>12 months from plan implementation."</p> <p>-"Verbal Abuse (VA). Threats, mocking or derisive language directed at others that is outside the context of a joke or banter. Current Baseline/Date: 0/month. June/July 2013. Objective: 10% reduction from baseline 12 months from plan implementation."</p> <p>Current Medications: -Abilify 10 milligrams for mood stabilization/psychosis.</p> <p>"Titration Criteria: -Recommendations for medication review will be based upon data collected through program data forms. Recommendations will be based on data indicating significant, sustained reduction in behavior (example: at least 75% improvement in rate, duration or intensity of behaviors to decrease lasting no less than 6 consecutive months unless otherwise indicated by prescribing physician), that effect health, safety and ability to cope. In the event of no significant changes in behavior (example: increase or decrease of 10% or less) 12 months following prescription change, medication review will also be recommended."</p> <p>"Review periods:</p>						

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	<p>-Review periods will occur quarterly."</p> <p>"Reduction recommendations, order of reductions, size of reductions and medication increases: -During each review period, IST members will review behavioral data and progress which will be communicated with the prescribing physician. The prescribing physician will then indicate their recommendations using the form on page 2. Based on this form, IST will follow the prescribing psychiatrist/physician's recommendations regarding order of reduction, size of reductions, or medication increases. A history of all medicine changes will be maintained by the nurse."</p> <p>Client #3's BPRs indicated the following:</p> <p>-January 2014: no recorded/documented incidents of VA or type 2 resistance.</p> <p>-February 2014: no recorded/documented incidents of VA or type 2 resistance.</p> <p>-March 2014: one recorded incident of VA on 3/3/14.</p> <p>-April 2014: no recorded/documented incidents of VA or type 2 resistance.</p> <p>-May 2014: no recorded/documented</p>						

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	<p>incidents of VA or type 2 resistance.</p> <p>-June 2014: no recorded/documented incidents of VA or type 2 resistance.</p> <p>-July 1 through review (7/15/14): one recorded incident of VA on 7/11/14.</p> <p>Client #3's POF dated 6/24/14 indicated client #3 had a physician's order dated 3/4/10 for Abilify 10 milligrams, tablet, take one tablet by mouth once daily for psychosis.</p> <p>Client #3's record did not indicate documentation of IST/IDT monitoring and/or recommendations regarding behavioral data progress/regression.</p> <p>Client #3's record did not indicate documentation of communication between the IST/IDT and the prescribing physician/psychiatrist and completion of the psychiatrist recommendations form regarding order of reduction, size of reductions, or medication increases.</p> <p>Client #3's record did not indicate documentation of reduction attempts for client #3's Abilify.</p> <p>PD (Program Director) #1 was interviewed on 7/15/14 at 1:50 PM. PD #1 indicated there was not documentation available for review regarding medication reduction attempts for client #1's</p>			

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W000323	<p>Fluoxetine and Clozapine. PD #1 indicated there was not documentation available for review regarding medication reduction attempts for client #3's Abilify. PD #1 indicated there was not IST/IDT review/monitoring or recommendations regarding clients #1 and #3's progression/regression of targeted behaviors. PD #1 indicated the medication titration protocol should be implemented as described in clients #1 and #3's BSP's. PD #1 indicated the PD/QIDP (Qualified Intellectual Disabilities Professional) was responsible for ensuring the IST/IDT monitored and tracked clients #1 and #3's progression/regression of targeted behaviors in order to make recommendations for reductions.</p> <p>9-3-5(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 4 sampled clients (#2), the facility failed to ensure client #2's visual care recommendations were followed.</p> <p>Findings include:</p>	W000323	<p>Due to a change over in administration at this group home, client 2's two year visual follow up examination was missed. The Home Manager or Program Nurse scheduled a vision exam</p>	08/15/2014			

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W000331	<p>Client #2's record was reviewed on 7/15/14 at 11:59 AM. Client #2's Vision examination form dated 7/9/12 indicated client #2 had cataracts and the recommendation for yearly examination. Client #2's record did not indicate additional documentation of vision examination for client #2 since the 7/9/12 recommendation.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 7/15/14 at 2:30 PM. LPN #1 indicated client #2's vision examination recommendations should be followed.</p> <p>HM (Home Manager) #1 was interviewed on 7/15/14 at 2:15 PM. HM #1 indicated client #2 had a vision examination scheduled for 8/30/14. HM #1 indicated there was not additional documentation of vision examination for client #2 since 7/9/12.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility nurse failed to assess client</p>	W000331	<p>for 8/30/2014.</p> <p>The Program Nurse reviews all appointments recommendations and followsup with the Home Manager regarding each appointment needing scheduled. The Program Nurse will review all appointments for clients at this hometo ensure no other appointments are outstanding. Ongoing the Area Director will complete random quarterly audits of the appointments forms to ensure that no other appointments are missed in the future.</p> <p>Responsible Party: Home Manager, Program Nurse, and Area Director</p> <p>The Program Nurse will follow up on scheduling an appointment for Client 1 to address the lethargic state that staff have</p>	08/15/2014

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	<p>#1's lack of physical stamina/fatigue.</p> <p>Findings include:</p> <p>Observations were conducted at client #1's day services facility on 7/14/14 from 11:30 AM through 12:20 PM. Client #1 was observed throughout the observation period. At 11:30 AM, client #1 was seated at a table in the cafeteria eating lunch. Client #1 slouched his body in a forward leaning position. Client #1 sat in a forward leaning position and would sit up straight then return to the forward leaning position.</p> <p>DSS (Day Service Staff) #1 was interviewed on 7/14/14 at 12:00 PM. DSS #1 stated, "[Client #1] is doing good. He's just always sleepy. He struggles to stay awake." DSS #1 indicated client #1 slouched his body in a forward posture while sitting.</p> <p>Observations were conducted at the group home on 7/14/14 from 4:27 PM through 6:08 PM. At 4:40 PM, client #1 was seated on the group home's living room couch. Client #1 was leaning his body in forward posture and not sitting in an upright position. Client #1 maintained his head in a downward position.</p> <p>Observations were conducted at the</p>		<p>reported him to be in. The Program Nurse will also follow up with the PCP for an assessment onPT to assist with the possible slouching/back pain client 1 seems to be in. If he is cleared medically, the Program Director will follow up withthe IDT to address adding in an exercise goal to assist with Client 1's energylevels. The Home Manager will be retrained on addressing all medical concernswith the Program Nurse and Program Director as they are noticed. Ongoing, the Program Nurse will complete 1 monthly observation on eachclient to ensure that no medical needs require attention. Responsible Party: Home Manager, Program Nurse, Program Director</p>				

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	<p>group home on 7/15/14 from 6:15 AM through 7:45 AM. At 7:25 AM, client #1 sat down at the dining room table with his housemates for the morning meal. Client #1 leaned his body forward in a slouching posture while at the table. HM (Home Manager) #1 stated, "Wake up. [Client #1] sit up while you're at the table."</p> <p>HM #1 was interviewed on 7/15/14 at 2:00 PM. HM #1 stated, "[Client #1] doesn't seem lethargic to me. He's coherent. He just seems like he doesn't have energy. Like he's not active enough in the house and when he does try to do things he doesn't have the energy. I took him to the store the other day and every few minutes we had to stop so he could rest. [Client #1] said his back was hurting. It's because he has a large front area (stomach) and it puts pressure on his back and makes it hard to walk." HM #1 indicated client #1 slouched and leaned in a forward posture while seated. HM #1 indicated she had not reported client #1's fatigue or slouching to the nurse.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 7/15/14 at 2:30 PM. LPN #1 indicated she was not aware of any concerns with client #1's energy/fatigue and slouching/leaning forward while seated. LPN #1 indicated client #1 had</p>			

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W000460	<p>not been assessed for fatigue, back pain or his slouching/leaning posture while seated.</p> <p>9-3-6(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation and interview for 1 additional client (#5), the facility failed to ensure client #5 was offered alternative food choices during meal time.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/14/14 from 4:27 PM through 6:08 PM. At 4:27 PM, DSPs (Direct Support Professional) #1 and #2 were in the group home's kitchen area preparing the evening meal. HM (Home Manager) #1 stated, "They are doing the cooking. [Client #5] is supposed to be helping but he's refusing. He doesn't like what we're fixing so he's mad and refusing to help cook."</p> <p>At 5:50 PM, client #5 joined his housemates for the evening family style meal. Client #5 stated, "I guess I will just have some salad." Client #5 ate salad,</p>	W000460	<p>The Direct Care Staff will be retrained on offering substitutions at each meal. The Home Manager will be retrained on ensuring that reasonable substitutions are available for the staff to offer to each client based on the menus created by the dietician. After the retraining occurs, the Home Manager and/or Program Director will complete two (2) weekly observations to ensure that family style dining is completed correctly, and substitutions are offered for all clients according to Indiana MENTOR policy and procedures for four (4) weeks. These will then be reviewed by the Program Director ensuring that there are no further training needs. After the initial four (4) weeks, the Home Manager and/or Program Director will complete weekly observations ongoing, and will ensure that all needed future retrainings will be completed. Ongoing each DSP will ensure</p>	08/15/2014

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W000478	<p>cooked green beans and pasta. Client #5 declined to eat the baked chicken breast. Client #5 was not offered a substitute for the chicken.</p> <p>HM #1 was interviewed on 7/14/14 at 4:35 PM. HM #1 indicated the group home's menu included suggested alternative food items for choice.</p> <p>Client #5 was interviewed on 7/14/14 at 4:50 PM. Client #5 stated, "That's why I don't like living here in this house anymore. [HM #1's] always trying to make us eat stuff we don't like. I don't like the food here. It has too much acid or something and I don't like the peppers they're using."</p> <p>PD (Program Director) #1 was interviewed on 7/15/14 at 1:50 PM. PD #1 indicated client #5 should be offered a substitute/choice of menu items. PD #1 indicated client #5 was not offered a substitute for chicken during the evening meal on 7/14/14.</p> <p>9-3-8(a)</p> <p>483.480(c)(1)(ii) MENUS Menus must provide a variety of foods at each meal.</p>		<p>dignity for each client as expected by Indiana MENTOR's policy and procedures. Responsible Party: Home Manager and Program Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G432	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2014
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3606 HIGHWOODS DR N INDIANAPOLIS, IN 46222
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	<p>Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) plus 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure clients #1, #2, #3, #4, #5, #6, #7 and #8 were given the opportunity to express their individual preference/choice regarding menu items.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/14/14 from 4:27 PM through 6:08 PM. At 4:27 PM, DSPs (Direct Support Professional) #1 and #2 were in the group home's kitchen area preparing the evening meal. HM (Home Manager) #1 stated, "They are doing the cooking. [Client #5] is supposed to be helping but he's refusing. He doesn't like what we're fixing so he's mad and refusing to help cook."</p> <p>At 5:50 PM, client #5 joined his housemates for the evening family style meal. Client #5 stated, "I guess I will just have some salad." Client #5 ate salad, cooked green beans and pasta. Client #5 declined to eat the baked chicken breast.</p> <p>HM #1 was interviewed on 7/14/14 at 4:35 PM. When asked if clients in the home had the opportunity to choose or provide input into the group home's</p>	W000478	<p>The Direct Care Staff will be retrained on offering substitutions ateach meal.</p> <p>The Home Manager will be retrained on ensuring that reasonable substitutionsare available for the staff to over to each client based on the menus createdby the dietician.</p> <p>After the retraining occurs, the Home Manager and/or Program Director willcomplete two (2) weekly observations to ensure that family style dining iscompleted correctly, and substitutions are offered for all clients according toIndiana MENTOR policy and procedures for four (4) weeks. These will then bereviewed by the Program Director ensuring that there are no further trainingneeds.</p> <p>After the initial four (4) weeks, the Home Manager and/or Program Directorwill complete weekly observations ongoing, and will ensure that all neededfuture retrainings will be completed.</p> <p>Ongoing each DSP will ensure dignity for each client as expected byIndiana MENTOR's policy and procedures.</p> <p>Responsible Party: Home Manager and Program Director</p>	08/15/2014

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	<p>menu, HM #1 stated, "No, we have a dietician that plans the menu." HM #1 indicated clients #1, #2, #3, #4, #5, #6, #7 and #8 were not given opportunities for choice regarding menu planning.</p> <p>Client #5 was interviewed on 7/14/14 at 4:50 PM. Client #5 stated, "That's why I don't like living here in this house anymore. [HM #1's] always trying to make us eat stuff we don't like. I don't like the food here. It has too much acid or something and I don't like the peppers they're using."</p> <p>PD (Program Director) #1 was interviewed on 7/15/14 at 1:50 PM. When asked if clients were given the opportunity to contribute to the menu or help plan their own meals, PD #1 stated, "No, we follow the dietician's menu."</p> <p>9-3-8(a)</p>				