

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/01/2016
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NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 720 ROYAL RD MICHIGAN CITY, IN 46360
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: January 28, 29, and February 1, 2016.</p> <p>Facility number: 000680 Provider number: 15G144 AIM number: 100243080</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/4/16.</p>	W 0000		
W 0257 Bldg. 00	<p>483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE</p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.</p> <p>Based on observation, record review, and interview, the facility failed to assure a training program to wear a helmet for 1 of 3 sampled clients (client #1) was reviewed and revised by the QIDP (Qualified Intellectual Disabilities</p>	W 0257	In order for this citation to be met now and in the future, the Q has revised this resident's goal to involved him more in the process of wearing his protective helmet due to seizure activity. He will be asked to put the helmet on himself with verbal prompts. As	02/16/2016

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>Professional) due to the client's refusals to wear the helmet.</p> <p>Findings include:</p> <p>Client #1 was observed at the group home during the 1/28/16 observation period from 4:50 A.M. until 7:00 A.M. At 5:25 A.M., client #1 came out of his room and sat at the dining room table. Direct care staff #2 retrieved the client's helmet and put it on the client. Client #1 immediately removed the helmet. Direct care staff #2 put the helmet back on client #1 and the client again immediately removed it. At 6:07 A.M., while eating a bowl of cereal, client #1 had a seizure and fell out of his chair onto the floor. Direct care staff #2, who was behind client #1, immediately grabbed the client and further lowered him to the floor. Direct care staff #2 remained with client #1 until the client regained consciousness. Direct care staff #2 assisted the client back to his chair. Direct care staff #2 again retrieved client #1's helmet and put it on the client. Client #1 immediately removed the helmet.</p> <p>Direct care staff #2 was interviewed on 1/28/16 at 7:11 A.M. Direct care staff #2 stated, "[Client #1] has drop seizures (seizures where the client loses</p>		<p>well as worn during meal times, to desensitize to eventually be worn at all times in the future. This goal will measure how many prompts for him to put on the helmet and record the percentages of the time wearing during the meals. In order to correct in the future, this data will be reviewed monthly and projected to meet the goal in three months. If goal is not met, will be revised again. Staff will be trained on this goal on 2/11/16. (Staff responsible: Q, Team Leader, DSPS)</p>		

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	<p>consciousness and falls to the floor/ground.) He (client #1) usually has two a day (seizures) and they are usually in the morning." When asked about the client's helmet use, direct care staff #2 stated, "He (client #1) refused to wear it (helmet) all of the time. We (direct care staff) put it on him and he immediately takes it off. He (client #1) has a goal (objective) to wear his helmet."</p> <p>Client #1's records were reviewed on 1/28/16 at 7:19 A.M. A review of 1/16 objective data indicated the client had an objective to "wear helmet at all times." Review of the data from 1/1/16 to 1/28/16 for the implementation of the objective of "wear helmet at all times" indicated out of 35 attempts to have client #1 wear his helmet, the client refused to wear it 34 times.</p> <p>Client #1's record was further reviewed on 1/29/16 at 8:21 A.M. Review of the client's 10/15/15 IPP (Individual Program Plan) indicated the client had an objective to "wear his helmet." Review data collected for the implementation of the objective indicated the following: October, 2015 data -- 20 attempts - 19 refusals; November, 2015 data -- 20 attempts - 14 refusals; December, 2015 - - No data available. Further review of client #1's 10/15/15 IPP failed to indicate</p>						

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W 0336 Bldg. 00	<p>the objective had been revised or modified since the objective's initial implementation date of 10/15/15.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/29/16 at 11:02 A.M.. QIDP #1 stated, "I was waiting until the end of the next review period to look at changing it (the objective)."</p> <p>9-3-4(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview, the facility failed to assure quarterly nursing exams were conducted at least quarterly (every ninety days) for 3 of 3 sampled clients (clients #1, #2, and #3).</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 1/29/16 at 8:21 A.M. A review of the client's quarterly nursing assessments from 1/1/15 to 1/29/16 indicated a</p>	W 0336	This citation will be back in compliance by 2/16/16. This has already started to occur. The nursing staff, which are now new, have been trained on completing quarterlies from the last date of the last quarterly. This will be done on a consistent basis for the future. Residential Director will review charts on a monthly basis to assure the quarterlies are timely.(RNs responsible)	02/16/2016

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	<p>quarterly nursing assessment was completed on 12/1/15. The review failed to indicate the client's quarterly nursing assessments were completed at least quarterly (every three months.)</p> <p>Client #2's records were reviewed on 1/29/16 at 9:09 A.M. A review of the client's quarterly nursing assessments from 1/1/15 to 1/29/16 indicated a quarterly nursing assessment was completed on 12/1/15. The review failed to indicate the client's quarterly nursing assessments were completed at least quarterly (every three months.)</p> <p>Client #3's records were reviewed on 1/29/16 at 10:15 A.M. A review of the client's quarterly nursing assessments from 1/1/15 to 1/29/16 indicated quarterly nursing assessments were completed on 12/1/15, 7/27/15, and 1/7/15. The review failed to indicate the client's quarterly nursing assessments were completed at least quarterly (every three months.)</p> <p>Director of Residential Services #1 was interviewed on 1/29/16 at 10:51 A.M. Director of Residential Services #1 stated, "We had nursing changes in the middle of the year. Later we realized the nursing quarterlies (exams) were not completed."</p>			

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

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	9-3-6(a)				