

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G720	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/09/2016
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 82 BENNY LN NORTH VERNON, IN 47265
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W 0000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: June 6, 7, 8 and 9, 2016</p> <p>Facility number: 004396 Provider number: 15G720 AIM number: 200511360</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 6/15/16.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>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 6 incident/investigative reports reviewed affecting clients #1, #2, #3 and #4, the facility neglected to implement its policies and procedures to prevent neglect of the clients during the overnight shift and appropriate corrective actions were implemented following two allegations of neglect during the overnight shift.</p> <p>Findings include:</p>	W 0149	<p>Staff in the home will be re-trained on preventing client abuse and neglect.</p> <p>The Program Director will be retrained on completing and administering corrective actions as determined following the findings of investigations within 3 business days of the investigation completion and maintaining copies of all completed documentation.</p>	07/09/2016

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>On 6/6/16 at 1:45 PM, a review of the facility's incident reports was conducted and indicated the following:</p> <p>1) On 4/3/16 at 7:00 AM when the first shift staff arrived for her shift, the third shift staff and her boyfriend were sleeping in the recliners in the living room. Clients #1, #2, #3 and #4 were still in bed.</p> <p>The 4/6/16 Summary of Internal Investigation Report indicated, in part, "On 4/3/16, first shift staff, [former staff #5], DSP (Direct Support Professional), arrived at 9am and allegedly found [former staff #6], DSP, and her boyfriend, asleep in one recliner in the living room of the home. [Staff #6] was immediately suspended following this report." The interview with staff #5 indicated in part, "...stated that she arrived at the group home on 4/3/16 about '10 til 9am.' She stated that the front door was locked so she knocked on it and no one answered. She stated that she 'could hear [client #3] in her room playing with her toys and could hear [client #2] ringing her bell 2-3 times from her bedroom.' [Staff #5] stated that she continued to knock on the door, she rang the doorbell twice and called the house phone twice and no one answered. [Staff</p>		<p>The Area Director will review all investigations to ensure necessary corrective actions are implemented as determined by the results of the investigation at weekly QIDP/AD meeting.</p> <p>All corrective actions completed will be reviewed with the Area Director weekly at the QIDP/Area Director weekly meeting and corrective action for the Program Director will be completed if the established timelines are not met, barring extenuating circumstances.</p> <p>Observations will be completed at least weekly on various shifts to monitor that staff are following client plans and are preventing client abuse and neglect.</p>	

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	<p>#5] stated that she thought maybe [staff #6] was with a client in the bathroom and couldn't get to the door but then started to worry so about 9:05am she called another staff that works in the home [staff #3] and asked her for the code to get in through the garage and then asked her how to get into the house and [staff #3] told her where the house key was. [Staff #5] stated that she walked into the house through the laundry room and around through the kitchen to the living room and found [staff #6] and her boyfriend asleep together in the recliner. [Staff #5] stated that she went to [staff #6] and 'tapped her on the shoulder and then I had to shake her pretty hard to wake her up...'. [Staff #5] stated that she went into [client #1's] bedroom and he was in bed and he was 'soaked and shivering and cold...'. [Staff #5] stated that she and [former staff #7] started getting [client #1] cleaned up and she asked [client #1] if he had been lying like that and wet a while and she stated '[client #1] nodded his head yes.' She stated that she was very upset about how she found him." Client #2's interview in the investigation indicated, "...reported to [staff #7] that she had rung her bell during the night and [staff #6] didn't come and help her..."</p> <p>The Conclusion of the investigation indicated, "There is evidence to support that [staff #6] was at least distracted if</p>			

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	<p>not asleep causing her to not respond to other staff and client requests for assistance resulting in neglect of clients. There is evidence to support that [staff #6] had her boyfriend in the house and he was asleep during her work shift." Staff #6's 4/28/16 Termination Notice indicated, in part, "On April 4, 2016 [staff #6] was suspended for an allegation of sleeping during her shift and having a non-Mentor person in the client's (sic) home with her. During the investigation [staff #6] admitted to letting her boyfriend into the clients' home. This is a direct violation of the Employee Information Guide and Code of Conduct which [staff #6] acknowledged understanding and being trained on... At this time we are ending [staff #6's] employment."</p> <p>There was no documentation of increased oversight of the facility following the incident during the night shift by administrative staff. The facility failed to implement appropriate corrective action following the incident.</p> <p>On 6/6/16 at 2:28 PM, the Area Director (AD) stated staff #6 was terminated for "neglect." The AD indicated the facility should prevent neglect of the clients. The AD indicated the facility had a policy and procedure prohibiting neglect of the</p>			

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	<p>clients.</p> <p>On 6/8/16 at 2:56 PM, the Program Director (PD) indicated there was no increased monitoring of the group home during the overnight shift following the incident.</p> <p>On 6/8/16 at 3:04 PM, the Quality Improvement Specialist (QIS) indicated there should have been increased supervision of the staff during the overnight shift following the incident. The QIS stated, "I would think that would be something the administrative staff would do." The QIS indicated there was no documentation of increased supervision and monitoring of the overnight shift staff.</p> <p>2) On 8/19/15 at 8:00 AM, staff did not implement client #4's positioning schedule. The 8/19/15 BDDS report indicated, "Staff not following positioning schedule and allowing client to lay in urine soaked sheets. Staff suspended pending investigation." The 8/24/15 Summary of Internal Investigation Report indicated, "An allegation was made that staff [#8], DSP, failed to follow [client #4's] positioning schedule and allowed her (sic) lay in urine soaked sheets on 8/19/15. [Staff #8] was suspended and 8/19/15</p>			

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	<p>immediately after allegation was reported." The investigation indicated, in part, "Based on the information obtained by staff, it appears that when [client #4] is repositioned at approximately 9pm, she is not repositioned again until arriving at day program the next morning if she sleeps throughout the night. The Positioning Schedule documents that [client #4] was repositioned even when staff stated that they didn't reposition her. The DSRs (Daily Support Records) stated that [client #4] slept during the night which contradicts the positioning schedule." The Conclusion of the investigation indicated, "There is not enough evidence to support that [staff #8] was intentionally neglectful of [client #4]. There is evidence to support that staff are not following [client #4's] positioning schedule according to how it is currently written."</p> <p>There was no documentation the facility increased the supervision and monitoring of the overnight shift staff following the incident. The facility failed to implement appropriate corrective action.</p> <p>On 6/6/16 at 2:28 PM, the AD indicated following the investigation, the group home staff were to receive retraining on client #4's positioning schedule. The AD indicated the Program Director (PD)</p>			

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	<p>should have the training documentation at the group home.</p> <p>On 6/8/16 at 2:56 PM, the Program Director (PD) indicated there was no increased monitoring of the group home during the overnight shift following the incident.</p> <p>On 6/6/16 at 6:38 PM, the PD indicated she was unable to locate documentation the staff were retrained on client #4's positioning schedule.</p> <p>On 6/8/16 at 3:04 PM, the Quality Improvement Specialist (QIS) indicated there should have been increased supervision of the staff during the overnight shift following the incident. The QIS stated, "I would think that would be something the administrative staff would do." The QIS indicated there was no documentation of increased supervision and monitoring of the overnight shift staff. On 6/9/16 at 12:09 PM, the QIS indicated in an email, in part, "...I just checked and I can't find any documentation for the training for [staff #8] from last August in my file either...."</p> <p>On 6/6/16 at 1:47 PM, a review of the facility's April 2011 abuse and neglect policy was conducted. The policy indicated the following, "Any allegation of abuse or human rights violation is thoroughly investigated by the Area</p>			

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	<p>Director in consultation with Human Resources Department and/or Quality Assurance/Risk Management Department." The policy indicated, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e. Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment... o. The following actions are prohibited by employees of Indiana MENTOR: 1) abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds. 2) violation of an individual's rights." The April 2011 Quality and Risk Management policy indicated, in part, "Indiana MENTOR is committed to ensuring the individuals we serve are provided with a safe and quality living environment. In order to ensure the highest standard of service delivery specific staff will be assigned to the monitoring and review of Quality Assurance. These staff will assist in providing Individual Support Teams with corporate supports, recommendations and resources for incident management and will review the effectiveness of the recommendations... The Area Director will review each incident and Quality Assurance recommendations monthly. This review will be completed with Program Director and other appropriate staff to assess the effectiveness of each recommendation made per incident... The Area Director will complete an Incident Summary Report detailing the progress made towards meeting the recommendations previously set forth. The report may include further recommendations that may have been provided by the Interdisciplinary Team or outside agency involved in the resolution of the incident. This procedure will provide Indiana MENTOR with the information needed to ensure the</p>			

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W 0157 Bldg. 00	<p>effectiveness of the recommendations and an opportunity to make additional recommendations as needed..."</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 6 incident/investigative reports reviewed affecting clients #1, #2, #3 and #4, the facility failed to implement appropriate corrective actions following two allegations of neglect during the overnight shift.</p> <p>Findings include:</p> <p>On 6/6/16 at 1:45 PM, a review of the facility's incident reports was conducted and indicated the following:</p> <p>1) On 4/3/16 at 7:00 AM when the first shift staff arrived for her shift, the third shift staff and her boyfriend were sleeping in the recliners in the living room. Clients #1, #2, #3 and #4 were still in bed.</p> <p>The 4/6/16 Summary of Internal Investigation Report indicated, in part, "On 4/3/16, first shift staff, [former staff</p>	W 0157	<p>The QIDP will be retrained on completing and administering corrective actions as determined following the findings of investigations within 3 business days of the investigation completion and maintaining copies of all completed documentation.</p> <p>The Area Director will review all investigations to ensure necessary corrective actions are implemented as determined by the results of the investigation at weekly QIDP/AD meeting.</p> <p>All corrective actions completed will be reviewed with the Area Director weekly at the QIDP/Area Director weekly meeting and corrective action for the QIDP will be completed if the established timelines are not met, barring extenuating circumstances.</p>	07/09/2016

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	#5], DSP (Direct Support Professional), arrived at 9am and allegedly found [former staff #6], DSP, and her boyfriend, asleep in one recliner in the living room of the home. [Staff #6] was immediately suspended following this report." The interview with staff #5 indicated in part, "...stated that she arrived at the group home on 4/3/16 about '10 til 9am.' She stated that the front door was locked so she knocked on it and no one answered. She stated that she 'could hear [client #3] in her room playing with her toys and could hear [client #2] ringing her bell 2-3 times from her bedroom.' [Staff #5] stated that she continued to knock on the door, she rang the doorbell twice and called the house phone twice and no one answered. [Staff #5] stated that she thought maybe [staff #6] was with a client in the bathroom and couldn't get to the door but then started to worry so about 9:05am she called another staff that works in the home [staff #3] and asked her for the code to get in through the garage and then asked her how to get into the house and [staff #3] told her where the house key was. [Staff #5] stated that she walked into the house through the laundry room and around through the kitchen to the living room and found [staff #6] and her boyfriend asleep together in the recliner. [Staff #5] stated that she went to [staff #6] and			

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	'tapped her on the shoulder and then I had to shake her pretty hard to wake her up...'. [Staff #5] stated that she went into [client #1's] bedroom and he was in bed and he was 'soaked and shivering and cold...'. [Staff #5] stated that she and [former staff #7] started getting [client #1] cleaned up and she asked [client #1] if he had been lying like that and wet a while and she stated '[client #1] nodded his head yes.' She stated that she was very upset about how she found him." Client #2's interview in the investigation indicated, "...reported to [staff #7] that she had rung her bell during the night and [staff #6] didn't come and help her..." The Conclusion of the investigation indicated, "There is evidence to support that [staff #6] was at least distracted if not asleep causing her to not respond to other staff and client requests for assistance resulting in neglect of clients. There is evidence to support that [staff #6] had her boyfriend in the house and he was asleep during her work shift." Staff #6's 4/28/16 Termination Notice indicated, in part, "On April 4, 2016 [staff #6] was suspended for an allegation of sleeping during her shift and having a non-Mentor person in the client's (sic) home with her. During the investigation [staff #6] admitted to letting her boyfriend into the clients' home. This is a direct violation of the Employee			

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	<p>Information Guide and Code of Conduct which [staff #6] acknowledged understanding and being trained on... At this time we are ending [staff #6's] employment."</p> <p>There was no documentation of increased oversight of the facility following the incident during the night shift by administrative staff. The facility failed to implement appropriate corrective action following the incident.</p> <p>On 6/8/16 at 2:56 PM, the Program Director (PD) indicated there was no increased monitoring of the group home during the overnight shift following the incident.</p> <p>On 6/8/16 at 3:04 PM, the Quality Improvement Specialist (QIS) indicated there should have been increased supervision of the staff during the overnight shift following the incident. The QIS stated, "I would think that would be something the administrative staff would do." The QIS indicated there was no documentation of increased supervision and monitoring of the overnight shift staff.</p> <p>2) On 8/19/15 at 8:00 AM, staff did not implement client #4's positioning schedule. The 8/19/15 BDDS report</p>			

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	<p>indicated, "Staff not following positioning schedule and allowing client to lay in urine soaked sheets. Staff suspended pending investigation." The 8/24/15 Summary of Internal Investigation Report indicated, "An allegation was made that staff [#8], DSP, failed to follow [client #4's] positioning schedule and allowed her (sic) lay in urine soaked sheets on 8/19/15. [Staff #8] was suspended and 8/19/15 immediately after allegation was reported." The investigation indicated, in part, "Based on the information obtained by staff, it appears that when [client #4] is repositioned at approximately 9pm, she is not repositioned again until arriving at day program the next morning if she sleeps throughout the night. The Positioning Schedule documents that [client #4] was repositioned even when staff stated that they didn't reposition her. The DSRs (Daily Support Records) stated that [client #4] slept during the night which contradicts the positioning schedule." The Conclusion of the investigation indicated, "There is not enough evidence to support that [staff #8] was intentionally neglectful of [client #4]. There is evidence to support that staff are not following [client #4's] positioning schedule according to how it is currently written."</p>			

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	<p>There was no documentation the facility increased the supervision and monitoring of the overnight shift staff following the incident. The facility failed to implement appropriate corrective action.</p> <p>On 6/6/16 at 2:28 PM, the AD indicated following the investigation, the group home staff were to receive retraining on client #4's positioning schedule. The AD indicated the Program Director (PD) should have the training documentation at the group home.</p> <p>On 6/8/16 at 2:56 PM, the Program Director (PD) indicated there was no increased monitoring of the group home during the overnight shift following the incident.</p> <p>On 6/6/16 at 6:38 PM, the PD indicated she was unable to locate documentation the staff were retrained on client #4's positioning schedule.</p> <p>On 6/8/16 at 3:04 PM, the Quality Improvement Specialist (QIS) indicated there should have been increased supervision of the staff during the overnight shift following the incident. The QIS stated, "I would think that would be something the administrative staff would do." The QIS indicated there was no documentation of increased</p>			

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 82 BENNY LN NORTH VERNON, IN 47265
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W 0249 Bldg. 00	<p>supervision and monitoring of the overnight shift staff. On 6/9/16 at 12:09 PM, the QIS indicated in an email, in part, "...I just checked and I can't find any documentation for the training for [staff #8] from last August in my file either..."</p> <p>9-3-2(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to ensure staff implemented the clients' program plans as written.</p> <p>Findings include:</p> <p>1) On 6/6/16 from 12:49 PM to 1:40 PM, an observation was conducted at the facility-operated day program. During the observation, client #1 did not have an electronic communication device for his use. At 1:02 PM when day program staff</p>	W 0249	Staff in the home and day program will be retrained on implementing program plans as written for all clients and ensuring Client #1's communication device is utilized both in the home and at day program. Administrative staff will complete observations 2x a week for one month, then weekly observations for three months and then 2x a month ongoing, both in the home and at the day program to ensure that Client #1 is utilizing his communication device.	07/09/2016

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	<p>#1 asked client #1 if he wanted to eat through his g-tube (gastrostomy tube - a tube inserted through the abdomen that delivers nutrition directly to the stomach), client #1 shook his head "no." Staff #1 asked client #1 if he wanted to have his g-tube flushed in the room or in another area, client #1 pointed to indicate he wanted to stay where he was. At 1:10 PM, client #1 indicated he had a communication device. Client #1 pointed indicating the device was at the group home. At 1:10 PM, day program staff #1 indicated client #1 did not bring his communication device to the day program on this day or any other day. Staff #1 indicated the day program staff had worked with client #1 long enough to know what he was communicating with his gestures.</p> <p>On 6/7/16 at 9:06 AM, a review of client #1's record was conducted. Client #1's 1/10/16 Individualized Support Plan included a training objective to improve his ability to express/respond to staff's questions. The ISP indicated, in part, "...At present [client #1] is able to express himself with vocalizations to gain attention or imply 'thank you,' a few gestures, pointing to symbols or words on his previous communication board and by answering yes/no questions. [Client #1] understands requests and can follow</p>			

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	<p>directions/instructions if physically able to do so. His primary means to communicate with staff is using yes/no questions then his DynaVox. [Client #1] understands what others are saying to him during conversations and is generally able to make his wants/needs known to staff. General conversation is achieved by use of yes/no questions as best he and staff can. [Client #1] can utilize a computer with assistance to email his mother or play games." Client #1's undated Goal Tracking Sheet indicated, in part, "[Client #1] will participate in ADL (Adult Daily Living) Skill Development - communication skills. [Client #1] will improve his ability to express/respond to staff questions. [Client #1] will request to use his DynaVox or staff will prompt him to use his DynaVox. Staff will place on chair or desk if in manual (wheelchair). [Client #1] will turn on DynaVox. Staff will ask [client #1] to respond to questions such as: tell me one thing you did at D/S (day services). Tell me what you want to do this evening. Tell me something funny what happened today. Provide verbal cues or greater assistance as needed for him to answer. Encourage use of 'talk button' to facilitate conversation with staff."</p> <p>On 6/7/16 at 8:41 AM, the Program Coordinator</p>			

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	<p>(PC) indicated client #1 should have his communication device with him at the facility-operated day program.</p> <p>On 6/7/16 at 10:40 AM, the Program Director (PD) indicated client #1's program goal should be implemented as written.</p> <p>2) An observation was conducted on 6/6/16 from 12:49 PM to 1:40 PM at the facility-operated day program. At 1:18 PM, day program staff #1 used a one person transfer to lift client #4 from her cart to a changing table while the positioning padding on her cart was rearranged.</p> <p>On 6/6/16 at 8:45 AM, a review of client #4's 3/15/16 ISP indicated, in part, "[Client #4] is diagnosed with osteoporosis and osteopenia (decreased bone density). Osteoporosis Protocol is in place at present. Fall precautions are utilized at all times. She is a recommended 2 person lift/transfer or transfer done by Arjo lift with T bar that is used for individuals who are unable to sit up. Staff are to use caution during transfers and personal care...." Client #4's 3/15/16 Risk Management Assessment and Plan indicated, in part, "Recommended two person transfer."</p> <p>On 6/7/16 at 8:45 AM, the Program Coordinator (PC) stated "prefer team lift" when transferring client #4. The PC indicated client #4's risk plan should be implemented as written.</p> <p>On 6/7/16 at 8:46 AM, the Area Director (AD) indicated client #4's plan should be implemented as written for a 2 person transfer or the mechanical lift used.</p> <p>3) Observations were conducted at the group home on 6/6/16 from 3:58 PM to 6:38 PM and 6/7/16 from 6:02 AM to 7:40 AM. On 6/6/16 at</p>			

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	<p>6:32 PM, dinner started. During client #3's meal, staff #5 did not prompt client #3 to touch her nose cup prior to taking a drink. On 6/7/16 at 7:19 AM, client #3 started to eat her oatmeal with assistance from staff #5. Client #3 was not prompted to touch her nose cup prior to taking a drink during breakfast. On 6/7/16 at 7:18 AM, staff #5 stated to client #2, "I know, I just realized I gave you the wrong spoon" when client #2 picked up her spoon. Staff #5 got another spoon and gave it to client #2.</p> <p>On 6/7/16 at 7:30 AM, a review of client #2's 7/19/15 Individual Support Plan (ISP) indicated, in part, "She requires much assistance in meal preparations but is able to assist in menu selection, mixing/stirring, wiping the table, setting items on the table, and so forth...." Client #2 had a training objective to put her silverware on the table for meals.</p> <p>On 6/7/16 at 9:48 AM, a review of client #3's 10/1/15 ISP indicated, in part, "She will drink from a nose cup with staff assistance; she does not assist by holding it at present...." Client #3 had a training objective to touch her nose cup prior to taking a drink.</p> <p>On 6/7/16 at 8:58 AM, the Program Coordinator indicated the clients' mealtime training objectives should be implemented as written.</p> <p>On 6/7/16 at 8:59 AM, the Area Director indicated the clients' mealtime training objectives should be implemented as written.</p> <p>On 6/7/16 at 10:40 AM, the Program Director indicated the clients' mealtime training objectives should be implemented as written.</p> <p>9-3-4(a)</p>						

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W 0381 Bldg. 00	<p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security.</p> <p>Based on observation and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to ensure all medications were secured in a locked cabinet.</p> <p>Findings include:</p> <p>On 6/7/16 at 10:35 AM while the surveyor was conducting a record review for client #3, the surveyor accessed client #3's drawer in the filing cabinet in order to return her program binders to the storage area. When the surveyor opened the drawer, there was a box of a sample medication (Myrbetriq - overactive bladder, 1 tray of 4 cartons with 7 tablets in each carton) in the unlocked filing cabinet. This affected clients #1, #2, #3 and #4.</p> <p>On 6/7/16 at 10:38 AM, the Area Director indicated the medications should be locked with the rest of client #3's medications.</p> <p>On 6/7/16 at 10:39 AM, the Program Director (PD) indicated the nurse placed</p>	W 0381	<p>Nurse, QIDP, Program Coordinator and all Staff in the homewill be retrained on medication administration procedures to ensure that allmedications are secured in a locked cabinet at all times upon arrival into thehome.</p> <p>Nurse, Program Director and/or Program Coordinator willcomplete weekly observations when in the home to ensure that medications aresecured in a locked cabinet as required.</p>	07/09/2016

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W 0436 Bldg. 00	<p>the sample medications in client #3's filing cabinet. The PD indicated the medication was prescribed by the urologist and sample medications were obtained during the visit. The PD indicated the medication should be locked up.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review for 1 of 2 clients in the sample with adaptive equipment (#1), the facility failed to ensure client #1's communication device was present and available for use at the facility-operated day program and client #1's wheelchair remained in good repair.</p> <p>Findings include:</p> <p>1) On 6/6/16 from 12:49 PM to 1:40 PM, an observation was conducted at the facility-operated day program. During the observation, client #1 did not have an</p>	W 0436	<p>QIDP will retrain staff on making sure Client #1's communication device is transported back and forth from day program so it can be utilized in all environments and on monitoring all clients adaptive equipment including wheelchairs are monitored and staff are documenting on the clients treatment sheets that all equipment in present and in good working condition. QIDP will train staff to report any issues or repairs needed to Program Director immediately so Program Director can have item replaced or repaired in a timely manner.</p> <p>QIDP or Program Coordinator will</p>	07/09/2016

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	<p>electronic communication device for his use. At 1:02 PM when day program staff #1 asked client #1 if he wanted to eat through his g-tube (gastrostomy tube - a tube inserted through the abdomen that delivers nutrition directly to the stomach), client #1 shook his head "no." Staff #1 asked client #1 if he wanted to have his g-tube flushed in the room or in another area, client #1 pointed to indicate he wanted to stay where he was. At 1:10 PM, client #1 indicated he had a communication device. Client #1 pointed indicating the device was at the group home. At 1:10 PM, day program staff #1 indicated client #1 did not bring his communication device to the day program on this day or any other day. Staff #1 indicated the day program staff had worked with client #1 long enough to know what he was communicating with his gestures.</p> <p>On 6/7/16 at 9:06 AM, a review of client #1's record was conducted. Client #1's 1/10/16 Individualized Support Plan included a training objective to improve his ability to express/respond to staff's questions. The ISP indicated, in part, "...At present [client #1] is able to express himself with vocalizations to gain attention or imply 'thank you,' a few gestures, pointing to symbols or words on his previous communication board and</p>		<p>review treatment sheets atleast weekly to ensure that adaptive equipment is being checked and that anyissues are being reported to QIDP.</p> <p>Client #1's pommel was located for his wheelchair and shouldbe inspected by the repair staff on 6/22/16 to determine whether it is able tobe fixed immediately or needs a replacement part.</p> <p>Client #1's wheelchair will also be inspected for otherrequired repairs and these repairs will be completed as soon as possible.</p>	

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	by answering yes/no questions. [Client #1] understands requests and can follow directions/instructions if physically able to do so. His primary means to communicate with staff is using yes/no questions then his DynaVox. [Client #1] understands what others are saying to him during conversations and is generally able to make his wants/needs known to staff. General conversation is achieved by use of yes/no questions as best he and staff can. [Client #1] can utilize a computer with assistance to email his mother or play games." Client #1's undated Goal Tracking Sheet indicated, in part, "[Client #1] will participate in ADL (Adult Daily Living) Skill Development - communication skills. [Client #1] will improve his ability to express/respond to staff questions. [Client #1] will request to use his DynaVox or staff will prompt him to use his DynaVox. Staff will place on chair or desk if in manual (wheelchair). [Client #1] will turn on DynaVox. Staff will ask [client #1] to respond to questions such as: tell me one thing you did at D/S (day services). Tell me what you want to do this evening. Tell me something funny what happened today. Provide verbal cues or greater assistance as needed for him to answer. Encourage use of 'talk button' to facilitate conversation with staff."			

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	<p>On 6/7/16 at 8:41 AM, the Program Coordinator (PC) indicated client #1 should have his communication device with him at the facility-operated day program.</p> <p>2) On 6/6/16 from 12:49 PM to 1:40 PM, an observation was conducted at the facility-operated day program. Observations were conducted at the group home on 6/6/16 from 3:58 PM to 6:38 PM and 6/7/16 from 6:02 AM to 7:40 AM. During the observations, client #1 did not have a pommel (to help prevent person from sliding forward or out of wheelchair and separates the knees to help eliminate skin shear and promote air circulation) on his wheelchair. On 6/6/16 at 12:58 PM, day program staff #1 indicated client #1's wheelchair was missing the pommel. Day program staff #1 indicated she did not know where the pommel was located. She thought the pommel may be at client #1's group home but indicated the group home staff reported they could not locate it.</p> <p>On 6/7/16 at 9:06 AM, a review of client #1's record was conducted. There was no documentation in his record addressing the missing pommel from his wheelchair.</p> <p>On 6/9/16 at 10:09 AM, the Program Director forwarded an email from client #1's wheelchair repair company dated 5/11/16 at 2:34 PM. The email indicated, in part, "[Client #1] did not have his pommel for me to fix it. It was not in [client #4's] bag and they could not find it. I will need to submit for a new armrest pad and the parts for his footrest support bar." There was no documentation the pommel was located following this email.</p> <p>On 6/9/16 at 10:44 AM, the Program Director indicated in an email when asked about the</p>			

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W 0441 Bldg. 00	<p>pommel, "...I would say it is in the office/storage room for D/S (day services); I have no idea where [name of Quality Assurance Specialist] was looking yesterday. [Name of day program Program Coordinator] was going to keep it at Day Service as [name of wheelchair repair company] sees our folks there 95% of the time."</p> <p>On 6/8/16 at 3:04 PM, the Quality Assurance Specialist indicated client #1 should have a pommel on his wheelchair.</p> <p>On 6/8/16 at 3:42 PM, the Program Director indicated the staff from client #1's wheelchair repair company ordered a new pommel in early May 2016.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. Based on record review and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to ensure staff did not prepare the clients for evacuation drills until the evacuation drill was initiated.</p> <p>Findings include:</p> <p>On 6/6/16 at 4:18 PM, a review of the facility's evacuation drills was conducted. The overnight drills (10:00 PM to 6:00 AM) were conducted on 6/24/15 (2</p>	W 0441	<p>QIDP will retrain all staff in the home on proper implementation of evacuation drills. Administrative staff will complete unscheduled practice drills on each shift at least 1x each quarter for one year and then annually ongoing to ensure that staff are effectively evacuating clients without prior preparation. Any concerns or issues will be addressed immediately with the Area Director for client safety.</p>	07/09/2016

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W 0477	<p>minutes), 9/26/15 (2 minutes), 12/10/15 (3 minutes) and 3/17/16 (2 minutes).</p> <p>On 6/7/16 at 6:08 AM, staff #1 (overnight shift staff) indicated she prepared the clients prior to setting off the fire alarm system. Staff #1 indicated prior to setting off the alarm, she put slings under clients #1 and #2 in order to assist them from their beds using a mechanical lift. Staff #1 indicated she also placed the clients' wheelchairs in their rooms next to their beds in order to expedite the evacuation process. Staff #1 stated if there was an emergency, "Not sure I could get them out" due to all clients requiring assistance to be evacuated from the group home.</p> <p>On 6/7/16 at 8:50 AM, the Area Director (AD) indicated the staff should not pre-prepare the clients for evacuation drills. The AD indicated the drills needed to be conducted as if it was an emergency without any prior preparation for the drills. On 6/7/16 at 10:25 AM, the AD indicated the clients' beds were on wheels and could be rolled out of the doors during evacuation drills.</p> <p>9-3-7(a)</p> <p>483.480(c)(1)(i)</p>				

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Bldg. 00	<p>MENUS Menus must be prepared in advance. Based on observation, interview and record review for 1 of 2 clients in the sample (#3) and one additional client (#2), the facility failed to ensure there was a menu for the clients and staff to follow.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 6/6/16 from 3:58 PM to 6:38 PM and 6/7/16 from 6:02 AM to 7:40 AM. During the observations at the group home, there was no menu available for review. On 6/6/16 at 6:30 PM, clients #2 and #3 started to eat their dinner (chicken, noodles and peas). On 6/7/16 at 7:14 AM, clients #2 and #3 started to eat their breakfast (oatmeal).</p> <p>On 6/7/16 at 7:19 AM, staff #1 indicated the group home did not have a current menu to implement. Staff #1 indicated the staff was told the summer menu was coming. Staff #1 indicated a menu was not being implemented at the group home. Staff #1 indicated the staff prepare the items client #2 requests for meals.</p> <p>On 6/7/16 at 7:19 AM, staff #5 indicated the group home did not have a current</p>	W 0477	QIDP will retrain Program Coordinator on ensuring that current menus are placed in the home and available for clients and staff to follow. QIDP will ensure that the menus are available in the homes during their weekly visits.	07/09/2016

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W 0488 Bldg. 00	<p>menu to implement. Staff #5 indicated the staff was told the summer menu was coming. Staff #5 indicated a menu was not being implemented at the group home. Staff #5 indicated the staff prepare the items client #2 requests for meals.</p> <p>On 6/7/16 at 8:56 AM, the Program Coordinator (PC) indicated the staff should be implementing the menu at the group home. The PC indicated the menu was usually posted in the empty plastic sleeve attached to the kitchen cabinet. The PC indicated there should be a menu in the home and the menu should be implemented.</p> <p>On 6/7/16 at 8:56 AM, the Area Director (AD) indicated the staff should be implementing the menu at the group home. The AD indicated there should be a menu in the home and the menu should be implemented.</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 2 of 2 clients who intake nutrition by</p>	W 0488	QIDP and/or Program Coordinator will retrain staff on mealpreparation for all clients at	07/09/2016

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	<p>mouth at the group home (#2 and #3), the facility failed to ensure clients #2 and #3 were involved with preparing their meals and lunches.</p> <p>Findings include:</p> <p>On 6/6/16 from 3:58 PM to 6:38 PM, an observation was conducted at the group home. At 6:04 PM, staff #2 used the food processor to puree noodles. At 6:09 PM, staff #2 used the food processor to puree peas. At 6:11 PM, staff #5 put dishes on the table. At 6:13 PM, staff #2 put the noodle and peas on the table. Staff #3 placed mustard, barbeque sauce and ranch dressing on the table. At 6:18 PM, staff #2 pureed chicken. At 6:20 PM, staff #2 put the chicken on the table. At 6:22 PM, staff #2 poured client #2's drink. At 6:32 PM, staff #2 poured barbeque sauce on client #2's chicken.</p> <p>On 6/7/16 from 6:02 AM to 7:40 AM, an observation was conducted at the group home. At 6:33 AM, staff #5 packed client #2 and #3's lunches. At 6:33 AM, staff #5 stated, "Try to get them ready the night before." At 6:38 AM, staff #5 used the food processor to puree peas for client #3's lunch. At 6:42 AM, staff #5 told client #2 the items she packed in her lunch. Client #2 indicated she did not want raisins in her lunch. At 7:10 AM,</p>		<p>all opportunities.</p> <p>QIDP and or Program Coordinator will complete a daily observationfor 2 weeks to ensure staff are implementing meal preparation opportunities forall clients.</p> <p>QIDP and or Program Coordinator will complete an observation 3x aweek for 2 weeks to ensure staff are implementing meal preparationopportunities for all clients.</p> <p>QIDP and/or Program Coordinator will complete weekly observationsfor 2 months and then monthly ongoing to ensure that mealtime objectives arebeing implemented.</p>	

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W 9999 Bldg. 00	<p>staff #5 opened and poured the contents from an instant oatmeal pouch into a bowl after client #2 chose the flavor she wanted. Staff added water and put the bowl into the microwave. At 7:14 AM, staff #5 stated to client #2, "this is really, really warm" when she put client #2's bowl on the table. At 7:18 AM, staff #5 stated to client #2, "I know, I just realized I gave you the wrong spoon." Staff #5 gave client #2 another spoon. At 7:19 AM, staff #5 stirred client #3's oatmeal. At 7:25 AM, staff #1 stated to staff #5, "You got their lunches ready?" Staff #5 stated to client #2, "I put strawberry cookies in there." Staff #5 stated to staff #1, "I'm sending [client #3] a couple of strawberry granola bars."</p> <p>On 6/7/16 at 8:55 AM, the Program Coordinator (PC) indicated client #2 should be involved in all aspects of meal preparation and packing her lunch. The PC indicated the staff should attempt to involve client #3 to the best of her ability.</p> <p>9-3-8(a)</p> <p>State Findings</p>	W 9999	The QIDP will meet with the Area Director weekly to review all	07/09/2016	

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	<p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(a) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division:</p> <p>11. An emergency intervention for the individual resulting from: a. a physical symptom; b. a medical or psychiatric condition; c. any other event and 14. A significant injury to an individual that includes but is not limited to: f. any occurrence of skin breakdown related to decubitus ulcer, regardless of severity.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 6 incident reports reviewed affecting clients #1 and #3, the facility failed to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours in accordance with state law.</p> <p>Findings include:</p>		<p>incidents to ensure that all incidents that occurred in the homewere reported and reported timely. All reportable incidents will be sentto BDDS within the required timelines. Area Director will monitor toensure incident reports are being submitted in a timely manner and anynecessary corrective action will be taken as needed.</p>	

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	<p>On 6/6/16 at 1:45 PM, a review of the facility's incident reports was conducted and indicated the following:</p> <p>1) On 3/1/16 at 4:00 PM (reported to BDDS on 3/4/16), client #3 was taken to the emergency room (ER) to have an area on her head examined. Client #3 was found to have golf ball size soft lump on the left side of her head above her ear. The 3/4/16 BDDS report indicated, in part, "ER MD (medical doctor) assessed the area to be a 'bruise' although area is not discolored in anyway (sic). He felt certain she did not have a concussion or should be watched for one... Lump still remains soft and not bruised in color and is approx (approximately) 1/2 the size that it was. She seems to not experience pain when area is touched or pressed/when hair is combed..."</p> <p>On 6/6/16 at 2:28 PM, the Area Director indicated the timeframe for submitting reports to BDDS was 24 hours.</p> <p>On 6/7/16 at 10:41 AM, the Program Director indicated the timeframe for submitting reports to BDDS was 24 hours.</p> <p>2) On 6/7/16 at 9:06 AM, a review of client #1's record was conducted. Client #1's 5/23/16 Nursing Progress Note</p>			

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	<p>indicated, in part, "...[Client #1] also has a 2" (inch) diameter red area on his Rt (right) buttocks near his rectum. Asked staff to apply patch to area after his shower. Notified PD (Program Director) of area. Staff report last patch being used. No refills left on script. Faxed PCP's (primary care physician's) office for new script." Client #1's 5/27/16 Nursing Progress Note indicated, "Received new script from PCP for patches. Faxed script to pharmacy. Pharmacy reports patches not covered by Medicaid. Oked (sic) delivering and billing of patches. Pharmacy reports that they will be delivered today. Notified PD and PC (Program Coordinator)." Client #1's 5/31/16 Nursing Progress Note indicated, "...Red area on Rt buttocks remains. Patch covering area. There is now a 1" x (by) 2" red area on his Lt (left) buttocks with two 2mm (millimeters) peeling circles. Notified PD and PC. Asked staff to place patch on area and keep [client #1] off the area. Staff reports [client #1] has had more incontinent episodes and has refused showers. E-mailed day program PD and PC notifying them."</p> <p>There was no documentation the pressure areas on client #1's buttocks were reported to BDDS.</p>			

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	<p>On 6/7/16 at 10:38 AM, the PC indicated the red areas were stage 1 pressure sores and should have been reported to BDDS.</p> <p>On 6/7/16 at 10:41 AM, the PD indicated the red areas were not pressure ulcers. The PD stated, "Just red areas."</p> <p>On 6/8/16 at 12:13 PM, the Registered Nurse (RN) indicated client #1's red area on his buttocks stayed red longer than 20 minutes. The RN stated, "It was a pressure sore." The RN indicated client #1 was having issues with incontinence at the time.</p> <p>9-3-1(b)</p>			