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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G742 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/29/2016 |
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| NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 369 W WASHINGTON ST MORGANTOWN, IN 46160 |
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| W 0000 Bldg. 00 | <p>This visit was for a full recertification and state licensure survey.</p> <p>Survey Dates: April 25, 26, 27, 28 and 29, 2016</p> <p>Facility Number: 005659 Provider Number: 15G742 AIM Number: 100244210</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/6/16.</p> | W 0000 | | |
| W 0140 Bldg. 00 | <p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 1 of 4 clients in the sample (#2), the facility failed to keep an accurate accounting of the client's personal funds entrusted to the facility.</p> <p>Findings include:</p> <p>On 4/26/16 at 8:28 AM, a review of client #2's finances was conducted and</p> | W 0140 | <p>W140 Client Finances</p> <p>The facility failed to keep an accurate accounting of Client 2's personal funds entrusted to the facility.</p> <p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · A receipt for the \$2.00 over in Client 2's in-house account will be issued for \$2.00 "found money." · Program Coordinator will be | 05/29/2016 |

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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| W 0149 | <p>indicated the following: Client #2's April 2016 cash on hand ledger indicated he had \$53.27 in his group home account entrusted to the facility. The Program Coordinator (PC) counted client #2's finances and he had \$55.27. There were no receipts, deposits or additional documentation accounting for the discrepancy in his personal funds.</p> <p>On 4/26/16 at 8:45 AM, the PC indicated the facility should account for client #2's funds to the penny.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> | | <p>trained in regard to ensuring that all receipts will be scanned and change counted upon return from any outing.</p> <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All other client finances have been counted and are accurate and match balances. <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> Program Coordinator will check in-house to money 3x weekly and document to ensure accuracy. Program Director will review documentation of money reconciliation weekly. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> Program Director will review documentation of expenses and reconcile in-house money to balance. <p>1.What is the date by which the systemic changes will be completed?</p> <p>May 29, 2016</p> | | |

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| Bldg. 00 | <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 7 of 13 incident/investigative reports reviewed affecting clients #2, #3, #4 and #7, the facility neglected to implement its policies and procedures to prevent client to client abuse, submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner and ensure the results of an investigation were submitted to the administrator within 5 working days.</p> <p>Findings include:</p> <p>On 4/25/16 at 12:06 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 6/3/15 at 9:40 AM at the facility-operated day program, client #7 told client #3 to "shut up." Client #3 slapped client #7's face. Client #7 was not injured.</p> <p>2) On 6/11/15 at 2:40 PM at the facility-operated day program, client #7 was hit in the face by a peer. Client #7 was not injured.</p> <p>3) On 7/22/15 at 9:30 AM at the</p> | W 0149 | <p>W149 Staff Treatment of Clients The facility neglected to implement its policies and procedures to prevent client to client abuse (Clients 2, 3, 4 and 7), submit incident reports to BDDS in a timely manner and ensure the results of an investigation were submitted to the administrator within 5 working days.</p> <p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Client 7's Behavior Plan has been revised in regard to physical aggression. · Retraining with staff regarding how to prevent peer to peer incidents. · Retraining with Program Director and Area Director regarding completing investigations within the 5-day timeframe. · Investigations will be completed within 5 days of the alleged incident and submitted to the administrator for review. <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All clients have the potential to be affected by this practice. <p>1.What measures will be put into</p> | 05/29/2016 |

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| | <p>facility-operated day program, client #3 was hit by a peer three times. Client #3 was not injured.</p> <p>4) On 8/5/15 at 1:30 PM at the facility-operated day program, client #4 was hit by a peer two times. Client #4 had a red mark on her face. Client #4 was administered a pain reliever and ice was applied to her face.</p> <p>5) On 11/20/15 at 5:30 PM (reported to BDDS on 11/22/15), staff #6 reported staff #10 allegedly used inappropriate language in front of and directed toward client #2. The 12/1/15 BDDS Follow-Up Report indicated, in part, "During the investigation of this event, it was discovered that [client #2] was not the client who the alleged verbal abuse had occurred against. A subsequent report will be filed with the correct information for the correct client. The staff who reported the event had said that [client #2] was the client who had been allegedly verbally abused; however, when [client #2] was interviewed regarding the incident, he reported he was not in the house at this time. Staff was interviewed and confirmed that the allegation involved a different client. Administrative staff will ensure all facts that are relayed at the time of the initial report are correct."</p> | | <p>place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Behavior Analyst will do weekly observations at the group home to monitor for behavioral concerns and appropriate staff intervention. · Program Coordinator will do weekly observations at the group home to monitor for behavioral concerns and appropriate staff intervention. · Quality Improvement Specialist will be notified of all investigations immediately and will follow-up to ensure investigations are completed within proper timeframe. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Quality Improvement Specialist will review all investigations to ensure timeliness of investigations. · Program Director (QIDP) and Area Director will review all observations to ensure that peer to peer incidents are prevented. <p>1.What is the date by which the systemic changes will be completed?</p> <p>May 29, 2016</p> | |

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| | <p>6) On 11/20/15 at 5:30 PM (reported to BDDS on 12/1/15), the BDDS report indicated, in part, "Support Staff [staff #6] had notified Program Coordinator that [staff #10] had used inappropriate language toward a client. At the time of that notification, the name that had been given was not the client who the inappropriate language had been allegedly directed toward. It was discovered in the course of the investigation that the initial client was not in the home at the time of the incident. The staff confirmed that the actual client was [client #3]. The staff is still suspended pending the completion of this investigation...."</p> <p>The results of the investigation were not submitted to the administrator within 5 working days. The investigation indicated the dates of the investigation were 11/30/15, 12/1/15 and 12/4/15. The 12/4/15 Summary of Internal Investigation Report indicated staff #10 responded to two questions from client #3 stating she, "did not give a s---." The investigation indicated staff #10 left the shift without notifying her supervisor or anyone else on 11/20/15 at 5:30 PM. The investigation indicated the Area Director (AD) attempted to contact staff #10 on 11/20/15 and 11/24/15 with no success.</p> | | | |
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| | <p>On 11/30/15 the AD made contact with staff #10. Staff #10 denied verbally abusing client #3. The investigation indicated, "Evidence supports that [staff #10] left shift on 11/20/2015 at around 5:30 PM without notifying supervisor. Evidence supports that [staff #10] did not attempt to contact anyone at any time after leaving (sic) shift nor did she return to fulfill any shift obligations. Evidence supports that [staff #10] was not aware of her suspension until 11/30/15 because her phone had been broken, and no one had been able to contact her. Evidence supports that [staff #10] missed 6 scheduled days without notifying anyone that she was not coming in. Those days were 11/21, 11/22, 11/24, 11/25, 11/26 and 11/27. Evidence supports that [staff #10] had also been a no-call, no show on 11/19... Evidence does not support that [staff #10] was verbally abusive toward [client #3] on 11/20/2015."</p> <p>On 4/25/16 at 12:16 PM, the Area Director (AD) indicated client #2 was initially indicated as being the client involved. The AD indicated during the investigation, it was found out the incident involved client #3 not client #2. The AD indicated she thought the investigation was conducted timely. The AD indicated when she found out the incident involved client #3 and not client</p> | | | |

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| | <p>#2, the timeframe for reporting the results of the investigation changed to a later date. The AD indicated BDDS reports should be submitted within 24 hours. The AD indicated the timeframe for conducting investigations was 5 business days.</p> <p>7) On 4/5/16 at 7:35 PM, client #7 hit a peer with a photo album. The peer was not injured.</p> <p>On 4/26/16 at 8:52 AM, the Program Director (PD) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse of the clients. The PD indicated the timeframe for reporting incidents to BDDS was 24 hours.</p> <p>On 4/25/16 at 12:16 PM, the AD indicated the timeframe for reporting incidents to BDDS was 24 hours.</p> <p>The facility's policy and procedures related to abuse and neglect were reviewed on 4/25/16 at 12:37 PM. The facility's April 2011 Quality and Risk Management policy indicated, "Indiana MENTOR promotes a high quality of service and seeks to protect individuals receiving Indiana MENTOR services</p> | | | | | | |

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| | through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The April 2011 Human Rights policy indicated, in part, "The following actions are prohibited by employees of Indiana MENTOR: abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds; or violation of an individual's rights." The policy indicated, in part, "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." The policy indicated, in part, "Indiana MENTOR follows the BDDS Incident Reporting policy as outlined in the Provider Standards. An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS... An initial report regarding an incident shall be submitted within twenty-four (24) hours of: a) the occurrence of the incident; or b) the reporter becoming aware of or receiving information about an incident...." The | | | |

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| W 0153 Bldg. 00 | <p>policy indicated, in part, "Indiana MENTOR is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident...."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 of 13 incident reports reviewed affecting clients #2 and #3, the facility failed to ensure incident reports were submitted to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>1) On 11/20/15 at 5:30 PM (reported to BDDS on 11/22/15), staff #6 reported</p> | W 0153 | <p>W153 Staff Treatment of Clients The facility failed to ensure incident reports were submitted to BDDS within 24 hours, in accordance with state law.</p> <p>1.What corrective action will be accomplished? Incident reports will be submitted to BDDS within 24 hours of event.</p> <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective</p> | 05/29/2016 |

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| | <p>staff #10 allegedly used inappropriate language in front of and directed toward client #2. The 12/1/15 BDDS Follow-Up Report indicated, in part, "During the investigation of this event, it was discovered that [client #2] was not the client who the alleged verbal abuse had occurred against. A subsequent report will be filed with the correct information for the correct client. The staff who reported the event had said that [client #2] was the client who had been allegedly verbally abused; however, when [client #2] was interviewed regarding the incident, he reported he was not in the house at this time. Staff was interviewed and confirmed that the allegation involved a different client. Administrative staff will ensure all facts that are relayed at the time of the initial report are correct."</p> <p>2) On 11/20/15 at 5:30 PM (reported to BDDS on 12/1/15), the BDDS report indicated, in part, "Support Staff [staff #6] had notified Program Coordinator that [staff #10] had used inappropriate language toward a client. At the time of that notification, the name that had been given was not the client who the inappropriate language had been allegedly directed toward. It was discovered in the course of the investigation that the initial client was</p> | | <p>action will be taken?</p> <ul style="list-style-type: none"> All clients have the potential to be affected by this practice. <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> Training with Program Director (QIDP) regarding importance of filing reports within the 24-hour timeline. Area Director will be notified of all reportable events immediately. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> Program Director will forward all BDDS reports immediately upon submission to BDDS to the Area Director. If a report is not received within 12 hours of reportable event, Area Director will follow-up with Program Director to ensure report is filed. <p>1.What is the date by which the systemic changes will be completed?</p> <p>May 29, 2016</p> | |

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| W 0156 Bldg. 00 | <p>not in the home at the time of the incident. The staff confirmed that the actual client was [client #3]. The staff is still suspended pending the completion of this investigation...."</p> <p>On 4/26/16 at 8:52 AM, the Program Director indicated the timeframe for reporting incidents to BDDS was 24 hours.</p> <p>On 4/25/16 at 12:16 PM, the Area Director indicated the timeframe for reporting incidents to BDDS was 24 hours.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 13 incident/investigative reports reviewed affecting client #3, the facility failed to ensure the results of an investigation were reported to the administrator within 5 working days of the incident.</p> <p>Findings include:</p> | W 0156 | <p>W156 Staff Treatment of Clients The facility failed to ensure the results of an investigation were reported to the administrator within 5 working days.</p> <p>1.What corrective action will be accomplished?</p> <p>Retraining with Program</p> | 05/29/2016 | | | |

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| | <p>On 4/25/16 at 12:06 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 11/20/15 at 5:30 PM, the BDDS report indicated, in part, "Support Staff [staff #6] had notified Program Coordinator that [staff #10] had used inappropriate language toward a client. At the time of that notification, the name that had been given was not the client who the inappropriate language had been allegedly directed toward. It was discovered in the course of the investigation that the initial client was not in the home at the time of the incident. The staff confirmed that the actual client was [client #3]. The staff is still suspended pending the completion of this investigation...."</p> <p>The results of the investigation were not submitted to the administrator within 5 working days. The investigation indicated the dates of the investigation were 11/30/15, 12/1/15 and 12/4/15. The 12/4/15 Summary of Internal Investigation Report indicated staff #10 responded to two questions from client #3 stating she, "did not give a s---." The investigation indicated staff #10 left the shift without notifying her supervisor or anyone else on 11/20/15 at 5:30 PM. The investigation indicated the Area Director</p> | | <p>Director and Area Director regarding completing investigations within the 5-day timeframe.</p> <ul style="list-style-type: none"> Investigations will be completed within 5 days of the alleged incident and submitted to the administrator for review. <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All clients have the potential to be affected by this practice. <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> Quality Improvement Specialist will be notified of all investigations immediately and will follow-up to ensure investigations are completed within proper timeframe. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> Quality Improvement Specialist will review all investigations to ensure timeliness of investigations. <p>1.What is the date by which the systemic changes will be completed?</p> | |

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| | <p>(AD) attempted to contact staff #10 on 11/20/15 and 11/24/15 with no success. On 11/30/15 the AD made contact with staff #10. Staff #10 denied verbally abusing client #3. The investigation indicated, "Evidence supports that [staff #10] left shift on 11/20/2015 at around 5:30 PM without notifying supervisor. Evidence supports that [staff #10] did not attempt to contact anyone at any time after leaving (sic) shift nor did she return to fulfill any shift obligations. Evidence supports that [staff #10] was not aware of her suspension until 11/30/15 because her phone had been broken, and no one had been able to contact her. Evidence supports that [staff #10] missed 6 scheduled days without notifying anyone that she was not coming in. Those days were 11/21, 11/22, 11/24, 11/25, 11/26 and 11/27. Evidence supports that [staff #10] had also been a no-call, no show on 11/19... Evidence does not support that [staff #10] was verbally abusive toward [client #3] on 11/20/2015."</p> <p>On 4/25/16 at 12:16 PM, the Area Director (AD) indicated client #2 was initially indicated as being the client involved. The AD indicated during the investigation, it was found out the incident involved client #3 not client #2. The AD indicated she thought the investigation was conducted timely. The</p> | | May 29, 2016 | | | | |

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| W 0159 Bldg. 00 | <p>AD indicated when she found out the incident involved client #3 and not client #2, the timeframe for reporting the results of the investigation changed to a later date. The AD indicated the timeframe for conducting investigations was 5 business days.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 1 of 4 clients in the sample (#2), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor client #2's program plans and application for a Bureau of Developmental Disabilities Services Community Integration and Habilitation (CIH) waiver. The QIDP failed to effectively communicate with client #2's former QIDP to ensure follow-up was conducted to ensure BDDS received the required information for client #2's CIH waiver application.</p> <p>Findings include:</p> | W 0159 | <p>W159 QIDP - REVISED The facility's Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor Client 2's program plans and application for BDDS CIH waiver. The QIDP failed to effectively communicate with Client 2's former QIDP to ensure follow-up was conducted to ensure BDDS received the required information for Client 2's CIH waiver application.</p> <p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · All paperwork for CIH waiver for Client 2 has been forwarded to current QIDP from former QIDP. · Current QIDP has | 05/29/2016 | | | |

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| | <p>On 4/26/16 at 6:37 AM, client #2 indicated he wanted to move out to an apartment on his own. Client #2 indicated he thought the process was started last year following the annual recertification survey however when he spoke to the BDDS Coordinator in January 2016, the Coordinator told him he had not received the application for a waiver for client #2. Client #2 indicated he had worked hard to become as independent as possible over the past year. Client #2 stated, "I did my end and they didn't hold up their end. Frustrating."</p> <p>On 4/28/16 at 10:09 AM, the QIDP - Designee (QIDP-D) indicated when the group home transitioned from one Mentor office to another for oversight on 10/1/15, she was not informed client #2 was in the process of applying for a waiver. The QIDP-D indicated she became aware of the situation when client #2 brought it to her attention. The QIDP-D indicated client #2 called the BDDS Coordinator to ask about the progress being made. The QIDP-D indicated client #2 was told BDDS had not received an application for his waiver.</p> <p>On 4/27/16 at 12:37 PM, the BDDS Service Coordinator (SC) indicated he</p> | | <p>communicated with BDDS Service Coordinator regarding paperwork that is still necessary for CIH waiver.</p> <ul style="list-style-type: none"> Current QIDP has forwarded paperwork to guardian for applicable signatures necessary for CIH waiver. Paperwork not completed properly by former QIDP will be updated and forwarded to BDDS for consideration for CIH waiver. <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All clients and guardians will have the opportunity at annual ISP to express interest in CIH waiver. <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> Prior to a transfer of programs from one area to another, the QIDP will ensure that all appropriate paperwork is transferred. A checklist will be created for transition times to ensure that all applicable paperwork, and anything in process is followed up on. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> Area Director will review checklist prior to any transition | |

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| | <p>received a call from the (former) Program Director (PD) on 5/7/15 indicating client #2 was interested in a waiver. The SC set up a meeting with client #2 and the PD. The SC indicated they met on 5/19/15 to discuss the waiver and how it compared to a group home. The SC indicated he explained the difference between the two and client #2 was interested in applying for a waiver. The SC indicated he emailed the application packet to the PD on 5/19/15. The SC indicated the PD did not submit the application. The SC stated the PD "never got back to me." The SC indicated he did not hear anything from them until client #2 called him on 1/26/16. The SC informed client #2 he did not receive an application for a waiver. The SC indicated he did not receive an application for client #2's waiver.</p> <p>On 4/27/16 at 12:54 PM, the former PD stated, "That's a good question" when asked why client #2's application was not submitted to BDDS. The PD indicated she submitted all the paperwork to the SC. The PD indicated when the SC received the paperwork, he asked for a signature from client #2's guardian due to the guardian signing the form in the wrong place. The PD indicated she obtained the signature from the guardian and resubmitted the application. The PD</p> | | <p>period to ensure that all has been processed prior to transition.</p> <ul style="list-style-type: none"> · Prior to transfer of programs from one area to another area, the IDT will convene with each client and families, guardians of clients and BDDS to ensure that anything in process is continued. · Prior to transfer of programs, all paperwork connected to that program (including BDDS reports, prior surveys, client-specific paperwork, etc) will be transferred to administrators of new area. Transfer will not occur until all paperwork has been forwarded to new area. · Prior to transfer of programs, Area Director will consult with state agencies to ensure that anything in process (such as waiver applications) will continue. <p>1. What is the date by which the systemic changes will be completed?</p> <p>May 29, 2016</p> | |

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| | <p>indicated she was not sure why the SC said she did not send him anything. The PD indicated on 10/1/15, the group home's oversight moved from her office to another office. The PD indicated at the time of the transition from one office to the other, she informed the new office of the pending waiver application for client #2.</p> <p>On 4/27/16 at 4:27 PM, the former PD sent an email with the application for client #2's waiver to the surveyor and the BDDS SC. The application was dated 7/10/15 as evidenced by the guardian's signature and date. The application for a waiver indicated, in part, "[Client #2] has lived in [name of group home] over 5 years. State Board of Health has requested BDDS be contacted for [client #2] to receive a waiver rather than a (W)198 citation being given. The email indicated, "[Name of surveyor], attached is the waiver application that was sent to [SC] last summer. [Name of SC], every few months our email purges old email and I don't have the email records from our communication last summer regarding [client #2's] waiver. [Client #2] and I had a phone conversation with you around June, you sent me the waiver application, which is attached, and we met with his guardian in July to have it filled out. In June he had his COD</p> | | | |
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| | <p>(Confirmation of Diagnosis) form completed and I believe I scanned and sent everything to you sometime in July. For purposes of the [name of group home] annual group home survey can you look back through your emails, if they do not purge and see if you have our emails from July/August 2015."</p> <p>On 4/28/16 at 7:59 AM, the BDDS SC responded to the PD's email, "Good morning [PD's name], Hope you had a pleasant weekend? (sic) The CIH waiver application is not dated. The application needs to be dated. Please have legal guardian date the application and scan it back to me. Also, the COD does not reflect all the diagnosis (sic) [client #2] has. Please have physician list all diagnosis (sic) on the COD with onset dates. Please have the physician sign and date the COD. Thank you."</p> <p>On 4/28/16 at 11:49 AM, the QIDP for the group home indicated she was not aware and did not know who client #2 was. The QIDP indicated she was not aware of client #2 applying for a waiver and was not informed when her office took over supervision of the group home in October 2015. The QIDP stated, "It's not my home so I don't know. I don't deal with that house. I sign off on the data sheets but I don't think I have signed</p> | | | |

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| | <p>off on anything for [name of group home]." The QIDP stated, "I'm not involved in it."</p> <p>On 4/28/16 at 11:56 AM, the Area Director (AD) indicated when her office took over administration of client #2's group home, the former office staff did not communicate (or she did not recall) that client #2 was in the process of applying for a waiver. The AD indicated she became aware of client #2 wanting a waiver during his annual on 3/17/16. The AD indicated from 10/1/15 (when her office took over administration of the group home) to 3/17/16, client #2 did not say anything about the waiver. The AD indicated client #2 said he thought his application for a waiver was being taken care of. The AD indicated her office would assist client #2 with applying for the waiver. The AD indicated the QIDP-D needed to fill out the application. The AD indicated following the 3/17/16 meeting, she was aware of client #2's desire to apply for a waiver but had not had the chance to fill out the application. The AD stated, "It's something that's on my list." The AD was informed the former PD submitted the application to BDDS on 4/27/16. The AD indicated the former office had not communicated anything to her office. The AD stated until 3/17/16, "I didn't</p> | | | |

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| W 0198 Bldg. 00 | <p>even know he was interested in a waiver." The AD indicated the QIDP oversees the group home. When told the QIDP indicated she did not know who client #2 was, the AD indicated the QIDP should know who client #2 was. The AD stated, "I'm surprised she doesn't (know)." The AD indicated the QIDP should be involved and performing the QIDP duties.</p> <p>9-3-3(a)</p> <p>483.440(b)(1) ADMISSIONS, TRANSFERS, DISCHARGE Clients who are admitted by the facility must be in need of and receiving active treatment services.</p> <p>Based on observation, interview and record review for 1 of 4 clients in the sample (#2), the facility failed to ensure client #2 was in need of and received active treatment services.</p> <p>Findings include:</p> <p>On 4/25/16 from 3:50 PM to 5:46 PM, an observation was conducted at the group home. Client #2 was not present during the observation due to having a community job (he worked 9:00 AM to 6:00 PM on this date).</p> | W 0198 | <p>W198 Admission, Transfers, Discharge The facility failed to ensure Client 2 was in need of and received active treatment services.</p> <p>1.What corrective action will be accomplished? · CIH waiver paperwork has been turned into BDDS for Client 2.</p> <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All clients will be assessed on an annual basis in terms of active</p> | 10/26/2016 |

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| | <p>On 4/25/16 at 3:39 PM, staff #4 indicated client #2 had the skills to live on his own. Staff #4 indicated client #2 had talked to her several times over the years about wanting to move out to an apartment. Staff #4 indicated client #2 had money management skills, medication administration skills, cooking skills and laundry skills. Staff #4 indicated client #2 was accepted as a transfer student at a college. Staff #4 indicated client #2 was able to use his laptop independently. Staff #4 indicated client #2 did not have any maladaptive behaviors. Staff #4 stated, "He can figure out things. Very intelligent." Staff #4 indicated client #2 participated in and met his training goals.</p> <p>On 4/25/16 at 4:54 PM, staff #2 indicated client #2 had the skills to move out of the group home. Staff #2 indicated client #2 did not need active treatment services due to his functioning level being so high. Staff #2 indicated client #2 had a smart phone and was independent with its use. Staff #2 indicated client #2 was taking college classes. Staff #2 indicated client #2 had money management skills, laundry skills, pedestrian safety skills and no behaviors. Staff #2 stated client #2 was "very skilled." Staff #2 indicated client #2 worked very hard this past year (the amount of time she had worked at the group home) to be as independent as</p> | | <p>treatment needs.</p> <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Training with Program Director (QIDP) regarding assessment of individuals and desires of individuals in terms of active treatment. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Area Director will review annual assessments to ensure clients still qualify for active treatment services. <p>1.What is the date by which the systemic changes will be completed?</p> <p>October 26, 2016</p> | |

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| | <p>possible.</p> <p>On 4/25/16 at 5:11 PM, the Program Coordinator (PC) indicated the Bureau of Developmental Disabilities Services (BDDS) Coordinator promised client #2 he would get a waiver. The PC indicated client #2 needed a waiver due to his level of independence.</p> <p>On 4/26/16 from 6:13 AM to 7:59 AM, an observation was conducted at the group home. At 6:37 AM, client #2 was dressed for work at a community job. At 7:04 AM, client #2 ate breakfast independently and took his dishes to the kitchen when he was finished eating. Client #2 utilized his electric wheelchair to move around the group home, onto the ramp to the van and into position in the van with no issues noted.</p> <p>On 4/26/16 at 6:37 AM, client #2 indicated he started working 33 hours a week at a store on 4/20/16 as a greeter. Client #2 indicated he transferred his college to a local college due to transportation issues on the former college's campus. Client #2 indicated he wanted to move out to an apartment on his own. Client #2 indicated he thought the process was started last year however when he spoke to the BDDS Service Coordinator in January 2016, the</p> | | | |

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| | <p>Coordinator told him he had not received the application for a waiver for client #2. Client #2 indicated he had worked hard to become as independent as possible over the past year. Client #2 stated, "I did my end and they didn't hold up their end. Frustrating."</p> <p>On 4/26/16 at 8:56 AM, a review of client #2's record was conducted. Client #2 did not have a Behavior Support Plan to address maladaptive behaviors. Client #2's 3/17/16 Individual Support Plan indicated he had the following training objectives: budgeting, packing lunch, hygiene skills, social interaction in the community, going to the medication room independently and taking his prescribed medications, participate in community activities of his choice, community employment and investigating college classes. Client #2's 4/25/16 Individual Plan of Protective Oversight indicated, in part, "Can the individual explain medical information to medical professionals? Yes. Can the individual apply simple first aid or identify their need for first aid? Yes. How does the individual respond to pain? [Client #2] can communicate pain and health concerns to staff. Behavior Management Programs/Staff Guidelines? No. Is person aware of personal rights and can protect self? No. Comments:</p> | | | |

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| | <p>While [client #2] can advocate for his rights, he does have a guardian to ensure that he (sic) his rights are protected... Can the individual dial 911? Yes. If yes, can the individual relay pertinent information to the 911 dispatcher? Yes... Money Management - [Client #2] understands the value of money and can relate cost of items to money. He requires guidance in making appropriate purchases, but he is able to make purchases independently... [Client #2] is able to carry \$20.00 on his person... Able to select appropriate clothing? Yes... Supervision in the Community - [Client #2] is able to be at his community job without staff supervision... [Client #2] will not misuse hazardous materials and they are available for his use."</p> <p>Client #2's Indiana Mentor Monthly Summaries indicated the following regarding his program plan training objectives: -April 2015: "[Client #2] works part-time at [name of store]... [Client #2] is also attending classes at [name of community college]... Twice daily, [client #2] will come to the med room at the time of medication administration with no more than 1 verbal prompt - met 100%. Three times weekly, [client #2] will engage in conversation with a peer independently 100% of the time - met 100%. Weekly,</p> | | | |

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| | <p>[client #2] will pack his lunch - met 100%. During the first week of each month, [client #2] will help balance his cash-on-hand account - met 100%.</p> <p>-May 2015: [Client #2] works part-time at [name of store]... [Client #2] is also attending classes at [name of community college]...</p> <p>-June 2015: [Client #2] works part-time at [name of store]... [Client #2] is also attending classes at [name of community college]... At least once weekly, [client #2] will prepare a side dish - met 100%. Three times weekly, [client #2] will engage in conversation with a peer independently 100% of the time - met 75%. Weekly, [client #2] will pack his lunch - met 75%. During the first week of each month, [client #2] will help balance his cash-on-hand account - met 75%.</p> <p>-July 2015: [Client #2] works part-time at [name of store]... [Client #2] is also attending classes at [name of community college]... Three times weekly, [client #2] will engage in conversation with a peer independently 100% of the time - met 100%. During the first week of each month, [client #2] will help balance his cash-on-hand account - met 100%.</p> <p>-August 2015: [Client #2] works part-time at [name of store]... [Client #2] is also attending classes at [name of community college]... Three times</p> | | | |

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| | <p>weekly, [client #2] will engage in conversation with a peer independently 100% of the time - met 100%. During the first week of each month, [client #2] will help balance his cash-on-hand account - met 100%.</p> <p>-September 2015: [Client #2] works part-time at [name of store]... [Client #2] is also attending classes at [name of community college]... At least once weekly, [client #2] will prepare a side dish - met 100%. Three times weekly, [client #2] will engage in conversation with a peer independently 100% of the time - met 100%. Weekly, [client #2] will pack his lunch - met 75%. During the first week of each month, [client #2] will help balance his cash-on-hand account - met 100%.</p> <p>-October 2015: Client #2 met his packing lunch training objective at 81%, volunteering in the community at 80%, and putting his shirt on independently 81%."</p> <p>-November 2015: No data</p> <p>-December 2015: Client #2 met his medication administration training objective 100%.</p> <p>-January 2016: Client #2 met his packing lunch training objective at 100%, volunteering in the community at 80%, medication administration training objective 96%, and putting on his shirt independently 97%.</p> | | | |

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| | <p>-February 2016: Client #2 met his medication administration training objective 100% and putting on his shirt independently 81%.</p> <p>-March 2016: Client #2 met his packing lunch training objective at 100%, volunteering in the community at 100% and putting on his shirt independently 71%.</p> <p>On 4/28/16 at 10:09 AM, the Program Director (PD) indicated client #2 was ready to move out of the group home. The PD stated, "he would thrive a lot more." The PD stated, "Very bright. Computer, Xbox, smartphone. iPad. Signed up for college courses. Wants to do something with his life. Would do well." The PD indicated client #2 had no behavior issues. The PD indicated he had money management skills, medication administration skills and laundry and cooking skills. The PD indicated client #2 completed his training objectives. The PD stated client #2, "has the skills." The PD stated client #2 "hates being in a group home."</p> <p>On 4/29/16 at 10:58 AM, client #2's Employment Consultant (EC) indicated client #2 was working 33 hours a week at a store as a greeter. The EC indicated she had known client #2 for 7 years. The EC indicated client #2 was ready to move</p> | | | |

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| W 0259 Bldg. 00 | <p>into his own apartment. The EC stated client #2 was "sensible, very capable and very independent." The EC indicated there were no issues with his past, part-time employment at a store and at his new job. The EC stated client #2 "wants to have the same independence as everyone else."</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 2 of 4 clients in the sample (#5 and #6), the facility failed to ensure the clients' comprehensive functional assessments (CFA) were reviewed for relevancy and updated at least annually.</p> <p>Findings include: On 4/26/16 at 9:52 AM, a review of client #5's record was conducted. Client #5's most recent CFA was conducted on 6/15/14. There was no documentation in client #5's record indicating his CFA was reviewed and updated annually since 6/15/14.</p> | W 0259 | <p>W259 Program Monitoring and Change The facility failed to ensure the clients (5 and 6) comprehensive functional assessments (CFA) were reviewed for relevancy and updated at least annually.</p> <p>1.What corrective action will be accomplished? · Comprehensive Functional Assessment updated for Client 5 and 6.</p> <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> | 05/29/2016 |

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| W 0263 Bldg. 00 | <p>On 4/26/16 at 10:21 AM, a review of client #6's record was conducted. Client #6's most recent CFA was conducted on 6/5/14. There was no documentation in client #6's record indicating his CFA was reviewed and updated annually since 6/5/14.</p> <p>On 4/26/16 at 10:47 AM, the Area Director indicated the clients' CFAs should be reviewed and updated at least annually or more frequently if there was a change in their status.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on observation, record review and interview for 2 of 4 clients in the sample (#2 and #3), the facility's specially constituted committee (Human Rights</p> | W 0263 | <ul style="list-style-type: none"> Program Director (QIDP) will review all clients CFAs to ensure that they have been reviewed and updated. <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> Training with Program Director in regard to ISP process and updating CFAs. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> Area Director will review CFAs prior to annual meeting to ensure that updates have occurred. <p>1.What is the date by which the systemic changes will be completed?</p> <p>May 29, 2016</p> <p>W263 Program Monitoring and Change The facility's specially constituted committee (Human Rights Committee – HRC) failed to ensure</p> | 05/29/2016 |

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| | <p>Committee - HRC) failed to ensure written informed consent was obtained for the use of 1) door knob covers and 2) exit door alarms.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 4/25/16 from 3:50 PM to 5:46 PM and 4/26/16 from 6:13 AM to 7:59 AM. During the observations, the kitchen half door and one bathroom door had a cover over the door knobs. This affected clients #2 and #3.</p> <p>On 4/26/16 at 7:15 AM, staff #9 indicated the door knob covers were in place to deter client #6 from drinking water due to excessive fluid seeking. Staff #9 indicated the covers were always in place.</p> <p>On 4/26/16 at 8:56 AM, a review of client #2's record was conducted. Client #2's record indicated he had a guardian. There was no documentation in client #2's record indicating written informed consent was obtained from client #2's guardian for the use of the door knob covers.</p> <p>On 4/26/16 at 9:21 AM, a review of client #3's record was conducted. Client #3's record indicated he was</p> | | <p>written informed consent was obtained for the use of door knob covers and exit door alarms for Client 2 and 3.</p> <p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · HRC approval obtained for restriction of Client 2 and 3 in regard to door alarms and door knob covers. · Informed consent obtained from Client 2 and 3, along with guardian consent, for the restriction. <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · Informed consent will be obtained from all clients in the home for the restrictions, and HRC approval obtained. <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Training with Program Director (QIDP) regarding restrictive measures that must have approval. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Area Director will review behavior plans annually to ensure restrictions have HRC approval. | |

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| | <p>emancipated. There was no documentation in client #3's record indicating written informed consent was obtained from client #3 for the use of the door knob covers.</p> <p>On 4/26/16 at 10:19 AM, the Area Director (AD) indicated the use of the door knob covers was a restriction requiring written informed consent to be obtained.</p> <p>2) Observations were conducted at the group home on 4/25/16 from 3:50 PM to 5:46 PM and 4/26/16 from 6:13 AM to 7:59 AM. During the observations when one of the two back doors to the group home was opened, an audible alert sounded. On 4/25/16 at 4:16 PM, client #4 opened the back door and an alarm sounded. At 4:19 PM when the back door opened, the alarm sounded. This affected clients #2 and #3.</p> <p>On 4/26/16 at 8:56 AM, a review of client #2's record was conducted. Client #2's record indicated he had a guardian. There was no documentation in client #2's record indicating written informed consent was obtained from client #2's guardian for the use of the door alarms.</p> <p>On 4/26/16 at 9:21 AM, a review of client #3's record was conducted. Client</p> | | <p>1.What is the date by which the systemic changes will be completed?</p> <p>May 29, 2016</p> | | |

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| W 0264 Bldg. 00 | <p>#3's record indicated he was emancipated. There was no documentation in client #3's record indicating written informed consent was obtained from client #3 for the use of the door alarms.</p> <p>On 4/26/16 at 10:19 AM, the Area Director (AD) indicated the use of the door alarms was a restriction requiring written informed consent to be obtained.</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 other areas that the committee believes need to be addressed.</p> <p>Based on observation, record review and interview for 2 of 4 clients in the sample (#2 and #3), the facility's specially constituted committee (Human Rights Committee - HRC) failed to review, approve and monitor the use of door knob covers to prevent client #2 and #3's peer from drinking out of the bathroom</p> | W 0264 | <p>W264 Program Monitoring and Change The facility's HRC failed to review, approve and monitor the use of door knob covers to prevent Client 2 and 3's peer from drinking out of the bathroom and kitchen sinks and bathroom toilets and showers.</p> | 05/29/2016 |

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| | <p>and kitchen sinks and bathroom toilets and showers.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/25/16 from 3:50 PM to 5:46 PM and 4/26/16 from 6:13 AM to 7:59 AM. During the observations, the kitchen half door and one bathroom door had a cover over the door knobs. This affected clients #2 and #3.</p> <p>On 4/26/16 at 7:15 AM, staff #9 indicated the door knob covers were in place to deter client #6 from drinking water due to excessive fluid seeking. Staff #9 indicated the covers were always in place.</p> <p>On 4/26/16 at 8:56 AM, a review of client #2's record was conducted. There was no documentation in client #2's record indicating the HRC reviewed, approved and monitored the use of the door knob covers.</p> <p>On 4/26/16 at 9:21 AM, a review of client #3's record was conducted. There was no documentation in client #3's record indicating the HRC reviewed, approved and monitoring the use of the door knob covers.</p> | | <p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> HRC approval obtained for restriction of Client 2 and 3 in regard to door knob covers. <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> HRC approval will be obtained for restriction of door knob covers for all clients. <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> Training with Program Director (QIDP) regarding restrictive measures that must have approval. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> Area Director will review behavior plans annually to ensure restrictions have HRC approval. <p>1.What is the date by which the systemic changes will be completed?</p> <p>May 29, 2016</p> | | | | |

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| W 0312 Bldg. 00 | <p>On 4/26/16 at 10:19 AM, the Area Director (AD) indicated the facility's HRC did not review, approve or monitor the use of the group home's door knob covers. The AD indicated this was a restriction requiring the review and approval of the facility's HRC.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 2 of 3 clients (#3 and #6) in the sample who were prescribed psychotropic medications, the facility failed to ensure the clients' program plans included a plan to reduce the use of the psychotropic medications.</p> <p>Findings include:</p> <p>On 4/26/16 at 9:21 AM, a review of client #3's record was conducted. Client #3's 8/27/15 Behavior Support Plan included the use of psychotropic medications. The plan indicated client #3</p> | W 0312 | <p>W312 Drug Usage The facility failed to ensure the clients' program plans included a plan to reduce the use of the psychotropic medications for Client 3 and 6.</p> <p>1.What corrective action will be accomplished? · Client 3 and Client 6's behavior plan has been updated to include a plan of reduction for their psychotropic medications.</p> <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective</p> | 05/29/2016 |

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| | <p>was prescribed the following medications: Lexapro as an anti-depressant and Zyprexa as an anti-psychotic. The 8/27/15 Medication Management Plan was blank in the Description of Criteria for Medication Reduction section. The Criteria for Reduction section was blank. The Current Medication Targeted if Achieved section was blank. The Reduction Amount if Achieved section was blank.</p> <p>On 4/26/16 at 10:21 AM, a review of client #6's record was conducted. Client #6's 8/27/15 Behavior Support Plan included the use of psychotropic medications. The plan indicated client #6 was prescribed the following medications: Fluoxetine for obsessiveness, Olanzapine for "reactive" (sic), and Lorazepam and Alprazolam for anti-anxiety. The 8/27/15 Medication Management Plan was blank in the Description of Criteria for Medication Reduction section. The Criteria for Reduction section was blank. The Current Medication Targeted if Achieved section was blank. The Reduction Amount if Achieved section was blank.</p> <p>On 4/26/16 at 9:26 AM, the Area Director indicated the clients should have psychotropic medication reduction plans.</p> | | <p>action will be taken?</p> <ul style="list-style-type: none"> All clients behavior plans will be reviewed to ensure that a plan of reduction is in place for psychotropic medications. <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> Training with Program Director (QIDP) regarding ensuring behavior plans are updated when a psychotropic medication is added. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> Program Director (QIDP) will ensure plans are updated when additional medication is added to a plan. Program Director (QIDP) will review all behavior plans at least annually to ensure that psychotropic medications are accurate and that a plan of reduction is in place. <p>1.What is the date by which the systemic changes will be completed?</p> <p>May 29, 2016</p> | |

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| W 0436 Bldg. 00 | <p>9-3-5(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 2 of 2 clients (#2 and #8) utilizing wheelchairs for mobility, the facility failed to ensure their wheelchairs remained in good repair.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 4/25/16 from 3:50 PM to 5:46 PM and 4/26/16 from 6:13 AM to 7:59 AM. During the observation on 4/26/16 (client #2 was not at the group home on 4/25/16 due to being at work during the observation), client #2's feet were hanging off the end of his footplates. The straps were not securing client #2's feet to the footplates. The straps were wrapped around client #2's lower leg however the straps did not secure his feet to the footplates. Client #2's controller pad cover was missing</p> | W 0436 | <p>W436 Space and Equipment The facility failed to ensure that Client 2 and 8's wheelchairs remained in good repair.</p> <p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Program Coordinator will continue to work with wheelchair provider regarding repairs of Client 2 and 8's wheelchairs. · Program Director (QIDP) will investigate other options for wheelchair providers if current provider is unable to facilitate repairs. <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · Client 2 and 8 are the only clients utilizing wheelchairs at this site. | 05/29/2016 |

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| | <p>(there were several holes exposed however none of them were labeled - the controller pad cover would have pieces going into the holes to make selections for functions of the wheelchair).</p> <p>On 4/26/16 at 6:37 AM, client #2 indicated he had continuous issues with his wheelchair since March 2015. Client #2 indicated the footplates on his wheelchair were loose and broken, the battery did not hold a charge, and the controller pad cover was missing (have to put a pen in the holes to make selections on the controller pad).</p> <p>On 4/26/16 at 8:56 AM, a review of client #2's record was conducted. There was documentation in client #2's record of wheelchair evaluations conducted on 10/6/15 and 10/15/15. The 10/6/15 Medical Appointment Form indicated, "w/c (wheelchair) repair. Chair left for repair. Pending insurance approval." No additional information regarding the repairs needed was indicated." The 10/15/15 Medical Appointment Form indicated, "w/c returned - able to use as is. Ins. (insurance) approval in process." There was no additional information indicated on the form. There was no additional documentation in client #2's record of wheelchair repairs being made or assessments being completed.</p> | | <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> Program Coordinator will contact wheelchair provider daily and document contact until repairs are made to chairs. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> Program Director will review daily documentation of contact with wheelchair repair provider. Program Director will contact wheelchair provider weekly to also ensure that repairs are completed. <p>1.What is the date by which the systemic changes will be completed?</p> <p>May 29, 2016</p> | | |

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| | <p>On 4/26/16 at 11:03 AM, the Program Director (PD) indicated on October 1, 2015, client #2's electric wheelchair was getting repaired. The PD indicated while his wheelchair was in for repair, he was in a manual wheelchair. The PD indicated when client #2's wheelchair was returned, it still needed new parts. The PD indicated there were on-going issues with client #2's footrests and battery. The PD indicated when she contacted the company conducting the repairs on client #2's wheelchair, the company indicated they were waiting on making the repairs until Medicaid approved the repairs. The PD indicated she told the wheelchair repair company that Mentor would pay the bill. The PD indicated the company would not make the repairs until Medicaid approved the repairs. The PD indicated Mentor staff went and picked up client #2's wheelchair and got a referral to another repair company. The PD indicated client #2's wheelchair required repairs to function properly.</p> <p>On 4/26/16 at 11:07 AM, the Area Director indicated Mentor was willing to pay for the repairs to client #2's wheelchair.</p> <p>On 4/27/16 at 12:24 PM, the nurse stated</p> | | | |

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| | <p>the wheelchair provider "just quit." The nurse indicated the group home took client #2's wheelchair in, left it for 2 days and the wheelchair repair company indicated the wheelchair was acceptable to use as is until they got the repairs approved by insurance. The nurse indicated the insurance did not approve the repairs. The nurse indicated client #2's physiatrist found another wheelchair repair company. The nurse indicated client #2 had an appointment to get his wheelchair assessed. The nurse indicated the issues she was aware of were the fit of the wheelchair since client #2 grew taller and gained some weight. The nurse indicated client #2 was having on-going issues with the footrests as well. The nurse indicated client #2's wheelchair needed repaired.</p> <p>2) Observations were conducted at the group home on 4/25/16 from 3:50 PM to 5:46 PM and 4/26/16 from 6:13 AM to 7:59 AM. During the observations, client #8 was in a loaner wheelchair.</p> <p>On 4/26/16 at 11:03 AM, the PD indicated on 10/1/15 client #8's electric wheelchair was taken in for repairs. While client #8's wheelchair was being repaired, she was in a manual wheelchair. The PD indicated when client #8 received her wheelchair back, it still needed</p> | | | |

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| | <p>repairs due to the wheelchair repair shop breaking her controller. The PD indicated client #8 was given a loaner electric wheelchair to use until her wheelchair was repaired. The PD indicated client #8 had been in the loaner wheelchair for approximately one month.</p> <p>On 4/26/16 at 11:07 AM, the Area Director indicated Mentor was willing to pay for the repairs to client #8's wheelchair.</p> <p>On 4/28/16 at 11:46 AM, a focused review of client #8's record was conducted. Client #8's 7/1/15 Medical Appointment Form indicated, "Wire broken on electric wheelchair. Chair is being left at [name of company] for a repair evaluation." A 9/25/15 Medical Appointment Form indicated, "W/C repair. W/C left for repair. Pending insurance approval." There was no documentation of the repairs needed. A 10/15/15 Medical Appointment Form indicated, "W/C returned - able to use as is. Ins. approval in process." No additional information was documented regarding the repairs needed to client #8's wheelchair. There was no documentation the repairs were made to client #8's wheelchair. There was no documentation of client #8's wheelchair being taken in for repairs since 10/15/15. There was no</p> | | | |

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| W 0440 Bldg. 00 | <p>documentation indicating when client #8 received the loaner wheelchair she was using during the survey.</p> <p>On 4/27/16 at 12:24 PM, the nurse indicated client #8's electric wheelchair's controller was damaged. The nurse indicated client #8 was currently in a loaner wheelchair. The nurse indicated she was not sure how long client #8 had been in the loaner wheelchair. The nurse indicated the controller and armrests needed to be repaired on client #8's wheelchair. The nurse indicated the repair company was contacted several times but would not make repairs without insurance approval. The nurse indicated she was not sure if client #8 had an appointment to get her wheelchair repaired or not at this time.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure quarterly evacuation drills were conducted for each shift of personnel.</p> | W 0440 | <p>W440 Evacuation Drills The facility failed to conduct evacuation drills for each quarter of each shift of personnel.</p> <p>1.What corrective action will be accomplished?</p> | 05/29/2016 |

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| W 0488 Bldg. 00 | <p>Findings include:</p> <p>On 4/25/16 at 3:33 PM, a review of the facility's evacuation drills was conducted and indicated the following: During the day shift (7:00 AM to 3:00 PM), the facility failed to conduct evacuation drills from 10/8/15 to 4/25/16. During the evening shift (3:00 PM to 11:00 PM), the facility failed to conduct evacuation drills from 5/11/15 to 11/7/15. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>On 4/26/16 at 11:15 AM, the Area Director indicated the facility should conduct one evacuation drill per shift per quarter.</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats</p> | | <ul style="list-style-type: none"> · First and second shift fire drills will be completed by May 29, 2016. <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All clients have the potential to be affected by this deficient practice. <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Program Coordinator provided with a tracking form to ensure drills are done in accordance to federal guidelines. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Area Director and Program Director will review drills monthly to ensure drills are being properly run. <p>1.What is the date by which the systemic changes will be completed?</p> <p>May 29, 2016</p> | | |

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| | <p>in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the clients were involved with grocery shopping.</p> <p>Findings include:</p> <p>On 4/25/16 from 3:50 PM to 5:46 PM, an observation was conducted at the group home. At 3:50 PM, the Program Coordinator (PC) arrived to the group home with groceries in her vehicle. Clients #1, #2, #3, #4, #5, #6, #7 and #8 were not home and not with the PC. At 3:53 PM, the PC indicated she attempted to time her arriving to the group home to when the clients returned home from the day program so the clients could assist her with carrying in the groceries. Clients #1, #2, #3, #4, #5, #6, #7 and #8 returned to the group home at 3:58 PM from the day program. On 4/25/16 at 4:09 PM, client #3 asked the PC if she bought salad. The PC stated, "I got 8 bags of salad!" The PC stated to client #7, "Look here what I got you (she showed him drinks she had purchased)."</p> <p>On 4/26/16 at 11:08 AM, the Program Director indicated the clients should be involved with grocery shopping.</p> | W 0488 | <p>W488 Dining and Areas and Service</p> <p>The facility failed to ensure the clients were involved with grocery shopping.</p> <p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Program Coordinator will give every client the opportunity to be involved in grocery on a monthly rotation schedule. · Program Coordinator will ensure that at least 2 clients are given the opportunity to grocery shop. · Program Coordinator will document activity on Daily Support Record for the clients who participate. <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All clients were affected by this practice. <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Program Coordinator will fax Daily Support Records of clients who participated in grocery shopping to Program Director (QIDP) following event. | 05/29/2016 |

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| W 9999 Bldg. 00 | <p>On 4/26/16 at 11:09 AM, the Area Director indicated the clients should be involved with grocery shopping.</p> <p>9-3-8(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(a) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 11. An emergency intervention for the individual resulting from: a. a physical symptom; b. a medical or psychiatric</p> | W 9999 | <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> Program Director will review Daily Support Records when submitted and monthly to ensure that clients are participating in grocery shopping. <p>1.What is the date by which the systemic changes will be completed?</p> <p>May 29, 2016</p> <p>W9999 Final Observations The facility failed to submit incident report to BDDS within 24 hours, in accordance with state law.</p> <p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> Incident reports will be submitted to BDDS within 24 hours of event. <p>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All clients have the potential to be affected by this practice. <p>1.What measures will be put into</p> | 05/29/2016 |

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| | <p>condition; c. any other event and 16. A medication error or medical treatment error as follows: a. wrong medication given; b. wrong medication dosage given; c. missed medication - not given; d. medication given wrong route; or e. medication error that jeopardizes an individual's health and welfare and requires medical attention.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 13 incident/investigative reports reviewed affecting clients #6 and #8, 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>On 4/25/16 at 12:06 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 10/28/15 at 8:00 PM (reported to BDDS on 11/3/15), staff (BDDS report did not indicate the staff's name) failed to administer client #8's methotrexate (rheumatoid arthritis). The 11/3/15 BDDS report indicated, "I tried filing this</p> | | <p>place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Training with Program Director (QIDP) regarding importance of filing reports within the 24-hour timeline. · Area Director will be notified of all reportable events immediately. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Program Director will forward all BDDS reports immediately upon submission to BDDS to the Area Director. · If a report is not received within 12 hours of reportable event, Area Director will follow-up with Program Director to ensure report is filed. <p>1.What is the date by which the systemic changes will be completed?</p> <p>May 29, 2016</p> | |

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| | <p>report on 10/29/15 and I didn't (sic) realize I had done something wrong so I'm resubmitting it today."</p> <p>2) On 12/4/15 at 11:30 AM (reported to BDDS on 12/8/15), client #6 was eating lunch when he started coughing and gagging. Client #6 coughed up phlegm and he took a drink. Staff called the nurse and instructed client #6 go to the emergency room to be checked out.</p> <p>On 4/26/16 at 8:52 AM, the Program Director indicated the timeframe for reporting incidents to BDDS was 24 hours.</p> <p>On 4/25/16 at 12:16 PM, the Area Director indicated the timeframe for reporting incidents to BDDS was 24 hours.</p> <p>9-3-1(b)</p> | | | |