

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G719 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/06/2013 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1406 W TARKINGTON DR GREENSBURG, IN 47240 | | |
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| W0000 | <p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: February 4, 5 and 6, 2013.</p> <p>Facility Number: 004375 Provider Number: 15G719 AIM Number: 200510170</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/13/13 by Ruth Shackelford, Medical Surveyor III.</p> | W0000 | | | |

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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| W0104 | <p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 1 of 2 clients in the sample (#3), the governing body failed to ensure the client did not incur service charges on his checking account.</p> <p>Findings include:</p> <p>A review of the client's financial records was conducted on 2/4/13 at 3:47 PM. Client #3 incurred service charges on his checking account on 11/8/12 (\$1.95), 12/10/12 (\$1.95), and 1/9/13 (\$5.95). There was no documentation the facility was attempting to eliminate the service charges on his account or change to a bank without service charges. There was no documentation the facility reimbursed client #3 for the service charges.</p> <p>An interview with the Home Manager (HM) was conducted on 2/4/13 at 3:58 PM. The HM indicated she did not handle the client's checking account and did not know what was being done to address the service charges.</p> <p>An interview with the Program Director (PD) was conducted on 2/5/13 at 10:53 AM. The PD indicated client #3's bank</p> | W0104 | <p>Area Director will submit request for Indiana Mentor to reimburse client #3 for all charges he has incurred in his checking account. Program Director will change clients checking account to a bank that does not charge fees. Program Director will review all other accounts to ensure that no other clients are incurring fees. Area Director will review bank statements monthly to ensure no fees are being incurred. Responsible Parties: Program Director, Area Director</p> | 03/08/2013 |

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| | <p>was purchased by another bank who instituted service charges due to not meeting a minimum balance. The PD indicated client #3 needed to change banks to avoid the service charges on his account. The PD indicated she had not taken steps to change the account to another bank.</p> <p>9-3-1(a)</p> | | | | |

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| W0125 | <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 2 of 2 clients in the sample (#3 and #4) and 2 additional non-sampled clients (#1 and #2), the facility failed to ensure the clients had the right to due process in regard to the use of audible bells hanging on the front door handle.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/4/13 from 3:20 PM to 6:32 PM and 2/5/13 from 5:39 AM to 7:33 AM. During the observations, the front door of the group home had bells hanging from the door knob. When the front door was opened, the bells sounded an audible alert.</p> <p>A review, conducted on 2/5/13 at 11:07 AM, of client #1's Individual Support Plan (ISP), dated 11/27/12, indicated there was no documentation regarding the use of bells on the front door.</p> <p>A review, conducted on 2/5/13 at 11:09</p> | W0125 | <p>Program Director will remove bells from door. Program Director will ensure that prior to using any type of restrictive measure that it is included in client's plan and approved by HRC prior to implementing. Area Director will complete quarterly home visits to ensure that no restrictive measures are in place without HRC approval and it being included in clients plan. Area Director will review client rights policy with Program Director. Responsible Parties: Program Director, Area Director</p> | 03/08/2013 | | | |

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| | <p>AM, of client #2's ISP, dated 11/27/12, indicated there was no documentation regarding the use of bells on the front door.</p> <p>A review of client #3's record was conducted on 2/5/13 at 11:15 AM. There was no documentation in client #3's ISP, dated 2/16/12 and updated on 12/19/12, and his Behavior Support Plan (BSP), dated 7/27/12, indicating client #3 required the bells on the front door. There was no documentation in client #3's record indicating the need for the bells.</p> <p>A review of client #4's record was conducted on 2/5/13 at 11:49 AM. There was no documentation in client #4's ISP, dated 2/16/12, indicating client #4 required the bells on the front door. There was no documentation in client #4's record indicating the need for the bells.</p> <p>An interview with the Program Director (PD) was conducted on 2/5/13 at 10:51 AM. The PD indicated the bells were put on the front door handle during Christmas as a decoration and then left on the door after the decorations were put away. The PD indicated the purpose of the bells was to alert staff when someone was entering or leaving the group home. The PD indicated the bells were not part of the clients' plans (#1, #2, #3 and #4).</p> | | | |

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| | 9-3-2(a) | | | |

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| W0140 | <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 2 non-sampled clients (#1), the facility failed to account for her cash on hand by not ensuring a withdrawal was documented.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 2/4/13 at 3:47 PM. Client #1's Cash on Hand ledger, not dated, did not contain documentation of a balance (the document was blank). Prior to counting the cash on hand, the Home Manager (HM) indicated she needed to go to her car to get the \$60.00 she took out of client #1's cash on hand earlier in the day to purchase hair care products. The HM went to her car and brought back \$60.00. The HM then counted client #1's money and documented she had \$71.88 on the form.</p> <p>An interview with the HM was conducted on 2/4/13 at 3:52 PM. The HM indicated she grabbed money from client #1's cash on hand earlier in the day due to being in a hurry. The HM indicated she did not document the withdrawal of \$60.00 from</p> | W0140 | <p>Area Director will retrain Program Director and Home Manager on client finances and finance management. Home Manager will do a weekly check of client finances to ensure proper procedures are being followed and implemented. Program Director will review finances monthly to ensure proper procedures are being followed and implemented. Area Director will review finances quarterly to ensure proper procedures are being followed and implemented. Responsible Parties: Home Manager, Program Director and Area Director</p> | 03/08/2013 | |

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| | <p>client #1's cash on hand.</p> <p>An interview with the Program Director (PD) was conducted on 2/5/13 at 10:53 AM. The PD indicated the HM was supposed to sign out the money from client #1's account at the time the money was withdrawn. The PD indicated the HM or other staff need to account for the money at the time of depositing or withdrawing money from the account.</p> <p>9-3-2(a)</p> | | | | |

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| W0149 | <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 16 incident/investigative reports reviewed affecting clients #1, #2, #3 and #4, the facility neglected to implement its policies and procedures to report incidents to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/4/13 at 12:47 PM.</p> <p>1. On 11/10/12 at 6:00 PM upon arrival to the group home from Special Olympics, the Home Manager (HM) observed two individuals on the side of the house trying to break in. The HM called the police. The police checked the house and the staff and clients entered the home (nothing was missing). The police were called a second time when the two individuals were observed outside the home again. The police arrested the two men. The incident was reported to BDDS on 11/12/12. This affected clients #1, #2, #3 and #4.</p> <p>2. On 11/23/12 at 6:00 PM, client #3 was observed to have a bruise on his elbow.</p> | W0149 | Area Director will retrain Program Director on incident reporting procedures. Program Director will ensure that all incidents requiring a BDDS report are completed within 24 hours. Area Director reviews all incident reports to ensure they are completed within a 24 hour period. Responsible Parties: Program Director, Area Director | 03/08/2013 |

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| | <p>Client #3 indicated he fell at the bowling alley three weeks ago. The BDDS report, dated 11/26/12, indicated, "Due to [client #3] not being able to identify how the bruise happened PD (Program Director) will complete an investigation to try to determine the cause of the bruising."</p> <p>A review of the facility's policy and procedure was conducted on 2/4/13 at 12:47 PM. The Operating Practices, dated April 2011, 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 with twenty-four (24) hours..."</p> <p>An interview with the Program Director (PD) was conducted on 2/4/13 at 1:15 PM. The PD indicated BDDS reports should be submitted within 24 hours.</p> <p>9-3-2(a)</p> | | | | |

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| W0153 | <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.</p> <p>Based on record review and interview for 2 of 16 incident/investigative reports reviewed affecting clients #1, #2, #3 and #4, the facility failed to report incidents to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/4/13 at 12:47 PM.</p> <p>1. On 11/10/12 at 6:00 PM upon arrival to the group home from Special Olympics, the Home Manager (HM) observed two individuals on the side of the house trying to break in. The HM called the police. The police checked the house and the staff and clients entered the home (nothing was missing). The police were called a second time when the two individuals were observed outside the home again. The police arrested the two men. The incident was reported to BDDS on 11/12/12. This affected clients #1, #2, #3 and #4.</p> | W0153 | <p>Area Director will retrain Program Director on incident reporting procedures. Program Director will ensure that all incidents requiring a BDDS report are completed within 24 hours. Area Director reviews all incident reports to ensure they are completed within a 24 hour period. Responsible Parties: Program Director, Area Director</p> | 03/08/2013 |

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| | <p>2. On 11/23/12 at 6:00 PM, client #3 was observed to have a bruise on his elbow. Client #3 indicated he fell at the bowling alley three weeks ago. The BDDS report, dated 11/26/12, indicated, "Due to [client #3] not being able to identify how the bruise happened PD (Program Director) will complete an investigation to try to determine the cause of the bruising."</p> <p>An interview with the Program Director (PD) was conducted on 2/4/13 at 1:15 PM. The PD indicated BDDS reports should be submitted within 24 hours.</p> <p>9-3-2(a)</p> | | | | |

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| W0227 | <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 of 2 clients in the sample (#3), the facility failed to ensure there was a program plan addressing making choices.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/4/13 from 3:20 PM to 6:32 PM and 2/5/13 from 5:39 AM to 7:33 AM. On 2/4/13 at 4:44 PM, staff #3 asked client #3 if he wanted to put a puzzle together or draw a picture. Client #3 stated, "I don't know." At 5:25 PM when asked by staff #2 what news channel he wanted to watch, client #3 stated, "I don't know." Staff #2 gave client #2 a list of stations and he stated, "I don't know." Staff #2 repeated, "I don't know" and then picked a station. On 2/5/13 at 6:52 AM, staff #5 asked client #3 what kind of cereal he wanted for breakfast. Client #3 stated, "I don't know." Staff #5 gave client #3 choices of cereal and he did not decide. Staff #5 prompted client #3 to sit down at the table and she would pick one for him.</p> | W0227 | <p>Program Director in conjunction with IDT will review all client's, including client #3's ISP's to ensure it includes a formal objective for developing and addressing choice making. Program Director will retrain all staff on any new formal objectives for choice making. Home Manager will complete weekly observations for 4 weeks to ensure that this new objective is being implemented correctly. Program Director will complete weekly observations for 4 weeks to ensure that this new objective is being implemented correctly. Program Director in conjunction with IDT will review progress quarterly on all formal objectives and make changes as needed. Responsible Parties: Program Director, Home Manager</p> | 03/08/2013 |

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| | <p>A review of client #3's record was conducted on 2/5/13 at 11:15 AM. Client #3's Individual Support Plan (ISP), dated 2/16/12 and revised on 12/19/12, indicated there was no formal training objective addressing choice making. The ISP indicated, in part, "But he can understand when choices are given to him on what to do and shows preferences by telling staff that he does or does not want to do something. He enjoys choosing what he is going to watch on television."</p> <p>An interview was conducted with client #3 on 2/4/13 at 2:35 PM. Client #3 indicated he did not know when asked what he liked to spend his money on. Client #3 was asked where he enjoyed eating and he indicated he did not know. Client #3 was given a choice of restaurants (3) to indicate his preference and he indicated he did not know. Client #3 was asked if he enjoyed going to the movies (lives right by the movie theater) and he indicated he did not know.</p> <p>An interview with the nurse was conducted on 2/5/13 at 11:18 AM. The nurse stated when she went on an appointment with client #3 recently it took him "forever" to make a choice on where to eat.</p> | | | | | | |

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| | <p>An interview with the Program Director (PD) was conducted on 2/5/13 at 11:18 AM. The PD indicated client #3 needed a formal training objective to increase his ability to make choices. The PD indicated client #3 did struggle with making choices.</p> <p>9-3-4(a)</p> | | | |

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| NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 1406 W TARKINGTON DR GREENSBURG, IN 47240 |
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| W0249 | <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, record review and interview for 1 of 2 clients in the sample (#3), the facility failed to ensure staff implemented his program plan to make toast.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 2/5/13 from 5:39 AM to 7:33 AM. At 6:52 AM, client #3 was asked what kind of cereal he wanted. Client #3 indicated he did not know. After he was given a choice but did not make a choice, staff #5 prompted him to sit down and she would choose for him. Staff #5 poured client #3's cereal and put toast in the toaster. Staff #5 buttered the toast and got out the milk. Staff #5 poured orange juice. At 6:57 AM, staff #5 gave client #3 his orange juice. Staff #5 stated to client #3 as he sat at the table, "It's coming, it's coming." Staff #5 gave client #3 his cereal and toast. At 7:05 AM while eating his toast, client #3 stated to staff #5, "Did you make this yourself?"</p> | W0249 | <p>Program Director will retrain Home Manager and all staff on active treatment. Program Director will retrain Home Manager and all staff on all client's including Client #3's training objectives. Home Manager will do weekly observations for 4 weeks to ensure that active treatment is being implemented correctly. Program Director will do weekly observations for 4 weeks to ensure that active treatment is being implemented correctly. Home Manager will do weekly documentation checklist to ensure that formal training is being completed and documented correctly. Program Director will review formal trainings monthly to ensure they are being completed and documented correctly. Responsible Parties: Home Manager, Program Director</p> | 03/08/2013 |

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| | <p>Staff #5 stated, "I made it myself."</p> <p>A review of client #3's record was conducted on 2/5/13 at 11:15 AM. Client #3's Individual Support Plan (ISP), dated 2/16/12 and updated on 12/19/12, indicated he had a training objective to make his own toast.</p> <p>An interview with the Program Director (PD) was conducted on 2/5/13 at 11:06 AM. The PD indicated client #3's training objective for making toast should have been implemented as written.</p> <p>9-3-4(a)</p> | | | | |

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| W0264 | <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, interview and record review for 2 of 2 clients in the sample (#3 and #4) and 2 additional non-sampled clients (#1 and #2), the specially constituted committee (HRC) failed to review and monitor the facility in regard to the use of audible bells hanging on the front door handle.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/4/13 from 3:20 PM to 6:32 PM and 2/5/13 from 5:39 AM to 7:33 AM. During the observations, the front door of the group home had bells hanging from the door knob. When the front door was opened, the bells sounded an audible alert. This affected clients #1, #2, #3 and #4.</p> <p>A review, conducted on 2/5/13 at 11:07 AM, of client #1's Individual Support Plan (ISP), dated 11/27/12, indicated there was no documentation regarding the</p> | W0264 | <p>Program Director will remove bells from door. Program Director will ensure that prior to using any type of restrictive measure that it is included in client's plan and approved by HRC prior to implementing. Area Director will complete quarterly home visits to ensure that no restrictive measures are in place without HRC approval and it being included in clients plan. Area Director will review client rights policy with Program Director. Responsible Parties: Program Director, Area Director</p> | 03/08/2013 | |

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| | <p>use of bells on the front door. There was no documentation the HRC reviewed and approved the use of bells.</p> <p>A review, conducted on 2/5/13 at 11:09 AM, of client #2's ISP, dated 11/27/12, indicated there was no documentation regarding the use of bells on the front door. There was no documentation the HRC reviewed and approved the use of bells.</p> <p>A review of client #3's record was conducted on 2/5/13 at 11:15 AM. There was no documentation in client #3's ISP, dated 2/16/12 and updated on 12/19/12, and his Behavior Support Plan (BSP), dated 7/27/12, indicating client #3 required the bells on the front door. There was no documentation in client #3's record indicating the need for the bells. There was no documentation the HRC reviewed and approved the use of bells.</p> <p>A review of client #4's record was conducted on 2/5/13 at 11:49 AM. There was no documentation in client #4's ISP, dated 2/16/12, indicating client #4 required the bells on the front door. There was no documentation in client #4's record indicating the need for the bells. There was no documentation the HRC reviewed and approved the use of bells.</p> | | | | | | |

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| | <p>An interview with the Program Director (PD) was conducted on 2/5/13 at 10:51 AM. The PD indicated the bells were put on the front door handle during Christmas as a decoration and then left on the door after the decorations were put away. The PD indicated the purpose of the bells was to alert staff when someone was entering or leaving the group home. The PD indicated the bells were not part of the clients' plans (#1, #2, #3 and #4). The PD indicated there was no HRC consent for the use of bells on the front door.</p> <p>9-3-4(a)</p> | | | |

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| W0340 | <p>483.460(c)(5)(i) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. Based on observation and interview for 3 of 4 clients in the group home who receive their medications crushed (#1, #2 and #4), the facility's nursing services failed to ensure staff washed the pill crushers after each use.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 2/5/13 from 5:39 AM to 7:33 AM. During the observation, the pill crushers (3) were noted to contain pill residue on the mortars and pestles. On 2/5/13 at 12:15 PM, the pill crushers contained pill residue on the mortars and pestles.</p> <p>An interview with the nurse was conducted on 2/5/13 at 12:18 PM. The nurse indicated the pill crushers should be cleaned after each use. On 2/6/13 at 1:19 PM, the nurse indicated this affected clients #1, #2 and #4.</p> <p>An interview with the Program Director (PD) was conducted on 2/5/13 at 12:19</p> | W0340 | <p>Program Director will purchase individual pill crushers for each client that requires their medication to be crushed. Pill crushers are to be labled. Program Director will retrain Home Manager and all staff on washing pill crushers after each use and to use only pill crusher that is labled for that client. Home Manager, Program Director, and Nurse will do med administration observations to ensure this new procedure is being followed as implemented. Responsible Parties: Program Director, Nurse, Home Manager</p> | 03/08/2013 | | | |

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| | PM. The PD indicated the pill crushers should be washed after each use. 9-3-6(a) | | | | |

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| W0473 | <p>483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. Based on observation and interview for 3 of 3 clients who ate dinner by mouth (#1, #3 and #4), the facility failed to ensure staff served food within 15 minutes of removal from a temperature controlled device.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 2/4/13 from 3:20 PM to 6:32 PM. At 5:15 PM, staff #3 took salad and salad dressing from the refrigerator, placed the salad in a serving bowl and put the serving bowl and dressing on the table. At 5:34 PM, staff #3 removed the beef stew and biscuits from the oven. Clients #1, #3 and #4 started eating dinner at 6:25 PM.</p> <p>An interview with the Program Director (PD) was conducted on 2/6/13 at 1:59 PM. The PD indicated food removed from the refrigerator or oven should be served within 10 minutes. The PD indicated it was acceptable to allow the food to cool off and the staff needed time to puree the food for clients #1 and #4.</p> <p>9-3-8(a)</p> | W0473 | <p>Program Director will retrain Home Manager and all staff on food safety procedures. All food should be served within 15 minutes from being removed from refrigerator or oven. Home Manager and Program Director will do meal time observations to ensure that this procedure is being followed. Responsible Parties: Home Manager, Program Director</p> | 03/08/2013 | | | |

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| W0488 | <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.</p> <p>Based on observation and interview for 3 of 3 clients living at the group home who were observed to eat by mouth (#1, #3 and #4), the facility failed to ensure the clients were involved with dinner and breakfast preparation.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 2/4/13 from 3:20 PM to 6:32 PM. At 5:04 PM, staff #3 opened two cans of beef stew using an electric can opener. Staff #3 opened a can of biscuits and placed the biscuits on top of the beef stew in a glass baking dish. At 5:12 PM, staff #3 made tea. At 5:15 PM, staff #3 removed salad from the refrigerator. Staff #3 got plates and bowls out of the cabinet. Staff #3 opened the salad container and poured the salad into a serving bowl. Staff #3 put salad dressing and the salad on the table. At 6:04 PM, staff #3 used the food processor to puree the salad. At 6:08 PM, staff #3 washed the food processor. At 6:10 PM, staff #3 used the food processor on the beef stew. At 6:16 PM, the Home Manager (HM) gave client #3 his drinks (tea and water) while he sat at the table.</p> | W0488 | <p>Program Director will retrain Home Manager and all staff on active treatment including client's being involved in meal preparation. Home Manager will do weekly observations for 4 weeks to ensure that active treatment is being implemented correctly. Program Director will do weekly observations for 4 weeks to ensure that active treatment is being implemented correctly. Responsible Parties: Home Manager, Program Director</p> | 03/08/2013 |

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| | <p>At 6:20 PM, client #3 was asked by staff #2 to hand her his plate. Staff #2 scooped and served client #3 his beef stew. At 6:22 PM when the HM prompted client #3 to serve himself salad, client #3 stated, "I've never done this before." The HM served client #2's salad dressing after measuring it. At 6:25 PM, the HM asked client #3 if he wanted butter, client #3 indicated he did. The HM got up to get a knife and then put butter on client #3's biscuit. At 6:27 PM, client #3 was prompted to take a drink. Client #3 asked what was in his cups. He was told tea. Clients #1, #3 and #4 were not prompted to assist with the food preparation listed above. Clients #1, #3 and #4 were present and available to assist with meal preparation.</p> <p>An observation was conducted at the group home on 2/5/13 from 5:39 AM to 7:33 AM. At 6:52 AM, client #3 was asked what kind of cereal he wanted. Client #3 indicated he did not know. After he was given a choice but did not make a choice, staff #5 prompted him to sit down and she would choose for him. Staff #5 poured client #3's cereal and put toast in the toaster. Staff #5 buttered the toast and got out the milk. Staff #5 poured orange juice. At 6:57 AM, staff #5 gave client #3 his orange juice. At 7:00 AM, staff #5 removed grits from the</p> | | | |

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| | <p>microwave and stirred. Staff #5 stated to client #3 as he sat at the table, "It's coming, it's coming." Staff #5 poured client #1's drink. Staff #5 gave client #3 his cereal and toast. At 7:05 AM while eating his toast, client #3 stated to staff #5, "Did you make this yourself?" Staff #5 stated, "I made it myself." At 7:10 AM, staff #4 poured client #4's orange juice. At 7:21 AM, staff #5 packed client #1 and #4's lunches (client #3 going out to eat for lunch). Clients #1, #3 and #4 were not prompted to assist with the food preparation listed above. Clients #1, #3 and #4 were present and available to assist with meal preparation.</p> <p>An interview with the Program Director (PD) was conducted on 2/5/13 at 11:06 AM. The PD indicated clients #1, #3 and #4 should participate in meal preparation. The PD indicated the staff should involve the clients in some way. The PD indicated the clients could push the button on the food processor or perform tasks with hand over hand assistance.</p> <p>9-3-8(a)</p> | | | | |

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| W9999 | <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 (15. A fall resulting in injury, regardless of the severity of the severity of the injury.).</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 16 incident/investigative reports reviewed affecting client #3, the facility failed to ensure a fall with injury was reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was</p> | W9999 | Area Director will retrain Program Director on incident reporting procedures including reporting fall with injury incidents within 24 hours. Program Director will ensure that all incidents requiring a BDDS report will be completed within 24 hours. Area Director will review all incident reports to ensure they are completed within 24 hours. Responsible Parties: Area Director, Program Director | 03/08/2013 | |

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| | <p>conducted on 2/4/13 at 12:47 PM. On 11/2/12 at 4:20 PM, client #3 fell and scraped his right elbow while at Special Olympics bowling. Client #3 turned around to walk back to sit down, missed a step and fell. There was no documentation the fall was reported to BDDS.</p> <p>An interview with the Program Director (PD) was conducted on 2/4/13 at 1:15 PM. The PD indicated if the injury was known or small in size then she did not report a fall with injury to BDDS.</p> <p>9-3-1(b)</p> | | | | |