STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARENTS AND FRIENDS INC	1709 FARRAND AVE LA PORTE, IN46350

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W0000	This visit was for a fundamental annual recertification and state licensure survey. Dates of Survey: December 12, 13, 14, 15 and 16, 2011. Facility number: 000849 Provider number: 15G331 AIM number: 100243820 Surveyors: Kathy Wanner, Medical Surveyor III/Team Leader. Tracy Brumbaugh, Medical Surveyor III. The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12-22-11 by C. Neary, Program Coordinator.	W0000		
W0104	The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, the governing body failed to exercise operating direction in a manner that resulted in the facility being well maintained for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) who lived in the group home. Findings include:	W0104	In order for this deficiency to be corrected now and systemically, the maintenance issues have all been corrected: ceiling vent cleaned, towel bar fixed, holes fixed, and chairs cleaned. Kitchen walls cleaned and refrigerator cleaned. Maintenance is getting quotes for a new countertop. We are refuting the part of Tag 104 where there are no closet doors on	01/15/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	On 12-12-11 from 3:15 P.M. until 5:20 P.M. an observation at the home of clients #1, #2, #3, #4, #5, and #6, was conducted. At 3:30 P.M. the bathroom with the fish decor had a ceiling vent covered in dust and a rusted towel bar. At 3:45 P.M. the living room wall behind the recliner had 20 small holes and torn/peeled paint which covered the wall. The fabric on two club chairs and a footstool in the living room was worn and discolored. At 4:00 P.M. the walls and the trim in the kitchen had debris and food on them, the hood above the stove was covered with oil and dust and had peeled paint, the refrigerator was spattered with food, the cabinets were sticky, and the counter top had 4 quarter size holes in it. At 4:15 P.M. client #3 and #4's closets in their bedrooms were observed to have no doors. On 12-14-11 at 9:15 A.M. an interview with the Qualified Mental Retardation Professional indicated the house repairs needed to be addressed and the house should be kept clean.		consumer 3 and 4's bedroom. These individuals have access to their personal needs/space with no arguments ever happening. They have their personal space. There is no need to put doors on the closet. The surveyor stated, "It is not normal to not have doors on a closet." That is an opinion, rather a fact. Both consumers are fine without the doors. One person has cerebral palsy that would make it very difficult to open doors, and the other person has plastic bins in the closet where she puts personal belongings in (see attachment A). In order for this citation to be met systemically, staff will write up orders when there are maintenance issues. The Residential Director does house observations and checks maintenance issues when at the homes. An environmental list will be completed by the Residential Director and given to the Maintenance supervisor to review and go over with maintenance to make repairs.(Team Leader, Residential Director, Maintenance, direct care staff and Executive Director responsible.)	
W0112	9-3-1(a) The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. Based on observation, record review, and	W0112	In order for this citation to be corrected now and systemically,	01/15/2012

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	interview, the facility failed for 1 of 4 sampled clients (client #3) and 1 additional client (client #4) to ensure their daily program schedule, with their names, was kept confidential. Findings include: On 12-12-11 from 3:15 P.M. until 5:20 P.M. an observation at the home of clients #3 and #4 was observed. At 3:30 P.M. client #3 and #4's daily program schedule was posted in the hallway outside of their bedrooms. The schedule indicated client #3 and #4's routine for the day which included grooming, eating, goals, and medication administration. The schedule also posted client #3 and #4's name. On 12-13-11 at 12:30 P.M. a record review for client #3 was conducted. The Individualized Support Plan (ISP) dated 9-28-11 indicated client #3 had a goal to follow her picture schedule. On 12-14-11 at 10:30 A.M. a record review for client #4 was conducted. The ISP dated 8-10-11 indicated client #4 had a goal to organize his day by grouping activities into time slots. On 12-14-11 at 9:15 A.M. an interview with the Qualified Mental Retardation Professional indicated client #3 and #4's		all consumer daily program schedules were taken down from the hallways to protect confidentiality. The daily schedules were placed in the consumers bedrooms. Staff will be trained as to why this is important to keep off of hallway walls. IDT will obsesrve on a weekly basis to make sure the schedules do not go back up on walls where confidentality is interrupted.(QMRP, Residential Coordinator, Behavior Specialist, RN, Team Leader and Director Care staff responsible.)	

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	programing schedule was posted in the hall for everyone to see.			
W0126	9-3-1(a) The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Based on interview, observation and record review, the facility failed to allow and promote financial independence for 3 of 3 sampled clients (clients #1, #2 and #3) by not establishing a system for the clients to have unimpeded access their money. Findings include: Observations were conducted at the group home on 12/13/11 from 6:40 A.M. until 8:02 A.M.. Clients #1, #2, and #3 were not observed to have any money to take with them to the workshop. Direct Care Staff (DCS) #1 was interviewed on 12/13/11 at 7:55 A.M.. When asked about the clients having access to their money, DCS #1 stated, "Only the Team Leader (TL) has access to the money. The TL puts out money when there are planned events." DCS #1 indicated there was no money available for any of the clients at the time.	W0126	In order for this citation to be met now and systemically, each consumer will have an immediate access to a certain amount of cash out of their personal budgets and placed in their specific spot in the medication cart for small impulse purchases. The money will be used by the consumers at the homes at any given time frame to allow consumers to work on goals in a natural setting and have choices. This will be a systemic practive for all consumers in group homes. IDT will observe weekly to see if consumer money is available. (QMRP, Residential Coordinator, Behavior Specialist, RN, Team Leaders and Direct Care staff responsible)	01/15/2012

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	Client #1's record was reviewed on 12/13/11 at 10:35 A.M.. Client #1's financial assessment dated 5/3/11 indicated client #1 could purchase minor items with supervision, save money, accepted supervision with money management, and recognized correct change for $1.00 with supervision. Client #1's Individual Program Plan (IPP) dated 5/4/11 indicated she had a goal to make a purchase with the next dollar amount. Client #2's record was reviewed on 12/13/11 at 11:30 A.M.. Client #2's financial assessment dated 8/2/11 indicated client #2 accepted supervision with money management and was not usually impulsive in purchasing. Client #3's record was reviewed on 12/13/11 at 12:30 P.M.. Client #3's financial assessment dated 9/26/11 indicated client #3 accepted supervision with money management and an interested party managed her money. Client #3's IPP dated 9/28/11 indicated she had a goal to identify coins and bills. The facility policy for Money Management dated 9/91 was reviewed on 12/14/11 at 10:55 A.M.. The policy indicated the following: "It is [Name of Facility] policy that consumer management of personal income is the			

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	responsibility of each consumer...Consumers will receive financial counseling so that, to the greatest extent possible a consumer may independently control his own finances..." An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 12/13/11 at 11:08 A.M.. When asked about the clients not having access to any of their money, the QMRP stated, "The TL is the only one who has access to the safe. The TL leaves money out for a known activity. No, the clients do not have immediate access. They can ask for it. We can get it to them in a pretty quick time frame." 9-3-2(a)			
W0140	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, the facility failed for 3 of 3 sampled clients (clients #1, #2, and #3) to ensure a system was established for individual receipts to be maintained. Findings include: On 12-14-11 at 8:30 A.M. a record review of client #1, #2, and #3's financial records was conducted. The receipts dated	W0140	In order for this citation to be met now and systemically, the budget pack procedure has been revised to eliminate errors that were made. From here forward, Team Leaders responsible for completing budget packs were trained on consumers being reimbursed for meals if they do not choose to go out to eat. Consumers will be reimbursed if money is not available on a weekend if they want/need a hair cut, etc. Consumers will have	01/15/2012

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	February 2011 through October 2011 failed to provide an individual account of which client had purchased the items on the receipt. Further review indicated meals in the community and haircuts had not been reimbursed for the months of February 2011 through October 2011 for clients #1, #2, and #3. The facility Consumer Budget-Pack Procedure dated 2/07 was reviewed on 12/14/11 at 10:55 A.M.. The policy indicated "All of the purchases made by consumers are to be recorded individually...and each must have a separate numbered receipt...after verification, the Residential Coordinator (RC) will retain the budget packs for proper filing...." On 12-14-11 at 9:30 A.M. an interview with the Qualified Mental Retardation Professional (QMRP) indicated the facility should pay for a meal if it replaces a meal at the home and the facility should pay for haircuts. The QMRP also indicated there was only one receipt for multiple clients available for review and each receipt had multiple purchases on the receipts so there was no way of knowing how much each client would have spent or what they had bought. 9-3-2(a)		individual receipts when at all possible. If not, appropriate tax will be figured in for each consumer so all are paying equally. All budget packs will be monitored on a monthly basis for accuracy, along with the normal month end checks.(Team Leaders, Residential Coordinator and direct care staff responsible)	

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W0247	The individual program plan must include opportunities for client choice and self-management. Based on observation and interview, the facility failed for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) to ensure they had a choice of when to complete tasks, turn off their lights, turn off their television, have a snack, to sit at their kitchen table, and to make their dinner plate before prayer. Findings include: On 12-12-11 from 3:15 P.M. until 5:20 P.M. an observation at the home of clients #1, #2, #3, #4, #5, and #6 was conducted. At 3:30 P.M. an "obligation" sign was posted in the kitchen of clients #1, #2, #3,#4, #5, and #6. The sign indicated all obligations would be done by 9:30 P.M., lights would be out by 10:00 P.M., and televisions would be off by 11:00 P.M. At 4:30 P.M. client #3 took a graham cracker from a package in her kitchen. Direct care staff (dcs) #3 took the graham cracker from client #3 and told her she was not allowed to have a snack before supper. At 4:45 P.M. client #5 attempted to sit at his kitchen table when dcs #3 indicated to client #5 he needed to stay away from the table until it was time to eat. At 5:00 P.M. client #3 indicated she wanted her graham cracker. Dcs #3	W0247	To ensure that this citation is met now and systemically, a training will be completed on 1/12/12 in regards to dignity/respect towards consumer choices. Training on consumer rights must be able to be made for themselves, and not by staff will be discussed. The "obligation chart" was removed from the kitchen cork board. If consumers are making choices that staff do not believe is correct, staff can offer better choices with an explanation, yet consumers are not mandated to follow. IDT will observe on a weekly basis to ensure this is being followed. (QMRP, Residential Coordinator, RN, Behavior Specialist, Team Leader and Direct Care staff responsible)	01/15/2012

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	indicated she could have it with her fruit at supper. At 5:00 P.M. client #4 sat at the table to eat. Client #4 took a dinner roll and attempted to serve himself some beets. Dcs #2 and #3 indicated to him prayer needed to be said before plates could be made. On 12-12-11 at 4:45 P.M. an interview with client #5 indicated he followed the rules so he didn't get into trouble. On 12-14-11 at 9:15 A.M. an interview with Qualified Mental Retardation Professional (QMRP) indicated dcs #2 and #3 should encourage choice for all clients who live in the home. The QMRP indicated client #3 should have been allowed to get herself a snack, the house obligations should be a choice to follow, they should be allowed to sit at their table and clients #1, #2, #3, #4, #5, and #6 should have a choice of when they want to make their plate.			
W0323	9-3-4(a) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview, the facility failed to ensure 1 of 3 sampled clients (client #2) had an annual physical which included an evaluation of client	W0323	This citation was corrected by a simple revision to our Annual Physical form for our consumers. The form was changed to include lines for vision test and hearing	01/15/2012

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	#2's vision and hearing. Findings include: Client #2's record was reviewed on 12/13/11 at 11:30 A.M.. Client #2's record indicated he had a vision examination completed on 7/29/10. The note on the vision form indicated client #2 was to return in one year. Client #2's record indicated client #2 had a hearing evaluation completed on 6/29/10. Client #2's record did not indicate his vision and hearing had been evaluated since 6/29/10. The facility RN #1 was interviewed on 12/13/11 at 11:50 A.M.. When asked about client #2 having a vision and hearing evaluation within the past year, RN #1 indicated client #2 had not had his vision evaluated since 7/29/10, and had not returned one year later as recommended by the physician. The RN indicated client #2's hearing had not been evaluated since 6/29/10.		test (which weren't included before). This form will be filled out by the attending physician on an annual basis, along with consumers going to the eye and ear doctor within the Medicaid limitations. If the primary doctor sees a problem with these two areas, the RN will contact the necessary physicians to get appointments made before the Medicaid limitations.(RN, medical support responsible)	
W0381	9-3-6(a) The facility must store drugs under proper conditions of security. Based on observation, record review and interview, the facility failed to establish a system for the secure storage of scheduled (controlled) medications, for 2 of 2 clients who took controlled medications (clients	W0381	In order for this citation to be corrected now and systemically, the PAF QMRP and RN will retrain staff on January 12, 2012 at the staff meeting on the mandate to always have the	01/15/2012

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	#3 and #4). Findings include: Observation of the morning medication administration was completed on 12/13/11 from 6:45 A.M. until 7:07 A.M.. During the observation Direct Care Staff (DCS) #3 passed client #4 his morning medications including Clonazepam (Benzodiazepine). DCS #3 was observed to remove and replace the medication card for client #4's Clonazepam into the medication cart along with his other medications. DCS #3 then locked the medication cart. DCS #3 was interviewed at 6:50 A.M. on 12/13/11. When asked if the group home double locked controlled medications DCS #3 stated, "Controlled medications are not double locked. They are just in with the others." When asked if there were any other clients prescribed controlled medications. DCS #3 stated, "Yes, [client #6] had a hormone patch which was a controlled medication." DCS #3 indicated client #6's medication was also not double locked. Client #4's Physician's Order (PO) dated 11/15/11 for 12/11 was reviewed on 12/13/11 at 12:35 P.M.. Client #4's PO indicated he was prescribed Clonazepam.		controlled medications under double lock and key. This can be done with the current med carts being used. There is a keyed storage space inside the medication cart where all controlled medications will be stored, then the med cart will be locked after medication dispensation. The cabinet will be locked at all times with the keys secured on a staff or a safe location, not on the med cart. If the staff steps away from the cart, the cart will be double locked up and the keys will be in possession of the staff. IDT makes weekly observations at the homes during medication passes. IDT will check to make sure the cart is double locked.(Team Leader, Director care staff, Residential Coordinator, QMRP, RN, Residential Coordinator)	

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	This medication is a controlled substance schedule IV medication. Client #6's PO dated 11/15/11 for 12/11 was reviewed on 12/13/11 at 12:37 P.M.. Client #6's PO indicated he was prescribed Androgel (Testosterone). This medication is a controlled substance schedule III medication. A review of the Nursing Drug Handbook 2010 edition was conducted on 12/15/11 at 9:18 A.M.. The Handbook indicated the above medications were controlled substances. A review of the Living in The Community medication Core A and Core B curriculum was conducted on 12/15/11 at 9:42 A.M. The medication curriculum indicated scheduled (controlled) medications should be double locked. On 12-13-11 at 11:50 A.M. an interview with the facility RN (Registered Nurse) was conducted. When asked if the facility had a system in place to ensure controlled medications were double locked, the RN indicated they did not have the controlled medications double locked. They were kept locked in the medication cart with all the other medications. The RN indicated client #4 and client #6 were both on scheduled medications.			

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W0460	9-3-6(a) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review, and interview, the facility failed for 3 of 3 sampled clients (client #1, #2, #3) and 3 additional clients (#4, #5, #6) to ensure milk was offered at the supper meal per the menu. Findings include: On 12-12-11 from 3:15 P.M. until 5:20 P.M. an observation at the home of clients #1, #2, #3, #4, #5, and #6 was conducted. At 4:45 P.M. direct care staff (dcs) #3 poured red Koolaid into cups for clients #1, #2, #3, #4, #5, and #6. Client #5 placed each cup of red Koolaid at each person's place setting. At 5:00 P.M. clients #1, #2, #3, #4, #5, and #6 sat at the table for supper. Clients #1, #2, and #3 had a cup of red Koolaid and clients #4 and #6 had a small can of soda and a cup of red Koolaid. Clients #1, #2, #3, #4, #5, and #6 were not offered milk for the supper meal. On 12-12-11 at 4:15 P.M. a record review of the facility menu dated 12-12-11 indicated one cup of skim milk was to be served with the supper meal.	W0460	In order for this citation to be met now and systemically, staff will be trained on 1/12/12 on menus and consumers being offered what is on the menus. Staff will also allow consumers to have condiments on the table during meal times. Active Treatment training will also occur in regards to consumers being offered milk (on the menu) and allow consumers to pour their own drink (with assistance if necessary). IDT will monitor this, along with the dietician when observing during meal times. (QMRP. RN, Residential Director, Behavior Specialist, Team Leader, Direct Care staff and dietician responsible)	01/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, IN46350	

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	On 12-14-11 at 9:15 A.M. an interview with the Qualified Mental Retardation Professional indicated milk should be served at supper per the menu. 9-3-8(a)			