

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G663	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/29/2012
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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5662 N CRESTVIEW AVE INDIANAPOLIS, IN 46220
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W0000	<p>This visit was for the annual recertification and state licensure survey. This visit included the investigation of complaint #IN00119419.</p> <p>Complaint #IN00119419: Substantiated, federal and state deficiencies related to the allegation are cited at W104, W159, W189, W250 and W436.</p> <p>Survey dates: 11/20/12, 11/21/12, 11/26/12, 11/27/12, 11/28/12 and 11/29/12.</p> <p>Facility Number: 001216 Provider Number: 15G663 AIMS Number: 100233690</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/10/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
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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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W0102	<p><b>483.410 GOVERNING BODY AND MANAGEMENT</b> The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 2 of 2 sampled clients (A and B) plus 2 additional clients (C and D). The governing body failed to exercise general policy and operating direction over the facility to ensure client B's finances were not in excess of predetermined maximum amounts allowed by Medicaid.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to report all allegations of abuse/mistreatment/neglect/injuries of unknown origin to the Bureau of Developmental Disabilities Services (BDDS)/Adult Protection Services (APS) regarding eight separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER (Emergency Room) admission for client B and an incident of client to client aggression for client B and an unknown peer.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility</p>	W0102	The Home Manager and Program Director will be retrained on the \$1500.00 Medicaid cap on all client bank accounts. Client B will complete a guardian approved spend down to ensure that he does not exceed the \$1500 limit. Ongoing, the Client Financial Specialist will review all monthly finances and report to the Area Director who is over the \$1500 limit All staff will be retrained on Indiana MENTOR's policy and procedure for abuse, reporting abuse, and documentation of unknown injuries. Ongoing, the Home Manager and/or Program Director will complete random Active Treatment observations three times per week for the first four weeks, and then once a week on going. All Direct Care Staff will be retrained on Indiana MENTOR's policy and procedure for reporting emergency circumstances to the on call supervisor. This training will include what qualifies as an emergency situation that needs to be reported and who to report it to. Ongoing, the Home Manager and/or Program Director will complete random Active Treatment observations three times per week for the first four weeks, and then once a week on going. The Home Manager will be	12/29/2012			

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	<p>implemented its policy and procedures to complete a thorough investigation regarding nine separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER visit for client B, an incident of client to client aggression for client B and an incident of client C implementing a physical restraint of client B.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to put in place corrective actions for client B's elopement, to address client B's ingestion of or attempts to ingest non food items, to address client C's physical restraint of client B, to put in place corrective actions regarding facility staff's use of non agency physical restraints and to put in place corrective actions to address client B's attempts to vacate from a moving vehicle.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the QMRP (Qualified Mental Retardation Professional) provided facility staff with an active treatment schedule for clients A and B, to ensure the QMRP reviewed/monitored client B's program to determine when objectives needed revisions, to ensure the QMRP ensured</p>		<p>retrained to complete documentation reviews to ensure that anything that would be considered to be BDDS reportable that is documented in writing in a client file will be reported to the Program Director so that a BDDS report can be completed and the information also sent on to APS. Ongoing, the Program Director will complete random monthly audits of client files to ensure that all BDDS reportable incidents are completed correctly. The Program Director will be retrained on completing investigations to ensure that all incidents requiring an investigation are completed within the 5 day time period expected. Ongoing, the Quality Assurance Specialist will continue to monitor the investigations weekly, that are completed by this Program Director. All incomplete investigations will be referred to the Area Director for further follow up. The Program Director will be retrained on completing Active Treatment schedules that are client specific, and ensuring that they are available to the direct support staff at all times. These Active Treatment schedules will be review quarterly, or more as needed, and the Program Director will be retrained on this also. Ongoing, the Area Director and/or Quality Assurance will be completing random quarterly audits to ensure that these are written and kept up to date for</p>		

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	<p>client B's CFA (Comprehensive Functional Assessment) was reviewed annually, to ensure the QMRP ensured the facility's HRC (Human Rights Committee) reviewed, approved and monitored restrictive programs for client A and to ensure the QMRP ensured the facility obtained client B, C and D's guardian approval before implementation of a BSP (Behavior Support Plan), behavior medications or modification of client rights.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure there were adequate staff levels to implement client B's BSP, to ensure there were adequate staff in the group home during the evening shift for clients A, B, C and D, and to ensure staff were trained to work with client A.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure client B's finances were not in excess of predetermined maximum amounts allowed by Medicaid. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to report all allegations of</p>		<p>each client. Ongoing, the Program Director and/or Area Director will complete random monthly Active Treatment Observations to ensure that the Direct Support Staff are following the schedules that are available to them. The Program Director will be retrained on client specific program goals. The Program Director will also be retrained on the appropriate way to update these goals and ensure that staff are documenting these goals appropriately. Ongoing, the Program Director and/or Area Director will complete random monthly observations to ensure that the Direct Support Staff are following the goals, and documenting them as they are available to them. The Home Manager will be retrained on assisting with completing annual assessments with each client annually, or more, as needed. This retraining will include the Home Manager ensuring that none of these assessments exceed the 365 day limit, and are updated as any changes occur. The Program Director will be retrained on ensuring that these staff up to date, to ensure that these are including in the updating of the Individualized Support Plan for each client, annually, or more. Ongoing, the Area Director and/or Quality Assurance will be completing random quarterly audits to ensure that these are</p>		

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	<p>abuse/mistreatment/neglect/injuries of unknown origin to the Bureau of Developmental Disabilities Services (BDDS)/Adult Protection Services (APS) regarding eight separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER (Emergency Room) admission for client B and an incident of client to client aggression for client B and an unknown peer.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to complete a thorough investigation regarding nine separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER visit for client B, an incident of client to client aggression for client B and an incident of client C implementing a physical restraint of client B.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to put in place corrective actions for client B's elopement, to address client B's ingestion of or attempts to ingest non food items, to address client C's physical restraint of client B, to put in place</p>		<p>written and kept up to date for each client. The Program Director will be retrained on obtaining guardian approval for all restrictions, med changes, and Behavior Support Plans BEFORE obtaining HRC approval as well. Ongoing, the Area Director and/or Quality Assurance will be completing random quarterly audits to ensure that these are written and kept up for each client. The Area Director, Program Director, and Home Manager reviewed the house staffing schedule to ensure that all levels are appropriate at all times. The Program Director will complete random weekly 'drop ins' in the house to ensure that all staffing levels are appropriate at the time. Please also see W104 Please also see W122 Please also see W156 Completion Date: 12-29-2012 Responsible Party: Home Manager and Program Director.</p>				

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	<p>corrective actions regarding facility staff's use of non agency physical restraints and to put in place corrective actions to address client B's attempts to vacate from a moving vehicle.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the QMRP (Qualified Mental Retardation Professional) provided facility staff with an active treatment schedule for clients A and B, to ensure the QMRP reviewed/monitored client B's program to determine when objectives needed revisions, to ensure the QMRP ensured client B's CFA (Comprehensive Functional Assessment) was reviewed annually, to ensure the QMRP ensured the facility's HRC (Human Rights Committee) reviewed, approved and monitored restrictive programs for client A and to ensure the QMRP ensured the facility obtained client B, C and D's guardian approval before implementation of a BSP (Behavior Support Plan), behavior medications or modification of client rights.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure there were adequate staff levels to implement client B's BSP, to ensure there were adequate staff in the group home during the evening shift for clients A, B, C and D,</p>			

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	<p>and to ensure staff were trained to work with client A. Please see W104.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to report all allegations of abuse/mistreatment/neglect/injuries of unknown origin to the BDDS/APS regarding eight separate instances, five separate instances of the use of physical intervention regarding client B, an ER admission for client B, an incident of client to client aggression for client B and an unknown peer.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to complete a thorough investigation regarding nine separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER visit for client B, an incident of client to client aggression for client B, and an incident of client C implementing a physical restraint of client B.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to put in place corrective actions for client B's elopement, client B's ingestion of or attempts to ingest non food items, client</p>			

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	<p>C's physical restraint of client B, facility staff's use of non agency physical restraints and client B's attempts to vacate from a moving vehicle. Please see W122.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure there were adequate staff levels to implement client B's BSP. The governing body failed to exercise general policy and operating direction over the facility to ensure there were adequate staff in the group home during the evening shift for clients A, B, C and D. The governing body failed to exercise general policy and operating direction over the facility to ensure staff were trained to work with client A. Please see W158.</p> <p>9-3-1(a)</p>				

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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 2 of 2 sampled clients (A and B) plus 2 additional clients (C and D), the governing body failed to exercise general policy and operating direction over the facility to ensure client B's finances were not in excess of predetermined maximum amounts allowed by Medicaid. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to report all allegations of abuse/mistreatment/neglect/injuries of unknown origin to the Bureau of Developmental Disabilities Services (BDDS)/Adult Protection Services (APS) regarding eight separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER (Emergency Room) admission for client B and an incident of client to client aggression for client B and an unknown peer.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to complete a thorough investigation</p>	W0104	<p>The Home Manager and Program Director will be retrained on the \$1500.00 Medicaid cap on all client bank accounts. Client B will complete a guardian approved spend down to ensure that he does not exceed the \$1500 limit. Ongoing, the Client Financial Specialist will review all monthly finances and report to the Area Director who is over the \$1500 limit All staff will be retrained on Indiana MENTOR's policy and procedure for abuse, reporting abuse, and documentation of unknown injuries. Ongoing, the Home Manager and/or Program Director will complete random Active Treatment observations three times per week for the first four weeks, and then once a week on going. All Direct Care Staff will be retrained on Indiana MENTOR's policy and procedure for reporting emergency circumstances to the on call supervisor. This training will include what qualifies as an emergency situation that needs to be reported and who to report it to. Ongoing, the Home Manager and/or Program Director will complete random Active Treatment observations three times per week for the first four weeks, and then once a week on going. The Home Manager will be</p>	12/29/2012			

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	<p>regarding nine separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER visit for client B, an incident of client to client aggression for client B and an incident of client C implementing a physical restraint of client B.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to put in place corrective actions for client B's elopement, to address client B's ingestion of or attempts to ingest non food items, to address client C's physical restraint of client B, to put in place corrective actions regarding facility staff's use of non agency physical restraints and to put in place corrective actions to address client B's attempts to vacate from a moving vehicle.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the QMRP (Qualified Mental Retardation Professional) provided facility staff with an active treatment schedule for clients A and B, to ensure the QMRP reviewed/monitored client B's program to determine when objectives needed revisions, to ensure the QMRP ensured client B's CFA (Comprehensive Functional Assessment) was reviewed</p>		<p>retrained to complete documentation reviews to ensure that anything that would be considered to be BDDS reportable that is documented in writing in a client file will be reported to the Program Director so that a BDDS report can be completed and the information also sent on to APS. Ongoing, the Program Director will complete random monthly audits of client files to ensure that all BDDS reportable incidents are completed correctly. The Program Director will be retrained on completing investigations to ensure that all incidents requiring an investigation are completed within the 5 day time period expected. Ongoing, the Quality Assurance Specialist will continue to monitor the investigations weekly, that are completed by this Program Director. All incomplete investigations will be referred to the Area Director for further follow up. The Program Director will be retrained on completing Active Treatment schedules that are client specific, and ensuring that they are available to the direct support staff at all times. These Active Treatment schedules will be review quarterly, or more as needed, and the Program Director will be retrained on this also. Ongoing, the Area Director and/or Quality Assurance will be completing random quarterly audits to ensure that these are written and kept up to date for</p>		

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	<p>annually, to ensure the QMRP ensured the facility's HRC (Human Rights Committee) reviewed, approved and monitored restrictive programs for client A and to ensure the QMRP ensured the facility obtained client B, C and D's guardian approval before implementation of a BSP (Behavior Support Plan), behavior medications or modification of client rights.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure there were adequate staff levels to implement client B's BSP, to ensure there were adequate staff in the group home during the evening shift for clients A, B, C and D, and to ensure staff were trained to work with client A.</p> <p>Findings include:</p> <p>1. Client B's financial record was reviewed on 11/27/12 at 12:00 PM. Client B's facility based cluster account ledger dated 7/3/12 through 11/14/12 indicated the following:</p> <p>-7/3/12, SSD (Social Security Deposit), \$638.00 with an ending balance in the amount of \$4,400.00.</p> <p>-7/10/12, PSW (Personal Spending Withdrawal), \$200.00 with an ending balance in the amount of \$4,200.00.</p>		<p>each client. Ongoing, the Program Director and/or Area Director will complete random monthly Active Treatment Observations to ensure that the Direct Support Staff are following the schedules that are available to them. The Program Director will be retrained on client specific program goals. The Program Director will also be retrained on the appropriate way to update these goals and ensure that staff are documenting these goals appropriately. Ongoing, the Program Director and/or Area Director will complete random monthly observations to ensure that the Direct Support Staff are following the goals, and documenting them as they are available to them. The Home Manager will be retrained on assisting with completing annual assessments with each client annually, or more, as needed. This retraining will include the Home Manager ensuring that none of these assessments exceed the 365 day limit, and are updated as any changes occur. The Program Director will be retrained on ensuring that these staff up to date, to ensure that these are including in the updating of the Individualized Support Plan for each client, annually, or more. Ongoing, the Area Director and/or Quality Assurance will be completing random quarterly audits to ensure that these are</p>		

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	<p>-7/17/12, LW (Liability Withdrawal), \$586.00 with an ending balance in the amount of \$3,614.00.</p> <p>-8/3/12, SSD, \$638.00 with an ending balance in the amount of \$4,252.00.</p> <p>-8/20/12, LW, \$586.00 with an ending balance in the amount of \$3,666.00.</p> <p>-8/27/12, PSW, \$250.00 with an ending balance in the amount of \$3,416.00.</p> <p>-8/31/12, SSD, \$638.00 with an ending balance in the amount of \$4,054.00.</p> <p>-9/11/12, LW, \$586.00 with an ending balance in the amount of \$3,468.00.</p> <p>-10/3/12, SSD, \$638.00 with an ending balance in the amount of \$4,106.00.</p> <p>-10/22/12, LW, \$586.00 with an ending balance in the amount of \$3,520.00.</p> <p>-11/2/12, SSD, \$638.00 with an ending balance in the amount of \$4,158.00.</p> <p>-11/14/12, LW, \$586.00 with an ending balance in the amount of \$3,572.00.</p> <p>AS (Administrative Staff) #1 was interviewed on 11/28/12 at 12:41 PM. AS #1 indicated the maximum allowable amount was \$1,500.00.</p> <p>2. The governing body failed to exercise</p>		<p>written and kept up to date for each client. The Program Director will be retrained on obtaining guardian approval for all restrictions, med changes, and Behavior Support Plans BEFORE obtaining HRC approval as well. Ongoing, the Area Director and/or Quality Assurance will be completing random quarterly audits to ensure that these are written and kept up for each client. The Area Director, Program Director, and Home Manager reviewed the house staffing schedule to ensure that all levels are appropriate at all times. The Program Director will complete random weekly 'drop ins' in the house to ensure that all staffing levels are appropriate at the time. The Program Director and Home Manager will be retrained to ensure that all staff are trained to work with any client, before actually working a shift. The client specific training spreadsheet will be reviewed by the Area Director monthly to ensure that no staff are working without being trained first. Please also see W102 Please also see W122 Please also see W156 Completion Date: 12-29-2012 Responsible Party: Home Manager and Program Director.</p>	

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	<p>general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to report all allegations of abuse/mistreatment/neglect/injuries of unknown origin to the Bureau of Developmental Disabilities Services (BDDS)/Adult Protection Services (APS) regarding eight separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER (Emergency Room) admission for client B and an incident of client to client aggression for client B and an unknown peer.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to complete a thorough investigation regarding nine separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER visit for client B, an incident of client to client aggression for client B and an incident of client C implementing a physical restraint of client B.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to put in place corrective actions for client</p>			

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	<p>B's elopement, to address client B's ingestion of or attempts to ingest non food items, to address client C's physical restraint of client B, to put in place corrective actions regarding facility staff's use of non agency physical restraints and to put in place corrective actions to address client B's attempts to vacate from a moving vehicle. Please see W149.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure the QMRP (Qualified Mental Retardation Professional) provided facility staff with an active treatment schedule for clients A and B, to ensure the QMRP reviewed/monitored client B's program to determine when objectives needed revisions, to ensure the QMRP ensured client B's CFA (Comprehensive Functional Assessment) was reviewed annually, to ensure the QMRP ensured the facility's HRC (Human Rights Committee) reviewed, approved and monitored restrictive programs for client A and to ensure the QMRP ensured the facility obtained client B, C and D's guardian approval before implementation of a BSP (Behavior Support Plan), behavior medications or modification of client rights. Please see W159.</p>			

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	<p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure there were adequate staff levels to implement client B's BSP. The governing body failed to exercise general policy and operating direction over the facility to ensure there were adequate staff in the group home during the evening shift for clients A, B, C and D. Please see W186.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure staff were trained to work with client A. Please see W189.</p> <p>This federal tag relates to complaint #IN00119419.</p> <p>9-3-1(a)</p>			

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 1 of 2 sampled clients (B), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policy and procedures to report all allegations of abuse/mistreatment/neglect/injuries of unknown origin to the Bureau of Developmental Disabilities Services (BDDS)/Adult Protection Services (APS) regarding eight separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER (Emergency Room) admission for client B and an incident of client to client aggression for client B and an unknown peer.</p> <p>The facility failed to implement its policy and procedures to complete a thorough investigation regarding nine separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER visit for client B, an incident of client to client aggression for client B and an incident of client C implementing a physical restraint of client B.</p> <p>The facility failed to implement its policy and procedures to put in place corrective actions for client B's elopement, to</p>	W0122	<p>All staff will be retrained on Indiana MENTOR's policy and procedure for abuse, reporting abuse, and documentation of unknown injuries. Ongoing, the Home Manager and/or Program Director will complete random Active Treatment observations three times per week for the first four weeks, and then once a week on going. All Direct Care Staff will be retrained on Indiana MENTOR's policy and procedure for reporting emergency circumstances to the on call supervisor. This training will include what qualifies as an emergency situation that needs to be reported and who to report it to. Ongoing, the Home Manager and/or Program Director will complete random Active Treatment observations three times per week for the first four weeks, and then once a week on going. The Home Manager will be retrained to complete documentation reviews to ensure that anything that would be considered to be BDDS reportable that is documented in writing in a client file will be reported to the Program Director so that a BDDS report can be completed and the information also sent on to APS. Ongoing, the Program Director will complete random monthly audits of client</p>	12/29/2012			

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	<p>address client B's ingestion of or attempts to ingest non food items, to address client C's physical restraint of client B, to put in place corrective actions regarding facility staff's use of non agency physical restraints and to put in place corrective actions to address client B's attempts to vacate from a moving vehicle.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to report all allegations of abuse/mistreatment/neglect/injuries of unknown origin to the BDDS/Adult Protection Services APS regarding eight separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER admission for client B, and client to client aggression for client B and an unknown peer. The facility failed to implement its policy and procedures to complete a thorough investigation regarding nine separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER visit for client B, an incident of client to client aggression for client B, and an incident of client C implementing a physical restraint of client B. The facility failed to implement its policy and procedures to put in place corrective actions for client B's elopement, to address client B's ingestion of or attempts to ingest non food items, client C's physical restraint of client B, facility staff's use of non</p>		<p>files to ensure that all BDDS reportable incidents are completed correctly. The Program Director will be retrained on completing investigations to ensure that all incidents requiring an investigation are completed within the 5 day time period expected. Ongoing, the Quality Assurance Specialist will continue to monitor the investigations weekly that are completed by this Program Director. All incomplete investigations will be referred to the Area Director for further follow up. Please also see W157 Completion Date 12.29.2012 Responsible Party: Area Director, Program Director, and Home Manager</p>				

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	<p>agency physical restraints and to address client B's attempts to vacate from a moving vehicle. Please see W149.</p> <p>2. The facility failed to immediately notify the administrator and BDDS in accordance with state law regarding eight separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER visit for client B and an incident of client to client aggression for client B and an unknown peer. Please see W153.</p> <p>3. The facility failed to complete a thorough investigation regarding nine separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER visit for client B, an incident of client to client aggression for client B and an incident of client C implementing a physical restraint of client B. Please see W154.</p> <p>4. The facility failed to put in place corrective actions/measures to prevent client B's elopement, to address client B's ingestion of or attempts to ingest non food items, to address client C's physical restraint of client B, to prevent facility staff from using non agency physical restraints and to address client B's attempts to vacate from a moving vehicle. Please see W157.</p> <p>9-3-2(a)</p>				

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W0126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS 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.</p> <p>Based on record review and interview for 1 of 2 sampled clients (B), the facility failed to allow and/or encourage client B to carry money on his person to the extent he was capable.</p> <p>Findings include:</p> <p>Client B's record was reviewed on 11/26/12 at 9:43 AM. Client B's ISP (Individual Support Plan) dated 12/10/11 indicated client B could handle money with assistance. Client B's ISP dated 12/10/11 did not indicate client B should be restricted from carrying his money. Client B's HRC (Human Rights Committee) form dated 10/3/12 indicated, "[Client B] can carry no more that \$1.00 on his person at any given time." Client B's financial record indicated client B had no access to his petty cash in the group home.</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1 on 11/26/12 at 12:45 PM indicated client B was not permitted to carry money on his person. QMRP #1 indicated staff carry client B's</p>	W0126	The Program Director will be retrained on updating the Individualized Support Plan and the High Risk Plan to match any changes that may occur. The Program Director will update the ISP and RMAP to show that the team decided that client B should not carry more than \$1.00 on him at a time. The IST agreed that it was in the client's best interest to have staff carry his money for him. Ongoing, the Area Director and/or Quality Assurance Specialist will continue to review all ISPs written by this Program Director, to ensure accuracy and completion.	12/29/2012			

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	<p>money for him.</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 1 of 2 sampled clients (B), the facility failed to implement its policy and procedures to report all allegations of abuse/mistreatment/neglect/injuries of unknown origin to the Bureau of Developmental Disabilities Services (BDDS)/Adult Protection Services (APS) regarding eight separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER (Emergency Room) admission for client B and an incident of client to client aggression for client B and an unknown peer.</p> <p>The facility failed failed to complete a thorough investigation regarding nine separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER visit for client B, an incident of client to client aggression for client B and an incident of client C implementing a physical restraint of client B.</p> <p>The facility failed to implement its policy and procedures to put in place corrective actions for client B's elopement, to address client B's ingestion of or attempts to ingest non food items, to address client</p>	W0149	<p>All staff will be retrained on Indiana MENTOR's policy and procedure for abuse, reporting abuse, and documentation of unknown injuries. Ongoing, the Home Manager and/or Program Director will complete random Active Treatment observations three times per week for the first four weeks, and then once a week on going. All Direct Care Staff will be retrained on Indiana MENTOR's policy and procedure for reporting emergency circumstances to the on call supervisor. This training will include what qualifies as an emergency situation that needs to be reported and who to report it to. The Home Manager will be retrained to complete documentation reviews to ensure that anything that would be considered to be BDDS reportable that is documented in writing in a client file will be reported to the Program Director so that a BDDS report can be completed and the information also sent on to APS. Ongoing, the Program Director will complete random monthly audits of client files to ensure that all BDDS reportable incidents are completed correctly. The Program Director will be retrained on completing investigations to</p>	12/29/2012

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	<p>C's physical restraint of client B, to put in place corrective actions regarding facility staff's use of non agency physical restraints and to put in place corrective actions to address client B's attempts to vacate from a moving vehicle.</p> <p>Findings include:</p> <p>1. Client B's record was reviewed on 11/26/12 at 9:43 AM. Client B's BPR's (Behavior Progress Report) indicated the following behavioral narrative entries:</p> <p>-7/12/12 at 8:30 PM indicated client B vacated the group home.</p> <p>-7/16/12 at 8:00 PM, "[Client B] got angry about the other guys using both showers. [Client B] walked out of the house while staff was in the kitchen. Staff could not follow (sic) the other boys were (sic) taking their shower. Later, took all the boys and found [client B] along [intersection]."</p> <p>-7/16/12 at 9:47 PM, "[Client B] walked into the living room as [staff #1] was pass (sic) information to this staff. [Client B] didn't want to wait until staff finished talking. [Client B] just turns (sic) around and walked out the front door (vacated)."</p> <p>-7/21/12 at 8:00 PM, "[Client B] got angry when staff asked him to put on his seatbelt. [Client B] got up his chair (sic) and opened the door. While staff was driving the van,</p>		<p>ensure that all incidents requiring an investigation are completed within the 5 day time period expected. Ongoing, the Quality Assurance Specialist will continue to monitor the investigations weekly that are completed by this Program Director. All incomplete investigations will be referred to the Area Director for further follow up. Responsible Party: Area Director, Program Director, and Home Manager</p>		

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	<p>staff had to grab [client B] by his shirt and try to control the van at the same time. Staff had to use PIA (Physical Intervention Assistance) to prevent [client B] from falling over the street (sic)...."</p> <p>-7/31/12 at 8:30 PM, "[Client B] was watching TV when he decided that he didn't want to be in the house. [Client B] ran out of the back door when (sic) into the streets...."</p> <p>-7/31/12 at 9:20 PM, "[Client B] had just got (sic) through a behavior, [client B] tried several times to attack staff, (sic) staff tried his best to handle the incident. Staff had to use PIA to protect himself and [client B]."</p> <p>-8/1/12 at 9:30 PM, "... was sitting in the living room watching a baseball game on TV. [Client B] suddenly went and unplugged the cable. [Client B] started using names toward (sic) housemates and attempted to throw storage cube (sic) to (sic) housemate. Was... escorted to his room...."</p> <p>-8/5/12 at 6:25 PM, "[Client B] was in his room listening to his music. Staff heard the front door open and look (sic) out to see [client B] running down Crestview Avenue (sic) staff could not immediately run after [client B] since on of the client's was in the bathroom and the other client was helping staff cook dinner. Staff called the on call and explained (sic) situation to her about what had happened. Staff late had to drive over (sic) at Kessler to get [client B]."</p>			

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	<p>-8/24/12 at 9:08 AM, "... [client B] was pacing around and singing song (sic) with bad words. [Client B] open (sic) up the front door and walks (sic) out. [Client B] did twice (sic) and both time (sic) he stood in the street and sing (sic)."</p> <p>-9/10/12 at 7:30 PM, "[Client B] had just come out of the bathroom after taking a shower. [Client B] tried several times to leave the house while physically trying to attack staff with fists and open hands (sic) he came back to the house and threw the phone on the ground breaking it in the process." The 9/10/12 BPR indicated, "Staff later use (sic) hand PIA...."</p> <p>-9/14/12 at 6:00 PM, "[Client B] was watching TV. [Client B] just walked out and started down the street. While staff walked after him (sic) talking to him he saw a car coming and threaten (sic) to kill himself. Staff held him to prevent him from jumping into a moving vehicle."</p> <p>-9/24/12 at 6:35 PM, "... [client B] was looking for lemonade to drink but could not find any remaining. [Client B] got upset that there was no lemonade remaining (sic) he approached a fellow housemate talking loud to him (sic) then they started hitting each other."</p> <p>-9/25/12 at 7:00 PM, "... [client B] got upset (sic) wanted to vacate but staff blocked the door. [Client B] hit staff on the face.... Staff put [client B] on (sic) hold for (sic) [client B]</p>						

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	<p>until he calmed down...."</p> <p>-10/2/12 at 8:50 PM, "...went in the bathroom stayed in the bathroom for two minutes came out (sic) said he swallow and drank hand sanitizer. Staff called the on call supervisor and poison control (sic) they suggested [client B] should be taken to emergency room. Staff took [client B] to [hospital] emergency room and stayed with him for awhile."</p> <p>-11/2/12 at 9:00 PM indicated client B vacated the house.</p> <p>-11/8/12 at 5:30 PM indicated client B vacated the house.</p> <p>A review of the facility's BDDS reports was conducted on 11/20/12 at 3:12 PM. The review did not indicate a BDDS report regarding client B's 7/12/12, 7/16/12, 7/16/12, 7/31/12, 8/24/12, 9/14/12, 11/2/12 and/or 11/8/12 incidents of elopement/vacating. The review did not indicate a BDDS report regarding client B's 7/21/12, 7/31/12, 8/1/12, 9/10/12 and/or 9/25/12 incidents of PIA use. The review did not indicate a BDDS report regarding client B's 9/24/12 incident of client to client aggression with an unnamed peer. The review did not indicate a BDDS report regarding client B's ER visit/admission.</p> <p>Interview with AS #1 on 11/26/12 at 2:15 PM indicated there were no additional BDDS reports available for review.</p>						

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	<p>Interview with AS #1 on 11/27/12 at 11:05 AM indicated BDDS reportable incidents included elopement, use of physical restraints, client to client aggression and the use of ER services.</p> <p>Interview with HM (Home Manager) #1 and QMRP (Qualified Mental Retardation Professional) #1 on 11/27/12 at 11:10 AM indicated facility staff should report instances of elopement/vacating, use of PIA, client to client aggression, and ER visits to HM #1 or the on call HM who should then report the incident QMRP #1 or the on call QMRP. HM #1 and QMRP #1 indicated the incidents of elopement/vacating, use of PIA, client to client aggression and ER visit should then be reported to the administrator and BDDS.</p> <p>The facility's policy and procedures were reviewed on 11/27/12 at 5:00 PM. The 4/2011 facility's policy entitled Quality and Risk Management indicated, "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: B (1)(a)(iii) Unauthorized restraint or confinement resulting from physical intervention; B(1)(e) Failure to provide appropriate supervision, care or training. 4.(c) Elopement of an individual that results in evasion of required supervision as described in the ISP (Individual Support</p>						

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	<p>Plan) for health and welfare;</p> <p>4. (d) Missing person when an individual wanders away and no one knows where they are;</p> <p>4.(f) Event with the potential for causing significant harm or injury and requiring medical or psychiatric treatments or services to or for an individual receiving services;</p> <p>4.(g) Admission of an individual to a nursing facility, including respite stays;</p> <p>4.(n) Use of any physical or manual restraint regardless of: (1) planning; (2) Human Rights Committee approval; (3) Informed consent;</p> <p>4.(p) Inadequate staff support of an individual, including inadequate supervision, with the potential for: (1) significant harm or injury to an individual; or (2) death of an individual;</p> <p>5. 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."</p> <p>2. The facility's policy and procedures were reviewed on 11/27/12 at 5:00 PM. The 4/2011 facility's policy entitled Quality and Risk Management indicated:</p> <p>"C. Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardized the health and safety of any individual served or other employee.</p> <p>1. Investigation findings will be submitted to the Area Director for review and development of further recommendations as</p>						

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	<p>needed within 5 days of the incident."</p> <p>The facility failed to immediately notify the administrator and the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law regarding eight separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER (Emergency Room) visit for client B and an incident of client to client aggression for client B and an unknown peer. Please see W153.</p> <p>The facility failed to complete a thorough investigation regarding nine separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER visit for client B, an incident of client to client aggression for client B, and an incident of client C implementing a physical restraint of client B. Please see W154.</p> <p>The facility failed to put in place corrective actions/measures to prevent client B's elopement, client B's ingestion of or attempts to ingest non food items, client C's physical restraint of client B, facility staff from using non agency physical restraints and client B's attempts to vacate from a moving vehicle. Please see W157.</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. Based on record review and interview for 15 of 34 allegations of abuse, neglect, mistreatment and/or injuries of unknown origin reviewed, the facility failed to immediately notify the administrator and the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law regarding eight separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an emergency room visit for client B and an incident of client to client aggression for client B and an unknown peer.</p> <p>Findings include:</p> <p>Client B's record was reviewed on 11/26/12 at 9:43 AM. Client B's BPR's (Behavior Progress Report) indicated the following behavioral narrative entries:</p> <p>-7/12/12 at 8:30 PM indicated client B vacated the group home.</p> <p>-7/16/12 at 8:00 PM, "[Client B] got angry about the other guys using both showers. [Client B] walked out of the house while staff was in the kitchen. Staff could not follow (sic) the other boys were taking their shower. Later, took all the boys and found [client B]</p>	W0153	<p>All staff will be retrained on Indiana MENTOR's policy and procedure for abuse, reporting abuse, and documentation of unknown injuries. Ongoing, the Home Manager and/or Program Director will complete random Active Treatment observations three times per week for the first four weeks, and then once a week on going. All Direct Care Staff will be retrained on Indiana MENTOR's policy and procedure for reporting emergency circumstances to the on call supervisor. This training will include what qualifies as an emergency situation that needs to be reported and who to report it to. The Home Manager will be retrained to complete documentation reviews to ensure that anything that would be considered to be BDDS reportable that is documented in writing in a client file will be reported to the Program Director so that a BDDS report can be completed and the information also sent on to APS. Ongoing, the Program Director will complete random monthly audits of client files to ensure that all BDDS reportable incidents are</p>	12/29/2012			

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	<p>along [intersection]."</p> <p>-7/16/12 at 9:47 PM, "[Client B] walked into the living room as [staff #1] was pass (sic) information to this staff. [Client B] didn't want to wait until staff finished talking. [Client B] just turns (sic) around and walked out the front door (vacated)."</p> <p>-7/21/12 at 8:00 PM, "[Client B] got angry when staff asked him to put on his seatbelt. [Client B] got up his chair (sic) and opened the door. While staff was driving the van, staff had to grab [client B] by his shirt and try to control the van at the same time. Staff had to use PIA (Physical Intervention Assistance) to prevent [client B] from falling over the street (sic)...."</p> <p>-7/31/12 at 8:30 PM, "[Client B] was watching TV when he decided that he didn't want to be in the house. [Client B] ran out of the back door when (sic) into the streets...."</p> <p>-7/31/12 at 9:20 PM, "[Client B] had just got (sic) through a behavior, [client B] tried several times to attack staff, (sic) staff tried his best to handle the incident. Staff had to use PIA to protect himself and [client B]."</p> <p>-8/1/12 at 9:30 PM, "... was sitting in the living room watching a baseball game on TV. [Client B] suddenly went and unplugged the cable. [Client B] started using names toward (sic) housemates and attempted to throw storage cube (sic) to (sic) housemate. Was... escorted to his room...."</p>		<p>completed correctly. The Program Director will be retrained on completing investigations to ensure that all incidents requiring an investigation are completed within the 5 day time period expected. Ongoing, the Quality Assurance Specialist will continue to monitor the investigations weekly that are completed by this Program Director. All incomplete investigations will be referred to the Area Director for further follow up. Responsible Party: Area Director, Program Director, and Home Manager</p>				

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	<p>-8/5/12 at 6:25 PM, "[Client B] was in his room listening to his music. Staff heard the front door open and look (sic) out to see [client B] running down Crestview Avenue (sic) staff could not immediately run after [client B] since on of the client's was in the bathroom and the other client was helping staff cook dinner. Staff called the on call and explained (sic) situation to her about what had happened. Staff late had to drive over (sic) at Kessler to get [client B]."</p> <p>-8/24/12 at 9:08 AM, "... [client B] was pacing around and singing song (sic) with bad words. [Client B] open (sic) up the front door and walks (sic) out. [Client B] did twice (sic) and both time (sic) he stood in the street and sing (sic)."</p> <p>-9/10/12 at 7:30 PM, "[Client B] had just come out of the bathroom after taking a shower. [Client B] tried several times to leave the house while physically trying to attack staff with fists and open hands (sic) he came back to the house and threw the phone on the ground breaking it in the process." The 9/10/12 BPR indicated, "Staff later use (sic) hand PIA...."</p> <p>-9/14/12 at 6:00 PM, "[Client B] was watching TV. [Client B] just walked out and started down the street. While staff walked after him (sic) talking to him he saw a car coming and threaten to kill himself. Staff held him to prevent him from jumping into a moving vehicle."</p>						

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	<p>-9/24/12 at 6:35 PM, "... [client B] was looking for lemonade to drink but could not find any remaining. [Client B] got upset that there was no lemonade remaining (sic) he approached a fellow housemate talking loud to him (sic) then they started hitting each other."</p> <p>-9/25/12 at 7:00 PM, "... [client B] got upset (sic) wanted to vacate but staff blocked the door. [Client B] hit staff on the face.... Staff put [client B] on (sic) hold for (sic) [client B] until he calmed down...."</p> <p>-10/2/12 at 8:50 PM, "...went in the bathroom stayed in the bathroom for two minutes came out (sic) said he swallow and drank hand sanitizer. Staff called the on call supervisor and poison control (sic) they suggested [client B] should be taken to emergency room. Staff took [client B] to [hospital] emergency room and stayed with him for awhile."</p> <p>-11/2/12 at 9:00 PM indicated client B vacated the house.</p> <p>-11/8/12 at 5:30 PM indicated client B vacated the house.</p> <p>A review of the facility's BDDS reports was conducted on 11/20/12 at 3:12 PM. The review did not indicate a BDDS report regarding client B's 7/12/12, 7/16/12, 7/16/12, 7/31/12, 8/24/12, 9/14/12, 11/2/12 and/or 11/8/12 incidents of</p>			

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	<p>elopement/vacating. The review did not indicate a BDDS report regarding client B's 7/21/12, 7/31/12, 8/1/12, 9/10/12 and/or 9/25/12 incidents of PIA use. The review did not indicate a BDDS report regarding client B's 9/24/12 incident of client to client aggression with an unnamed peer.</p> <p>Interview with AS #1 on 11/26/12 at 2:15 PM indicated there were no additional BDDS reports available for review.</p> <p>Interview with AS #1 on 11/27/12 at 11:05 AM indicated BDDS reportable incidents included elopement, use of physical restraints and client to client aggression.</p> <p>Interview with HM (Home Manager) #1 and QMRP (Qualified Mental Retardation Professional) #1 on 11/27/12 at 11:10 AM indicated facility staff should report instances of elopement/vacating, use of PIA, client to client aggression, and ER visits to HM #1 or on the call HM who should then report the incident QMRP #1 or the on call QMRP. HM #1 and QMRP #1 indicated the incidents of elopement/vacating, use of PIA and client to client aggression should then be reported to the administrator and BDDS.</p> <p>9-3-2(a) 9-3-1(b)(5)</p>				

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 18 of 34 allegations of abuse, neglect, mistreatment and/or injuries of unknown origin reviewed, the facility failed to complete a thorough investigation regarding nine separate instances of client B's elopement, five separate instances of the use of physical intervention regarding client B, an ER visit for client B, an incident of client to client aggression for client B, and an incident of client C implementing a physical restraint of client B.</p> <p>Findings include:</p> <p>Client B's record was reviewed on 11/26/12 at 9:43 AM. Client B's BPR's (Behavior Progress Report) indicated the following behavioral narrative entries:</p> <p>-7/12/12 at 8:30 PM indicated client B vacated the group home.</p> <p>-7/16/12 at 8:00 PM, "[Client B] got angry about the other guys using both showers. [Client B] walked out of the house while staff was in the kitchen. Staff could not follow (sic) the other boys were taking their shower. Later, took all the boys and found [client B] along [intersection]."</p> <p>-7/16/12 at 9:47 PM, "[Client B] walked into the living room as [staff #1] was pass (sic)</p>	W0154	<p>All staff will be retrained on Indiana MENTOR's policy and procedure for abuse, reporting abuse, and documentation of unknown injuries. Ongoing, the Home Manager and/or Program Director will complete random Active Treatment observations three times per week for the first four weeks, and then once a week on going. All Direct Care Staff will be retrained on Indiana MENTOR's policy and procedure for reporting emergency circumstances to the on call supervisor. This training will include what qualifies as an emergency situation that needs to be reported and who to report it to. The Home Manager will be retrained to complete documentation reviews to ensure that anything that would be considered to be BDDS reportable that is documented in writing in a client file will be reported to the Program Director so that a BDDS report can be completed and the information also sent on to APS. Ongoing, the Program Director will complete random monthly audits of client files to ensure that all BDDS reportable incidents are completed correctly. The Program Director will be retrained on completing investigations to</p>	12/29/2012			

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	<p>information to this staff. [Client B] didn't want to wait until staff finished talking. [Client B] just turns (sic) around and walked out the front door (vacated)."</p> <p>-7/21/12 at 8:00 PM, "[Client B] got angry when staff asked him to put on his seatbelt. [Client B] got up his chair (sic) and opened the door. While staff was driving the van, staff had to grab [client B] by his shirt and try to control the van at the same time. Staff had to use PIA (Physical Intervention Assistance) to prevent [client B] from falling over the street (sic)...."</p> <p>-7/31/12 at 8:30 PM, "[Client B] was watching TV when he decided that he didn't want to be in the house. [Client B] ran out of the back door when (sic) into the streets...."</p> <p>-7/31/12 at 9:20 PM, "[Client B] had just got (sic) through a behavior, [client B] tried several times to attack staff, (sic) staff tried his best to handle the incident. Staff had to use PIA to protect himself and [client B]."</p> <p>-8/1/12 at 9:30 PM, "... was sitting in the living room watching a baseball game on TV. [Client B] suddenly went and unplugged the cable. [Client B] started using names toward (sic) housemates and attempted to throw storage cube (sic) to (sic) housemate. Was... escorted to his room...."</p> <p>-8/5/12 at 6:25 PM, "[Client B] was in his room listening to his music. Staff heard the front door open and look (sic) out to see</p>		<p>ensure that all incidents requiring an investigation are completed within the 5 day time period expected. Ongoing, the Quality Assurance Specialist will continue to monitor the investigations weekly that are completed by this Program Director. All incomplete investigations will be referred to the Area Director for further follow up. Responsible Party: Area Director, Program Director, and Home Manager</p>	

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	<p>[client B] running down Crestview Avenue (sic) staff could not immediately run after [client B] since one of the clients was in the bathroom and the other client was helping staff cook dinner. Staff called the on call and explained (sic) situation to her about what had happened. Staff late had to drive over (sic) at Kessler to get [client B]."</p> <p>-8/24/12 at 9:08 AM, "... [client B] was pacing around and singing song (sic) with bad words. [Client B] open (sic) up the front door and walks (sic) out. [Client B] did twice (sic) and both time (sic) he stood in the street and sing (sic)."</p> <p>-9/10/12 at 7:30 PM, "[Client B] had just come out of the bathroom after taking a shower. [Client B] tried several times to leave the house while physically trying to attack staff with fists and open hands (sic) he came back to the house and threw the phone on the ground breaking it in the process." The 9/10/12 BPR indicated, "Staff later use (sic) hand PIA...."</p> <p>-9/14/12 at 6:00 PM, "[Client B] was watching TV. [Client B] just walked out and started down the street. While staff walked after him (sic) talking to him he saw a car coming and threaten (sic) to kill himself. Staff held him to prevent him from jumping into a moving vehicle."</p> <p>-9/24/12 at 6:35 PM, "... [client B] was looking for lemonade to drink but could not find any remaining. [Client B] got upset that</p>			

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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5662 N CRESTVIEW AVE INDIANAPOLIS, IN 46220
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	<p>there was no lemonade remaining (sic) he approached a fellow housemate talking loud to him (sic) then they started hitting each other."</p> <p>-9/25/12 at 7:00 PM, "... [client B] got upset (sic) wanted to vacate but staff blocked the door. [Client B] hit staff on the face.... Staff put [client B] on (sic) hold for (sic) [client B] until he calmed down...."</p> <p>-10/2/12 at 8:50 PM, "...went in the bathroom stayed in the bathroom for two minutes came out (sic) said he swallow and drank hand sanitizer. Staff called the on call supervisor and poison control (sic) they suggested [client B] should be taken to emergency room. Staff took [client B] to [hospital] emergency room and stayed with him for awhile."</p> <p>-11/2/12 at 9:00 PM indicated client B vacated the house.</p> <p>-11/8/12 at 5:30 PM indicated client B vacated the house.</p> <p>A review of the facility's BDDS reports and investigations was conducted on 11/20/12 at 3:12 PM. The review did not indicate the facility had conducted an investigation regarding client B's 7/12/12, 7/16/12, 7/16/12, 7/31/12, 8/24/12, 9/14/12, 11/2/12 and/or 11/8/12 incidents of elopement/vacating. The review did not indicate the facility had conducted an investigation regarding client B's 7/21/12,</p>			

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	<p>7/31/12, 8/1/12, 8/5/12, 9/10/12 and/or 9/25/12 incidents of PIA use. The review did not indicate the facility had conducted an investigation regarding client B's 9/24/12 incident of client to client aggression with an unnamed peer. The review did not indicate the facility had conducted an investigation regarding client B's alleged drinking of hand sanitizer which resulted in an ER visit/admission.</p> <p>The review indicated the following BDDS/investigation:</p> <p>-10/5/12 at 5:00 PM, "[Client B] was told that because there was no gas in the van we couldn't go on an outing. [Client B] started out going into the bathroom trying to put his head under the faucet to huff water and he came in the living room with a wash rag in his mouth. [Client B] attempted to vacate but both staff blocked the doors. I kept him on (sic) the area where he could be observed with both staff. [Client B] attempted to get in the cabinets (sic) throw cans but staff blocked his efforts, [client B] attempted to throw dishes and broke the toaster. [Client B] also attempted to break the glass in the microwave oven but was intercepted by staff and item was locked up. [Client B] got a spoon and broke it in half to use as a weapon or injure himself. [Client B] threatened to stab both staff with the spoon. Both staff were able to get the item from him and [client B] only scratched himself. On call arrived and [client B] attempted to throw the treadmill and it took both staff and on call to</p>						

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	<p>prevent that from happening. [Client B] went to the bathroom and was followed by on call. [Client B] broke the bathroom window with a long handled scrub brush. [Client B] calmed down for a bit and after on call left and window was covered (sic) [client B] started acting out again trying to get in the refrigerator attempting to assault both staff with fire extinguisher and throwing pots and pans. Housemate [client C] got fed up and told [client B] several times to stop tearing his home and up and tackled him when [client B] calmed down he let him go. Prior to being tackled [client B] got a phone cord and tried to strangle himself and used a cord to attempt to strangle staff. [Client B] also threw chairs."</p> <p>-10/6/12, "[Client B] has attempted to swallow hand sanitizer and became physically/verbally aggressive toward staff. Staff called 911 and the police responded to assist with the incident. It was determined that he needed to be evaluated (sic) to threats to harm himself and others. [Client B] was admitted to [respite] for a short term evaluation."</p> <p>-Summary of Internal Investigation Report (SIIR) dated 10/10/12 indicated the investigation reviewed the following incidents:</p> <p>-"On 10/5/12 [client B] was physically aggressive toward staff and attempted to harm himself."</p>			

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	<p>-"On 10/6/12 [client B] was physically aggressive toward staff, and attempted to harm himself, [Client B] was removed from the home by [police] and charged with battery by the police."</p> <p>The 10/10/12 SIIR indicated the following written statement/interview regarding the 10/5/12 incident with client B from staff #2, "[Client C] intervened by holding the cabinet doors shut to prevent [client B] from getting additional canned goods to throw, holding appliances down so [client B] could not throw them or damage them. While [client B] was attempting to pick up the treadmill again [client C] said, 'I am not going to allow you to hurt my staff or my house.' [Client C] tackled [client B] to the floor. [Client C] held [client B] to the floor with [client B] on his stomach and him straddling [client B] while he held [client B's] arms. [Client C] let [client B] up approximately 30 minutes later when [client B] became tired." The 10/10/12 SIIR indicated the following written statement/interview regarding the 10/6/12 incident with client B from staff #2, "[Staff #3] assisted the restraint at that time allowing [staff #2] to get [client B] onto his back while she held [client B's] arms and [staff #3] held his feet."</p> <p>The 10/10/12 SIIR did not indicate client B or client C had been interviewed. The 10/10/12 SIIR did not indicate a conclusion regarding client C's physical restraint of client B or if staff redirected client C's intervention. The 10/10/12 SIIR did not indicate a conclusion or review of staff's use</p>						

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	<p>of nonagency approved holds/restraints.</p> <p>Interview with AS #1 on 11/26/12 at 2:15 PM indicated there were no additional SIIR's available for review. AS #1 indicated incidents of elopement, client to client aggression, hospital visits and use of physical restraints should have been investigated. AS #1 indicated the 10/10/12 SIIR should have addressed client C's physical restraint of client B, staff's physical interventions and the circumstances of client B's hospitalization.</p> <p>9-3-2(a)</p>			

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 18 of 34 allegations of abuse, neglect, mistreatment and/or injuries of unknown origin reviewed, the facility failed to put in place corrective actions/measures to prevent client B's elopement, client B's ingestion of or attempts to ingest non food items, client C's physical restraint of client B, facility staff from using non agency physical restraints and client B's attempts to vacate from a moving vehicle.</p> <p>Findings include:</p> <p>Client B's record was reviewed on 11/26/12 at 9:43 AM. Client B's BPR's (Behavior Progress Report) indicated the following behavioral narrative entries:</p> <p>-7/12/12 at 8:30 PM indicated client B vacated the group home.</p> <p>-7/16/12 at 8:00 PM, "[Client B] got angry about the other guys using both showers. [Client B] walked out of the house while staff was in the kitchen. Staff could not follow (sic) the other boys were taking their shower. Later, took all the boys and found [client B] along [intersection]."</p> <p>-7/16/12 at 9:47 PM, "[Client B] walked into the living room as [staff #1] was pass (sic) information to this staff. [Client B] didn't</p>	W0157	The Program Director will be retrained on creating, addressing, and completing, all recommendations made as the result of an incident and/or investigation. The Program Director will ensure that all investigations and incidents have recommendations that follow up to assist in the incident, and prevent it from occurring again. All recommendations that are made will be reviewed by the Area Director, and IST when necessary. Ongoing, the Area Director will continue to monitor the investigations and ensure that the recommendations are followed up on after the incident. Responsible Party: Area Director and Program Director	12/29/2012			

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	<p>want to wait until staff finished talking. [Client B] just turns (sic) around and walked out the front door (vacated)."</p> <p>-7/21/12 at 8:00 PM, "[Client B] got angry when staff asked him to put on his seatbelt. [Client B] got up his chair (sic) and opened the door. While staff was driving the van, staff had to grab [client B] by his shirt and try to control the van at the same time. Staff had to use PIA (Physical Intervention Assistance) to prevent [client B] from falling over the street (sic)...."</p> <p>-7/31/12 at 8:30 PM, "[Client B] was watching TV when he decided that he didn't want to be in the house. [Client B] ran out of the back door when (sic) into the streets...."</p> <p>-7/31/12 at 9:20 PM, "[Client B] had just got (sic) through a behavior, [client B] tried several times to attack staff, (sic) staff tried his best to handle the incident. Staff had to use PIA to protect himself and [client B]."</p> <p>-8/1/12 at 9:30 PM, "... was sitting in the living room watching a baseball game on TV. [Client B] suddenly went and unplugged the cable. [Client B] started using names toward (sic) housemates and attempted to throw storage cube (sic) to (sic) housemate. Was... escorted to his room...."</p> <p>-8/5/12 at 6:25 PM, "[Client B] was in his room listening to his music. Staff heard the front door open and look (sic) out to see [client B] running down Crestview Avenue</p>			

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	<p>(sic) staff could not immediately run after [client B] since one of the clients was in the bathroom and the other client was helping staff cook dinner. Staff called the on call and explained (sic) situation to her about what had happened. Staff late had to drive over (sic) at Kessler to get [client B]."</p> <p>-8/24/12 at 9:08 AM, "... [client B] was pacing around and singing song (sic) with bad words. [Client B] open (sic) up the front door and walks (sic) out. [Client B] did twice (sic) and both time (sic) he stood in the street and sing (sic)."</p> <p>-9/10/12 at 7:30 PM, "[Client B] had just come out of the bathroom after taking a shower. [Client B] tried several times to leave the house while physically trying to attack staff with fists and open hands (sic) he came back to the house and threw the phone on the ground breaking it in the process." The 9/10/12 BPR indicated, "Staff later use (sic) hand PIA...."</p> <p>-9/14/12 at 6:00 PM, "[Client B] was watching TV. [Client B] just walked out and started down the street. While staff walked after him (sic) talking to him he saw a car coming and threaten (sic) to kill himself. Staff held him to prevent him from jumping into a moving vehicle."</p> <p>-9/24/12 at 6:35 PM, "... [client B] was looking for lemonade to drink but could not find any remaining. [Client B] got upset that there was no lemonade remaining (sic) he</p>			

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	<p>approached a fellow housemate talking loud to him (sic) then they started hitting each other."</p> <p>-9/25/12 at 7:00 PM, "... [client B] got upset (sic) wanted to vacate but staff blocked the door. [Client B] hit staff on the face.... Staff put [client B] on (sic) hold for (sic) [client B] until he calmed down...."</p> <p>-10/2/12 at 8:50 PM, "...went in the bathroom stayed in the bathroom for two minutes came out (sic) said he swallow and drank hand sanitizer. Staff called the on call supervisor and poison control (sic) they suggested [client B] should be taken to emergency room. Staff took [client B] to [hospital] emergency room and stayed with him for awhile."</p> <p>-11/2/12 at 9:00 PM indicated client B vacated the house.</p> <p>-11/8/12 at 5:30 PM indicated client B vacated the house.</p> <p>Client B's record did not indicate documentation of IST (Individual Support Team) or IDT (Interdisciplinary Team) meetings to discuss or make recommendations regarding the BPR incidents of elopement, attempts to eat non food items or attempts to vacate from a moving vehicle.</p> <p>A review of the facility's BDDS reports and investigations was conducted on 11/20/12 at</p>			

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	<p>3:12 PM. The review did not indicate the facility had conducted investigations to determine corrective actions regarding client B's 7/12/12, 7/16/12, 7/16/12, 7/31/12, 8/24/12, 9/14/12, 11/2/12 and/or 11/8/12 incidents of elopement/vacating.</p> <p>The review indicated the following BDDS report and investigation:</p> <p>-10/5/12 at 5:00 PM, "[Client B] was told that because there was no gas in the van we couldn't go on an outing. [Client B] started out going into the bathroom trying to put his head under the faucet to huff water and he came in the living room with a wash rag in his mouth. [Client B] attempted to vacate but both staff blocked the doors. I kept him on (sic) the area where he could be observed with both staff. [Client B] attempted to get in the cabinets (sic) throw cans but staff blocked his efforts, [client B] attempted to throw dishes and broke the toaster. [Client B] also attempted to break the glass in the microwave oven but was intercepted by staff and item was locked up. [Client B] got a spoon and broke it in half to use as a weapon or injure himself. [Client B] threatened to stab both staff with the spoon. Both staff were able to get the item from him and [client B] only scratched himself. On call arrived and [client B] attempted to throw the treadmill and it took both staff and on call to prevent that from happening. [Client B] went to the bathroom and was followed by on call. [Client B] broke the bathroom window with a long handled scrub brush. [Client B] calmed</p>				

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	<p>down for a bit and after on call left and window was covered (sic) [client B] started acting out again trying to get in the refrigerator attempting to assault both staff with fire extinguisher and throwing pots and pans. Housemate [client C] got fed up and told [client B] several times to stop tearing his home and up and tackled him when [client B] calmed down he let him go. Prior to being tackled [client B] got a phone cord and tried to strangle himself and used a cord to attempt to strangle staff. [Client B] also threw chairs."</p> <p>-10/6/12, "[Client B] has attempted to swallow hand sanitizer and became physically/verbally aggressive toward staff. Staff called 911 and the police responded to assist with the incident. It was determined that he needed to be evaluated (sic) to threats to harm himself and others. [Client B] was admitted to [respite] for a short term evaluation."</p> <p>-Summary of Internal Investigation Report (SIIR) dated 10/10/12 indicated the investigation reviewed the following incidents:</p> <p>-"On 10/5/12 [client B] was physically aggressive toward staff and attempted to harm himself."</p> <p>-"On 10/6/12 [client B] was physically aggressive toward staff, and attempted to harm himself, [Client B] was removed from the home by [police] and charged with</p>			

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	<p>battery by the police."</p> <p>The 10/10/12 SIIR indicated the following written statement/interview regarding the 10/5/12 incident with client B from staff #2, "[Client C] intervened by holding the cabinet doors shut to prevent [client B] from getting additional canned goods to throw, holding appliances down so [client B] could not throw them or damage them. While [client B] was attempting to pick up the treadmill again [client C] said, 'I am not going to allow you to hurt my staff or my house.' [Client C] tackled [client B] to the floor. [Client C] held [client B] to the floor with [client B] on his stomach and him straddling [client B] while he held [client B's] arms. [Client C] let [client B] up approximately 30 minutes later when [client B] became tired." The 10/10/12 SIIR indicated the following written statement/interview regarding the 10/6/12 incident with client B from staff #2, "[Staff #3] assisted the restraint at that time allowing [staff #2] to get [client B] onto his back while she held [client B's] arms and [staff #3] held his feet."</p> <p>The 10/10/12 SIIR did not indicate recommendations regarding client C's physical restraint of client B, client B's elopements or client B's attempts to ingest non food items.</p> <p>Interview with AS #1 on 11/26/12 at 2:15 PM indicated there were IST/IDT meetings regarding client B's behaviors. AS #1 provided a 10/9/12 IDT meeting to discuss</p>			

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	<p>client</p> <p>B's 10/5/12 and 10/6/12 incident and admission to an inpatient treatment center for evaluation. The 10/9/12 IDT note indicated discussion of client B's medications, behaviors observed, guardian concerns, a "possible behavior plan" and actions taken by an inpatient treatment center while client B was admitted. The 10/9/12 IDT note did not indicate program/support recommendations, monitoring recommendations or recommendations to address elopement or specific changes or recommendations for client B's behavior support plan. AS #1 indicated the 10/10/12 SIIR did not address client C's physical restraint of client B or staff's actions to redirect client C from intervening in client B's behavior. AS #1 did not provide additional documentation of IST/IDT notes regarding client B.</p> <p>9-3-2(a)</p>				

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W0158	<p>483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Facility Staffing for 2 of 2 sampled clients (A and B) plus 2 additional clients (C and D). The facility failed to ensure there were adequate staff levels to implement client B's BSP (Behavior Support Plan). The facility failed to ensure there were adequate staff in the group home during the evening shift for clients A, B, C and D. The facility failed to ensure staff were trained to work with client A.</p> <p>Findings include:</p> <p>1. The QMRP (Qualified Mental Retardation Professional) failed to provide facility staff with an active treatment schedule for clients A and B, to review/monitored client B's program to determine when objectives needed revisions, ensure client B's CFA (Comprehensive Functional Assessment) was reviewed annually, ensure the facility's HRC (Human Rights Committee) reviewed, approved and monitored restrictive programs for client A and failed to ensure the facility obtained client B, C and D's guardian approval before implementation of a BSP</p>	W0158	<p>The Program Director will be retrained on completing Active Treatment schedules that are client specific, and ensuring that they are available to the direct support staff at all times. These Active Treatment schedules will be review quarterly, or more as needed, and the Program Director will be retrained on this also. Ongoing, the Area Director and/or Quality Assurance will be completing random quarterly audits to ensure that these are written and kept up to date for each client. Ongoing, the Program Director and/or Area Director will complete random monthly Active Treatment Observations to ensure that the Direct Support Staff are following the schedules that are available to them. The Program Director will be retrained on client specific program goals. The Program Director will also be retrained on the appropriate way to update these goals and ensure that staff are documenting these goals appropriately. Ongoing, the Program Director and/or Area Director will complete random monthly observations to ensure that the Direct Support Staff are following the goals, and documenting them as they are available to them. The Home Manager will be retrained on</p>	12/29/2012			

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	<p>(Behavior Support Plan), behavior medications or modification of client rights. Please see W159.</p> <p>2. The facility failed to ensure there were adequate staff levels to implement client B's BSP. The facility failed to ensure there were adequate staff in the group home during the evening shift for clients A, B, C and D. Please see W186.</p> <p>3. The facility failed to ensure staff were trained to work with client A. Please see W189.</p> <p>9-3-3(a)</p>		<p>assisting with completing annual assessments with each client annually, or more, as needed. This retraining will include the Home Manager ensuring that none of these assessments exceed the 365 day limit, and are updated as any changes occur. The Program Director will be retrained on ensuring that these staff up to date, to ensure that these are including in the updating of the Individualized Support Plan for each client, annually, or more. Ongoing, the Area Director and/or Quality Assurance will be completing random quarterly audits to ensure that these are written and kept up to date for each client. The Program Director will be retrained on obtaining guardian approval for all restrictions, med changes, and Behavior Support Plans BEFORE obtaining HRC approval as well. Ongoing, the Area Director and/or Quality Assurance will be completing random quarterly audits to ensure that these are written and kept up for each client. The Area Director, Program Director, and Home Manager reviewed the house staffing schedule to ensure that all levels are appropriate at all times. The Program Director will complete random weekly 'drop ins' in the house to ensure that all staffing levels are appropriate at the time.</p>		

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W0159	<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 2 of 2 sampled clients (A and B), the QMRP (Qualified Mental Retardation Professional) failed to provide facility staff with an active treatment schedule for clients A and B, to review/monitor client B's program to determine when objectives needed revisions, ensure client B's CFA (Comprehensive Functional Assessment) was reviewed annually, ensure the facility's HRC (Human Rights Committee) reviewed, approved and monitored restrictive programs for client A and failed to ensure the facility obtained client B, C and D's guardian approval before implementation of a BSP (Behavior Support Plan), behavior medications or modification of client rights.</p> <p>Findings include:</p> <p>1. Client B's record was reviewed on 11/26/12 at 9:43 AM. Client B's 12/10/11 ISP (Individual Support Plan) indicated the client had the following objectives:</p> <p>-will wash himself completely in the shower. This objective is met when he is</p>	W0159	<p>The Program Director will be retrained on completing Active Treatment schedules that are client specific, and ensuring that they are available to the direct support staff at all times. These Active Treatment schedules will be review quarterly, or more as needed, and the Program Director will be retrained on this also. Ongoing, the Area Director and/or Quality Assurance will be completing random quarterly audits to ensure that these are written and kept up to date for each client. Ongoing, the Program Director and/or Area Director will complete random monthly Active Treatment Observations to ensure that the Direct Support Staff are following the schedules that are available to them. The Program Director will be retrained on client specific program goals. The Program Director will also be retrained on the appropriate way to update these goals and ensure that staff are documenting these goals appropriately. Ongoing, the Program Director and/or Area Director will complete random monthly observations to ensure that the Direct Support Staff are following the goals, and documenting them as they are</p>	12/29/2012			

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	<p>able to do this with no more than three prompts per try 75% of trials by 4/20/12.</p> <p>-will identify two coins. This objective is met when he is able to do this with no more than three prompts per trial 50% of the time by 4/20/12.</p> <p>-will brush his bottom teeth. The objective will be met when he is able to do this with no more that two prompts per trial 75% of the time by 4/20/12.</p> <p>-will identify his trileptal (seizures) with four verbal prompts for 65% of trials by 4/20/12.</p> <p>-will exercise for 30 minutes three times per week for 65% of trials by 4/20/12.</p> <p>-will prepare the drink for the evening meal for 65% of trials by 4/20/12.</p> <p>-will pull up his pant to his waist and secure them with a belt. The objective will be complete when he can do this with no more than three verbal prompts for 65% of trials by 3/12.</p> <p>Client B's Participant Monthly Status Summary dated March 2012 indicated a review of client B's goals and progress. Client B's record did not indicate a more recent review/revision of client B's goals.</p>		<p>available to them. The Home Manager will be retrained on assisting with completing annual assessments with each client annually, or more, as needed. This retraining will include the Home Manager ensuring that none of these assessments exceed the 365 day limit, and are updated as any changes occur. The Program Director will be retrained on ensuring that these staff up to date, to ensure that these are including in the updating of the Individualized Support Plan for each client, annually, or more. Ongoing, the Area Director and/or Quality Assurance will be completing random quarterly audits to ensure that these are written and kept up to date for each client. The Program Director will be retrained on obtaining guardian approval for all restrictions, med changes, and Behavior Support Plans BEFORE obtaining HRC approval as well. Ongoing, the Area Director and/or Quality Assurance will be completing random quarterly audits to ensure that these are written and kept up for each client. The Area Director, Program Director, and Home Manager reviewed the house staffing schedule to ensure that all levels are appropriate at all times. The Program Director will complete random weekly 'drop ins' in the house to ensure that all staffing levels are appropriate at</p>	

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	<p>Interview with QMRP #1 on 11/27/12 at 11:40 AM indicated he had not completed/reviewed client B's goals but was in the process of doing so. QMRP #1 indicated client B's goals should be reviewed every three months or more frequently if needed.</p> <p>2. The QMRP failed to provide facility staff with an active treatment schedule for clients A and B. Please see W250.</p> <p>3. The QMRP failed to ensure client B's CFA was reviewed annually. Please see W259.</p> <p>4. The QMRP failed to ensure the facility's HRC reviewed, approved and monitored restrictive programs for client A. Please see W262.</p> <p>5. The QMRP failed to ensure the facility obtained client B, C and D's guardian approval before implementation of a BSP, behavior medications or modification of client rights. Please see W263.</p> <p>6. The QMRP failed to ensure clients did not discipline other clients regarding a behavior episode for client B. Please see W274.</p> <p>This federal tag relates to complaint</p>		the time.				

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W0186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 2 of 2 sampled clients (A and B) plus 2 additional clients (C and D), the facility failed to ensure there were adequate staff levels to implement client B's BSP (Behavior Support Plan). The facility failed to ensure there were adequate staff in the group home during the evening shift for clients A, B, C and D.</p> <p>Findings include:</p> <p>1. Client B's record was reviewed on 11/26/12 at 9:43 AM. Client B's BPR's (Behavior Progress Report) indicated the following behavioral narrative entries:</p> <p>-7/12/12 at 8:30 PM indicated client B vacated the group home with one staff on duty.</p> <p>-7/16/12 at 8:00 PM, "[Client B] got angry about the other guys using both showers. [Client B] walked out of the house while staff was in the kitchen. Staff could not follow (sic) the other boys were taking their shower.</p>	W0186	<p>The Home Manager was retrained on the need for appropriate staffing levels for this particular home, with increases due to the nature of some of the behaviors. The Area Director, Program Director, and Home Manager reviewed the house staffing schedule to ensure that all levels are appropriate at all times. The Program Director will complete random weekly 'drop ins' in the house to ensure that all staffing levels are appropriate at the time. All staff will be retrained on the client's Behavior Support Plans to ensure that they are capable of implementing and completing them as expected and when expected. Responsible Party: Area Director, Program Director, and House Manager</p>	12/29/2012	

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	<p>Later, took all the boys and found [client B] along [intersection]."</p> <p>-8/5/12 at 6:25 PM, "[Client B] was in his room listening to his music. Staff heard the front door open and look (sic) out to see [client B] running down Crestview Avenue (sic) staff could not immediately run after [client B] since one of the clients was in the bathroom and the other client was helping staff cook dinner. Staff called the on call and explained (sic) situation to her about what had happened. Staff later had to drive over (sic) at Kessler to get [client B]."</p> <p>-9/10/12 at 7:30 PM, "[Client B] had just come out of the bathroom after taking a shower. [Client B] tried several times to leave the house while physically trying to attack staff with fists and open hands (sic) he came back to the house and threw the phone on the ground breaking it in the process." The 9/10/12 BPR indicated, "Staff later use (sic) hand PIA...." The 9/10/12 BDDS indicated one staff was on duty.</p> <p>Client B's BSP (Behavior Support Plan) dated 7/19/12 indicated the following:</p> <p>"Vacating (documented as Risk Taking Behavior)</p> <p>3. If staff observes [client B] attempting to leave and he ignores the prompt to stop, staff should use agency approved physical intervention techniques to prevent [client B] from leaving the home.</p> <p>4. If staff is unable to stop [client B] and he leaves anyway, a staff member must exit with him and stay with him to protect him from danger. The staff should take weather appropriate clothing and</p>			

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	<p>a cell phone. The staff should prompt [client B] to return to the home. If [client B] does not immediately turn around and return to the group home, staff should use agency approved physical intervention techniques to stop [client B]. This is to keep [client B] safe and because [client B's] history of property damage when he vacates. Staff should attempt to keep [client B] away from the road, other homes, property, and /or vehicles.</p> <p>7. If you are unable to catch up with [client B] after ten minutes, contact the on call supervisor for further instructions.</p> <p>8. If you do not see [client B] leave the area, contact the on-call supervisor as soon as you notice he is gone and initiate search procedures.</p> <p>9. If at any point [client B] is no longer in eyesight, immediately contact the on-call supervisor."</p> <p>The group home's time detail forms from 7/12/12 through 9/14/12 and 10/1/12 through 11/15/12 were reviewed on 11/28/12 at 6:55 PM. The review indicated the following:</p> <p>-7/12/12, one staff on duty from 3:00 PM through 10:00 PM.</p> <p>-9/10/12, one staff on duty from 3:00 PM through 9:00 PM.</p> <p>-9/14/12, one staff on duty from 2:00 PM through 9:00 PM.</p> <p>-11/1/12, one staff on duty from 3:00 PM through 9:00 PM.</p> <p>-11/5/12, one staff on duty from 3:00 PM through 9:00 PM.</p> <p>-11/6/12, one staff on duty from 3:00 PM through 9:00 PM.</p>				

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	<p>-11/7/12, one staff on duty from 3:00 PM through 9:00 PM.</p> <p>-11/8/12, one staff on duty from 3:00 PM through 9:00 PM.</p> <p>-11/9/12, one staff on duty from 3:00 PM through 9:00 PM.</p> <p>-11/10/12, one staff on duty from 3:00 PM through 9:00 PM.</p> <p>-11/11/12, one staff on duty from 3:00 PM through 9:00 PM.</p> <p>-11/13/12, one staff on duty from 3:00 PM through 9:00 PM.</p> <p>-11/14/12, one staff on duty from 3:00 PM through 9:00 PM.</p> <p>-11/15/12, one staff on duty from 3:00 PM through 9:00 PM.</p> <p>Interview with staff #4 on 11/26/12 at 6:10 AM indicated there were supposed to be two staff on the day shift 7:00 AM through 3:00 PM, two staff on duty during the 3:00 PM through 9:00 PM shift and one staff on the overnight shift from 9:00 PM through 7:00 AM. Staff #1 stated, "One staff is not enough for the evenings. We don't always have two staff on in the evenings."</p> <p>Interview with staff #5 on 11/27/12 at 10:10 AM indicated there should be two staff on the day and evening shifts to work with the clients. Staff #5 stated, "We don't always have two staff. Just this weekend it happened again. [Client B] took off and it was just me here alone."</p>			

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	<p>Interview with HM (Home Manager) #1 on 11/27/12 at 11:30 AM indicated the ratio for the group home is one staff per four clients. HM #1 indicated the ratio was not enough for staff to implement client B's BSP and continue supervision levels for clients A, C and D. HM #1 indicated he was responsible to fill shifts when there was only one staff assigned. HM #1 indicated he should sign each individual client's DSR (Daily Support Record) to document that he has worked a shift. HM #1 stated, "No, to be honest with you, I don't always fill them (DSR's) out when I work." HM #1 indicated there had been evening shifts that only had one staff assigned.</p> <p>Interview with AS (Administrative Staff) #1 was interviewed on 11/27/12 at 11:20 AM. AS #1 indicated there should be enough staff working to provide supervision to clients A, B, C and D. AS #1 indicated there should be enough staff to implement client B's BSP when he vacates from the home for his safety.</p> <p>9-3-3(a)</p>				

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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure staff were trained to work with client A.</p> <p>Findings include:</p> <p>Interview with staff #4 on 11/26/12 at 6:10 AM indicated she had not received specific training regarding client A. Staff #4 stated, "No, nothing specific for [client A]. Just general and very basic training. We talked about things like using hand over hand with him." When asked if staff #4 had received training regarding communication, behavioral supports or training objectives, staff #4 indicated no.</p> <p>Interview with staff #5 on 11/27/12 at 10:10 AM indicated he had been taught to use hand over hand with client A during meals. Staff #5 indicated he had not received specific training regarding supports, communication or ambulation.</p> <p>Client A's record was reviewed on 11/26/12 at 12:07 PM. Client A's ISP (Individual Support Plan) dated 10/23/12</p>	W0189	<p>The Home Manager was retrained on the need for appropriate staffing levels for this particular home, with increases due to the nature of some of the behaviors. The Area Director, Program Director, and Home Manager reviewed the house staffing schedule to ensure that all levels are appropriate at all times. The Program Director will complete random weekly 'drop ins' in the house to ensure that all staffing levels are appropriate at the time. The Program Director and Home Manager will be retrained to ensure that all staff are trained to work with any client, before actually working a shift. The client specific training spreadsheet will be reviewed by the Area Director monthly to ensure that no staff are working without being trained first. The Program Director will be retrained on updating the Individualized Support Plan and the High Risk Plan to match any changes that may occur.</p>	12/30/2012

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	<p>indicated client A's diagnosis included severe intellectual disability, disruptive behavior, autistic disorder, pica (eating disorder) and retinal digenesis in both eyes. Client A's 10/23/12 ISP indicated client A was nonverbal and made noises to communicate with staff. Client A's 10/23/12 ISP indicated client A needed hand over hand level of assistance with eating, bathing, dressing and supports while ambulating. Client A's BSP (Behavior Support Plan) dated 10/26/12 indicated the following targeted behaviors: self injurious behavior, physical aggression, incontinence, temper outbursts and pica. Client A's record did not indicate facility staff had been trained on client A's ISP or BSP.</p> <p>Interview with HM (Home Manager) #1 on 11/27/12 at 12:15 PM indicated client A did not attend day services or school. HM #1 indicated client A's daily routine was to return to his bed after breakfast. HM #1 stated, "[Client A] is kind of child like, kinda like a baby. [Client A] eats then wants to lay in his bed. [Client A] pretty much stays in bed most of the day. That's his routine."</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1 on 11/27/12 at 12:00 PM indicated client A's ISP dated 10/23/12 and BSP dated 10/26/12</p>			

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	<p>were awaiting guardian approvals and had not yet been implemented. QMRP #1 indicated client A had been admitted to the facility on 10/19/12. QMRP #1 indicated he had given staff general direction but no formal ISP or BSP training had occurred for direct care staff.</p> <p>This federal tag relates to complaint #IN00119419.</p> <p>9-3-3(a)</p>			

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W0250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on record review and interview for 2 of 2 sampled clients (A and B), the facility failed to provide an active treatment schedule for staff to follow.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 11/26/12 at 12:07 PM. Client A's record did not include an active treatment schedule that outlined his 10/23/12 ISP (Individual Support Plan)/programming goals.</p> <p>2. Client B's record was reviewed on 11/26/12 at 9:43 AM. Client B's record did not include an active treatment schedule that outlined his 12/10/11 ISP/programming goals.</p> <p>Interview with HM #1 (Home Manager) on 11/27/12 at 11:15 AM indicated client A did not attend school or other day programming outside of the group home. HM #1 indicated client A's routine during the day included going on appointments, rocking in his bed and lunch. HM #1 indicated client B did not attend school or other day programming outside of the</p>			W0250	<p>The Program Director will be retrained on completing Active Treatment schedules that are client specific, and ensuring that they are available to the direct support staff at all times. These Active Treatment schedules will be review quarterly, or more as needed, and the Program Director will be retrained on this also. Ongoing, the Area Director and/or Quality Assurance will be completing random quarterly audits to ensure that these are written and kept up to date for each client. Ongoing, the Program Director and/or Area Director will complete random monthly Active Treatment Observations to ensure that the Direct Support Staff are following the schedules that are available to them. Responsible Party: Program Director and Home Manager</p>		12/30/2012

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	<p>group home. HM #1 indicated client B participated in a home based education program. HM #1 indicated client A and client B did not have a formal active treatment schedule for staff to follow/implement.</p> <p>Interview with AS #1 (Administrative Staff) on 11/27/12 at 11:30 AM indicated clients A and B should have active treatment schedules available for staff.</p> <p>This federal tag relates to complaint #IN00119419.</p> <p>9-3-4(a)</p>			

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W0259	<p>483.440(f)(2) PROGRAM MONITORING &amp; 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 1 of 2 sampled clients (B), the facility failed to ensure client B's CFA (Comprehensive Functional Assessment) was reviewed annually.</p> <p>Findings include:</p> <p>Client B's record was reviewed on 11/26/12 at 9:43 AM. Client B's CFA was dated 12/10/10. The review did not indicate the CFA had been updated since 12/10/10.</p> <p>Interview with QMRP #1 on 11/27/12 at 11:30 AM indicated there was not a more current CFA to review.</p> <p>Interview with AS (Administrative Staff) #1 on 11/27/12 at 11:30 AM indicated client B's CFA should be updated/reviewed annually.</p> <p>9-3-4(a)</p>	W0259	<p>The Home Manager will be retrained on assisting with completing annual assessments with each client annually, or more, as needed. This retraining will include the Home Manager ensuring that none of these assessments exceed the 365 day limit, and are updated as any changes occur. The Program Director will be retrained on ensuring that these staff up to date, to ensure that these are including in the updating of the Individualized Support Plan for each client, annually, or more. Ongoing, the Area Director and/or Quality Assurance will be completing random quarterly audits to ensure that these are written and kept up to date for each client. Responsible Party: Home Manager, Program Director, and Area Director</p>	12/30/2012	

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W0262	<p>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview for 1 of 2 sampled clients (A), the facility's HRC (Human Rights Committee) failed to review, approve and monitor restrictive programs.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 11/26/12 at 12:07 PM. Client A's Physician Order form dated 10/22/12 indicated client A was taking Risperidone 0.5 milligram tablet (Antipsychotic), Trazodone 100 milligram tablet (Depression) and Risperidone 1 milligram tablet. Client A's record did not indicate HRC review/approval for the use of psychotropic medications. Client A's record did not indicate HRC review/approval of the group home locking stove control knobs, knives and sharp objects, aerosol cans, cleaning supplies and the thermostat.</p> <p>Interview with AS (Administrative Staff) #1 on 11/27/12 at 12:15 PM indicated HRC approval was needed for client A</p>	W0262	<p>The Program Director will be retrained on obtaining guardian and Human Right's Committee approval BEFORE initiating the changed. The Program Director will be retrained on what requires approval. The Program Director will work to seek approval for prior changes with the teams. Ongoing, the Program Director will seek approval for all changes prior to the change taking place. Ongoing, the Area Director and/or Quality Assurance will complete random audits to ensure that guardian and HRC approval is consistently being obtained as needed. Responsible Party: Program Director and Area Director</p>	12/30/2012	

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	<p>regarding the use of psychotropic medications, locking of stove control knobs, knives and sharp objects, aerosol cans, cleaning supplies and the thermostat.</p> <p>9-3-4(a)</p>			

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W0263	<p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; 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 record review and interview for 1 of 2 sampled clients (B) plus 2 additional clients (C and D), the facility failed to obtain the clients' guardian approval before implementation of a BSP (Behavior Support Plan), behavior medications or modification of client rights.</p> <p>Findings include:</p> <p>1. Client B's record was reviewed on 11/27/12 at 9:43 AM. Client B's ISP (Individual Support Plan) dated 12/10/11 indicated client B had a legal guardian. Client B's BSP dated 7/19/12 indicated the use of Ziprasidone 160 milligram tablet (antipsychotic), Oxycarbazepine 1800 milligrams, (seizures), Trazodone 50 milligrams (antipsychotic), Haloperidol 25 milligrams (antipsychotic) and Propranolol 80 milligrams (anxiety).</p> <p>Client B's HRC (Human Rights Committee) form dated 10/3/12 indicated the following restrictions:</p> <p>-money management: client B was</p>	W0263	<p>The Program Director will be retrained on obtaining guardian and Human Right's Committee approval BEFORE initiating the changed. The Program Director will be retrained on what requires approval. The Program Director will work to seek approval for prior changes with the teams. Ongoing, the Program Director will seek approval for all changes prior to the change taking place. Ongoing, the Area Director and/or Quality Assurance will complete random audits to ensure that guardian and HRC approval is consistently being obtained as needed. Responsible Party: Program Director and Area Director</p>	12/30/2012

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	<p>restricted to carrying no more than \$1.00 on his person at a time.</p> <p>-knives and sharp objects locked in the house.</p> <p>-household cleaning closet has been locked.</p> <p>-the house thermostat has been locked.</p> <p>-community access was restricted.</p> <p>-one to one supervision.</p> <p>-possession checks</p> <p>-room checks</p> <p>Client B's record did not indicate written informed consent from client B's guardian for the use of psychotropic medications or restrictive programs.</p> <p>2. Client C's record was reviewed on 11/28/12 at 4:00 PM. Client C's record indicated client C had a guardian. Client C's HRC form dated 10/3/12 indicated the following restrictions:</p> <p>-money management: client C was restricted to carrying no more than \$2.00 on his person at a time.</p>						

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	<p>-knives and sharp objects locked in the house.</p> <p>-household cleaning closet has been locked.</p> <p>-the house thermostat has been locked.</p> <p>-community access was restricted.</p> <p>Client C's record did not indicate written informed consent from client C's guardian for the use of restrictive programs.</p> <p>3. Client D's record was reviewed on 11/29/12 at 9:37 AM. Client D's record indicated client D had a guardian. Client D's HRC form dated 10/3/12 indicated the following restrictions:</p> <p>-money management: client D was restricted to carrying no more than \$1.00 on his person at a time.</p> <p>-knives and sharp objects locked in the house.</p> <p>-household cleaning closet has been locked.</p> <p>-the house thermostat has been locked.</p> <p>-community access was restricted.</p>				

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	<p>-client D was monitored every 10 minutes by staff.</p> <p>-the use of the following psychotropic medications: Apripirazole 5 milligram tablet (antidepressant) and methylphenidate 45 milligrams (attention deficit disorder).</p> <p>Client D's record did not indicate written informed consent from client D's guardian for the restrictive programs or use of psychotropic medications.</p> <p>Interview with AS (Administrative Staff) #1 on 11/27/12 at 12:15 PM indicated written informed consent was needed regarding the use of psychotropic medications, locking of stove control knobs, knives and sharp objects, aerosol cans, cleaning supplies and the thermostat.</p> <p>9-3-4(a)</p>				

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W0273	<p>483.450(a)(3) CONDUCT TOWARD CLIENT Clients must not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.</p> <p>Based on record review and interview for 1 of 2 sampled clients (B), the facility failed to ensure clients did not discipline other clients during behavior episodes.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations was conducted on 11/20/12 at 3:12 PM. The review indicated the following:</p> <p>-10/5/12 at 5:00 PM, "[Client B] was told that because there was no gas in the van we couldn't go on an outing. [Client B] started out going into the bathroom trying to put his head under the faucet to huff water and he came in the living room with a wash rag in his mouth. [Client B] attempted to vacate but both staff blocked the doors. I kept him on (sic) the area where he could be observed with both staff. [Client B] attempted to get in the cabinets (sic) throw cans but staff blocked his efforts, [client B] attempted to throw dishes and broke the toaster. [Client B] also attempted to break the glass in the microwave oven but was intercepted by staff and item was locked up. [Client B] got a spoon and broke it in half to use as a weapon or injure himself. [Client B] threatened to</p>	W0273	The Program Director and Home Manager will be retrained that clients do not discipline other clients at any time. This includes during behavioral episodes. The Direct Support Staff will be retrained to ensure that clients do not discipline other clients at any time. This includes during behavioral episodes. The Program Director and Home Manager will discuss with the clients the need to ensure that they do not discipline each other at any time. The PD and HM will also discuss with the clients their right's to call 911 if they ever were to not feel safe in their homes or around their roommates. Ongoing, the Program Director, Home Manager, and/or Quality Assurance will complete random quarterly Health and Safety Assessment Interviews with each client, to ensure them feeling safe in their home. Ongoing, the Program Director will complete random observations in the group home to ensure that the clients are not disciplining each other at any time. Responsibly Party: Home Manager, Program Director, and Area Director.	12/30/2012			

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	<p>stab both staff with the spoon. Both staff were able to get the item from him and [client B] only scratched himself. On call arrived and [client B] attempted to throw the treadmill and it took both staff and on call to prevent that from happening. [Client B] went to the bathroom and was followed by on call. [Client B] broke the bathroom window with a long handled scrub brush. [Client B] calmed down for a bit and after on call left and window was covered (sic) [client B] started acting out again trying to get in the refrigerator attempting to assault both staff with fire extinguisher and throwing pots and pans. Housemate [client C] got fed up and told [client B] several times to stop tearing his home and up and tackled him when [client B] calmed down he let him go. Prior to being tackled [client B] got a phone cord and tried to strangle himself and used a cord to attempt to strangle staff. [Client B] also threw chairs."</p> <p>-Summary of Internal Investigation Report (SIIR) dated 10/10/12 indicated the following written statement/interview regarding the 10/5/12 incident with client B from staff #2, "[Client C] intervened by holding the cabinet doors shut to prevent [client B] from getting additional canned goods to throw, holding appliances down so [client B] could not throw them or damage them. While [client B] was attempting to pick up the treadmill again [client C] said, 'I am not going to allow you to hurt my staff or my house.' [Client C] tackled [client B] to the floor. [Client C] held [client B] to the floor with [client B] on his</p>			

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	<p>stomach and him straddling [client B] while he held [client B's] arms. [Client C] let [client B] up approximately 30 minutes later when [client B] became tired." The 10/10/12 SIIR indicated the following written statement/interview regarding the 10/6/12 incident with client B from staff #2, "[Staff #3] assisted the restraint at that time allowing [staff #2] to get [client B] onto his back while she held [client B's] arms and [staff #3] held his feet."</p> <p>Interview with AS #1 on 11/26/12 at 2:15 PM indicated clients should not implement physical restraints with other clients. AS #1 indicated client C should have been redirected to release client B from the physical restraint.</p> <p>9-3-5(a)</p>				

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W0436	<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. Based on observation, record review and interview for 1 of 2 clients (A) with adaptive equipment, the facility failed to ensure client A utilized a walker.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/20/12 from 5:03 PM through 6:15 PM. Client A was observed in the home throughout the observation period. Client A was visually impaired in that he did not have vision in either of his eyes. Client A ambulated through the house while holding staff's arms to guide and support. Client A was not encouraged to use and did not use a walker during the observation period.</p> <p>Observations were conducted at the group home on 11/26/12 from 6:00 AM through 7:30 AM. Client A was observed in the home throughout the observation period. Client A did not use a walker to ambulate throughout the house.</p> <p>Client A's record was reviewed on</p>	W0436	<p>The Program Director will work with the Program Nurse to ensure that any adaptive equipment, specifically a walker, are made available to client A to use at all times. The Program Director will retrain the staff on assisting client A with utilizing his adaptive equipment, ongoing. Ongoing, the Direct Support Staff will ensure that client A has his adaptive equipment available to use at all times. Ongoing, the Program Director and/or Home Manager will complete random observations, once a week, to ensure that the DSPs are assisting client A with the use of his adaptive equipment. Responsible Party: Area Director, Program Director, and Home Manager</p>	12/30/2012			

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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5662 N CRESTVIEW AVE INDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>11/26/12 at 12:07 PM. Client A's ISP (Individual Support Plan) dated 10/23/12 indicated client A's adaptive equipment was a walker. Client A's ISP dated 10/23/12 indicated, "[Client A] has a walker that he uses to get around the house." Client A's ISP did not indicate a training objective to teach/encourage client A to use his walker.</p> <p>Interview with AS #1 (Administrative Staff) on 11/29/12 at 9:00 AM indicated client A should utilize his walker while ambulating in the house.</p> <p>This federal tag relates to complaint #IN00119419.</p> <p>9-3-7(a)</p>				

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W0440	<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 2 of 2 sampled clients (A and B) plus 2 additional clients (C and D), the facility failed to conduct evacuation drills for each quarter on each shift.</p> <p>Findings include:</p> <p>The facility's evacuation drill record was reviewed on 11/26/12 at 11:30 AM. The review indicated facility failed to conduct an evacuation drill for 4 of 4 clients (A, B, C and D) for the third quarter, July 2012 through September 2012 for the 11:00 PM through 7:00 AM overnight shift.</p> <p>Interview with AS (Administrative Staff) #1 on 11/26/12 at 12:33 PM indicated there were no additional evacuation drills to review.</p> <p>9-3-7(a)</p>	W0440	<p>All Direct Support Professionals will receive a retraining every other month to ensure that they understand the importance of completing the monthly fire drills. The retraining will include reviewing a copy of the Fire Drill Schedule.</p> <p>Ongoing, the Direct Support Professionals will complete one fire drill per month (or more as needed) according to the schedule to ensure that the health and safety of the client's needs are met.</p> <p>Ongoing, all completed fire drill reports will be turned into and reviewed by Quality Assurance for accuracy and thoroughness of each drill.</p> <p>Responsible Party: Home Manager</p>	12/30/2012	