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	15G305		04/14/2016

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W 0000 Bldg. 00	This visit was for the fundamental annual recertification and licensure survey. Survey Dates: April 11, 12, 13 and 14, 2016 Facility Number: 000824 Provider Number: 15G305 AIM Number: 100249060 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/20/16.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the governing body failed to exercise operating direction over the facility by failing to ensure a living room chair and love seat remained in good repair. Findings include: Observations were conducted at the	W 0104	New furniture is being ordered for the living room area of the home. A weekly checklist will be completed by the Program Coordinator (Home Manager) to monitor the condition of furniture and other household items and this will be reviewed by the Program Director (QIDP) weekly to ensure needed items or maintenance concerns are addressed timely.	05/14/2016

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	group home on 4/11/16 from 3:29 PM to 5:50 PM and 4/12/16 from 6:00 AM to 7:28 AM. During the observations, the love seat's left rear leg was broken. The love seat leaned to the left at an angle. The surface material was peeling off the cushions and armrests. The chair's back support and left armrest were broken. The back support and armrest were leaning to the left. The surface material on the chair was peeling off the seat cushion and armrests. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. On 4/11/16 at 4:18 PM, the Home Manager (HM) indicated both pieces of furniture were broken due to client #4's plopping down on the furniture. The HM indicated the furniture needed to be repaired or replaced. On 4/12/16 at 10:18 AM, the Program Director (PD) indicated the group home needed to order new furniture to replace the broken living room chair and love seat. The PD indicated at the end of February 2016, she informed the Area Director the home needed new living room furniture. The PD indicated she was not sure if the furniture was ordered or not. 9-3-1(a)			

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W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 3 of 4 clients in the sample (#1, #4 and #6) and two additional clients (#5 and #7), the facility failed to maintain a full and complete accounting of the clients' personal funds. Findings include: On 4/11/16 at 3:39 PM, a review of the clients' finances was conducted and indicated the following: -Client #1's April 2016 personal funds ledger indicated he had $9.68. When the Home Manager (HM) counted client #1's funds, client #1 had $4.68. -Client #4's April 2016 personal funds ledger indicated he had $22.22. When the HM counted client #4's funds, client #4 had $11.32. -Client #5's April 2016 personal funds ledger indicated he had $14.17. When the HM counted client #5's funds, client #5 had $9.17. -Client #6's April 2016 personal funds ledger indicated he had $14.68. When	W 0140	None of the client's money was unaccounted for at the time of this survey.Staff in the home have been retrained on recording clients' finances following making purchases, and balancing cash on hand records at the beginning and end of shifts. The Program Coordinator (HM) will review finances at least weekly to ensure that all receipts are documented and the client finances are balanced correctly.The Program Director (QIDP) will review the finances at least two times a month to ensure they are accurate and will complete corrective action as needed if there are discrepancies found.	05/14/2016

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	the HM counted client #6's funds, client #6 had $9.68. -Client #7's April 2016 personal funds ledger indicated he had $20.15. When the HM counted client #7's funds, client #7 had $15.15. The HM located receipts accounting for client #1, #4, #5, #6 and #7's funds. The money was not missing. The HM indicated the withdrawals from the clients' accounts should have been added to the ledger at the time the withdrawals were made. On 4/11/16 at 3:39 PM, the HM indicated when the clients and staff took money out of the clients' accounts, the staff and clients documented the withdrawal on a receipt. The HM indicated she entered the receipts on the clients' ledgers once or twice a week. The HM indicated although the ledgers and the clients' cash on hand didn't match, there was no money unaccounted for. On 4/12/16 at 9:50 AM, the Program Director (PD) indicated the HM balanced the clients' funds at least weekly. The PD indicated when the HM balanced the clients' funds, the receipts would be located and the transactions added at the time the HM balanced the clients' funds. The PD indicated the facility used to have			

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	the direct care staff document on the ledgers at the time money was withdrawn however it was stopped due to documentation issues. The PD indicated the facility needed to account for the clients' funds. 9-3-2(a)			
W 0149 Bldg. 00	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 3 of 7 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6, #7 and #8, the facility neglected to implement its policies and procedures to prevent client to client abuse and neglect. Findings include: On 4/11/16 at 12:02 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 4/6/16 at 6:10 AM when staff #5 arrived to the group home for her shift, she went into the downstairs bathroom and found a bag of what appeared to be	W 0149	Staff have been retrained on prevention of abuse and neglect and monitoring interactions between clients to prevent client to client abuse.Observations will be completed three times per week for two weeks, two times a week for two weeks and at least one time per week for two weeks and then at least one time per week ongoing to monitor that staff are following client plans and preventing client to client incidents.	05/14/2016

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	marijuana sitting on the edge of the bathtub. Staff #5 reported the discovery to the Home Manager (HM). The HM instructed staff #5 to put the bag in an envelope and lock it in the medicine cabinet until the police could be notified. The Program Director went to the group home and called the police. The police arrived and removed the bag from the group home. The police indicated the contents of the bag would be tested to determine if it was marijuana. The police contacted the Program Director and indicated the bag contained marijuana. The police took staff #5 and staff #12's contact information. Staff #12 worked the overnight shift from 4/5/16 to 4/6/16. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. On 4/12/16 at 9:42 AM, the Program Director (PD) indicated staff #5 found a bag of marijuana in the downstairs bathroom adjacent to the kitchen on 4/6/16 at 6:00 AM. The PD indicated the facility was conducting an investigation. The PD indicated the police asked the facility not to interview the two staff involved until their investigation was completed. The PD indicated staff #12 worked the overnight shift from 4/5/16 to 4/6/16. The PD indicated staff #12 quit on 4/6/16. The PD indicated none of the clients was aware of the incident at the			

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	group home. The PD indicated the investigation was on-going. The PD indicated staff #12 had worked at the group home for over a year with no prior suspicions of drug use at the group home. 2) On 3/15/16 at 7:00 AM, client #8 was upset due to client #4 not wanting to get out of bed to go to the day program. Client #4 said something and client #8 asked client #4 what he said. Client #8 ran into client #4's bedroom, jumped onto client #8's bed and hit client #8. Client #8 was not injured. 3) On 1/26/16 at 3:00 PM at the facility-operated day program, client #7 complained of his hip hurting. A peer at the day program thought client #7 was talking about him. The peer slapped client #7. The peer told another peer to "get him." The second peer hit client #7. Client #7 was not injured. On 4/12/16 at 10:21 AM, the Program Director (PD) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure in place prohibiting abuse of the clients. The facility's policy and procedures related to abuse and neglect were			

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	reviewed on 4/11/16 at 12:02 PM. The facility's April 2011 Quality and Risk Management policy indicated, "Indiana MENTOR promotes a high quality of service and seeks to protect individuals receiving Indiana MENTOR services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The April 2011 Human Rights policy indicated, in part, "The following actions are prohibited by employees of Indiana MENTOR: abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds; or violation of an individual's rights." The policy indicated, in part, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e. Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment." The policy defined neglect as, "e. Failure to provide appropriate supervision, care or training; f. Failure to provide a safe, clean and sanitary environment...." 9-3-2(a)			

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W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 1 of 4 clients in the sample (#2), the facility failed to ensure client #2 had a plan to address nutritional supplement refusals. Findings include: On 4/11/16 from 3:29 PM to 5:50 PM, an observation was conducted at the group home. At 5:14 PM, client #2 was offered Ensure (nutritional support) and refused to drink it. Client #2 stated the Ensure "tasted bad." At 5:20 PM, the Home Manager (HM), who was attempting to administer client #2's Ensure, indicated client #2 refused his Ensure at times. On 4/12/16 at 11:12 AM, a review of client #2's record was conducted. Client #2's 3/28/16 Physician's Orders indicated "Diet: regular, CIB (Carnation Instant Breakfast), Ensure, Boost or (generic drug) equivalent 2x's (two times) daily for nutritional support." There was no plan in place addressing refusals to take	W 0227	Client #2's nutritional supplement has been changed to another type to encourage him using it which has reduced the number of refusals he has given. His team will meet to discuss the need to continue with his doctor or possible other recommendations for his continued health and safety.The Program Director (QIDP) will continue to address client medical concerns as they arise.	05/14/2016

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	his nutritional support in his 10/23/15 Individual Support Plan or 10/9/15 Behavior Support Plan. On 4/13/16 at 11:45 AM, the Program Director (PD) indicated client #2 refused to take his Ensure 5 times since January 1, 2016. The PD indicated he refused to take it during the observation. The PD indicated he refused to take it on January 3 and 22 and March 16 and 20. The PD indicated the facility needed to try a different drink to see if he would take it instead. The PD indicated the Home Manager added Carnation Instant Breakfast (CIB) to the shopping list for the next shopping trip. On 4/12/16 at 10:45 AM, the Licensed Practical Nurse (LPN) indicated client #2 did refuse to drink his Ensure at times. The LPN indicated he was prescribed a nutritional supplement to maintain his weight. The LPN indicated she was not aware of a plan to address client #2's refusals to take his Ensure. On 4/12/16 at 10:46 AM, the Registered Nurse indicated the facility needed to try a different nutritional supplement like CIB. 9-3-4(a)			

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W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 2 of 4 clients in the sample (#1 and #6) and one additional client (#5), the facility failed to ensure staff implemented client #1's mealtime training objective as written, client #5's plans to use his adaptive equipment and pour his own water during medication administration and client #6's medication administration training objective. Findings include: 1) On 4/11/16 from 12:17 PM to 12:43 PM, an observation was conducted client #5's day program. At 12:26 PM, client #5 was eating lunch. Client #5 did not have a divided plate or utensils to use. Staff #11 was putting bite-sized pieces of sandwich directly into client #5's mouth with her fingers. Staff #11 used a plastic spoon to feed client #5 applesauce. At 12:28 PM, staff #11 indicated client #5 was trying to eat her fingers to the day	W 0249	Staff in the home were retrained on all client training objectives, implementing goals, mealtime dining plans and accurate medication administration including administration of topicals, sprays and creams. Staff #5 was retrained on Core A medication administration with the nurse on 4/18/16.Observations will be completed three times per week for two weeks, two times per week for two weeks and then one time per week for two weeks and then at least one time per week ongoing to ensure objectives are being completed, goals are implemented, dining plans and adaptive equipment is used correctly and medications are administered according to physicians orders.	05/14/2016

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	program supervisor. The day program supervisor told staff #11 to put his food on a plate and client #5 could feed himself. At 12:29 PM, the day program supervisor put a plate on the table for client #5 to use. Client #5 did not have any adaptive equipment (angled spoon or fork) to use. Staff #11 moved client #5's sandwich to the plate and continued to use her fingers to feed client #5. Staff #11 continued to feed client #5 bites of his sandwich using her fingers and a plastic spoon to feed client #5 bites of applesauce and yogurt until he finished his lunch at 12:42 PM. On 4/12/16 at 9:40 AM, a focused review of client #5's record was conducted. Client #5's 7/14/15 Risk Management Assessment and Plan indicated, "Uses a divided plate to keep food items separate and a 90 degree spoon and fork. Staff should sit beside [client #5] at meals/when eating, assist to eat slowly, and monitor for choking... Assist as needed to use the divided plate and angles (sic) spoon and fork." Client #5's 1/7/16 Dining Plan indicated, "Divided plate, angled spoon & (and) fork...." Client #5's 7/14/15 Individualized Support Plan indicated, "Dining equipment utilized: Divided plate, angled spoon and fork...." Client #5's 7/14/15 Individualized Support Plan indicated			

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	client #5 had a formal training objective. The training objective was as follows, "At each meal, [client #5] will use his specialized dining utensils when consuming food." On 4/12/16 at 9:34 AM, the Program Director (PD) indicated the day program should have client #5's adaptive equipment. The PD indicated staff should not feed client #5. The PD indicated client #5's plans to use his adaptive equipment should be implemented as written. On 4/12/16 at 10:39 AM, the Licensed Practical Nurse indicated the staff should implement client #5's plans as written. 2) On 4/11/16 from 3:29 PM to 5:50 PM, an observation was conducted at the group home. Client #1 ate dinner from 5:28 PM to 5:42 PM. During his meal, client #1 was not prompted after two or three bites of food to wipe his mouth and/or take a drink. During the meal, client #1 was not prompted to pause or slow down his consumption of food. During the meal, client #1 ate quickly. On 4/12/16 at 10:55 AM, a review of client #1's record was conducted. Client #1's 5/12/15 Individualized Support Plan indicated he had a training objective to			

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	pause after taking two or three bites of food by wiping his mouth with a napkin and/or taking a drink. On 4/12/16 at 12:38 PM, the Program Director indicated client #1's mealtime training objective should have been implemented as written. 3) On 4/12/16 from 6:00 AM to 7:28 AM, an observation was conducted at the group home. At 6:14 AM, client #5 received his medications from staff #5. During the medication administration to client #5, staff #5 did not prompt client #5 to pour his water. Staff #5 poured client #5's water. On 4/12/16 at 10:39 AM, a focused review of client #5's record was conducted. Client #5's 7/14/15 Individualized Support Plan indicated client #5 had the following training objective: "Twice daily (during morning and evening medication passes), [client #5] will pour water into his water cup during his medication pass." On 4/12/16 at 12:38 PM, the Program Director indicated client #5's medication administration training objective should have been implemented as written. 4) On 4/12/16 from 6:00 AM to 7:28			

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	AM, an observation was conducted at the group home. At 6:07 AM, client #6 received his medications from staff #5. During the medication administration to client #6, staff #5 did not prompt client #6 to collect a medicine cup for his medication pass. On 4/12/16 at 12:12 PM, a review of client #6's record was conducted. Client #6's 5/19/15 Individualized Support Plan indicated he had the following medication administration training objective: "Daily, [client #6] will collect a medicine (souffle) cup for his medication pass." On 4/12/16 at 12:38 PM, the Program Director indicated client #6's medication administration training objective should have been implemented as written. 9-3-4(a)			
W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision			

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	and hearing. Based on record review and interview for 1 of 4 clients in the sample (#6), the facility failed to ensure client #6 had an annual vision exam. Findings include: On 4/12/16 at 12:12 PM, a review of client #6's record was conducted. Client #6's most recent vision examination was conducted on 6/10/13. A 6/16/14 note from his optometrist indicated, "[Client #6] requires an eye exam every 2 years." A 6/16/14 Indiana Mentor/TSI Medical Appointment Form from the optometrist indicated, "[Client #6] needs an eye exam every 2 yrs (years) unless he develops a medical eye condition." Client #6's 4/17/15 annual physical did not include a vision assessment. On 4/12/16 at 12:58 PM, the Licensed Practical Nurse indicated client #6 was due for a vision exam in 2015. 9-3-6(a)	W 0323	Client #6 had his eye examination prior to this survey and received new glasses at that time.The Nurse will be retrained on monitoring client medical appointments to ensure scheduled evaluations that may result in extended periods of time between appointments are followed accurately and completed timely based on the physicians recommendations. All other clients required exams are completed or scheduled at this time. No other clients were affected by this deficiency.	05/14/2016
W 0365 Bldg. 00	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. Based on observation, record review and interview for 2 of 2 clients (#5 and #6)	W 0365	Staff #5 was retrained on Core A medication administration with the nurse on 4/18/16.Observations	05/14/2016

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	observed to receive their medications during the morning observation, the facility failed to ensure the staff did not initial the clients' Medication Administration Records (MAR) prior to the clients taking their medications. Findings include: On 4/12/16 from 6:00 AM to 7:28 AM, an observation was conducted at the group home. At 6:07 AM, client #6 received his medications from staff #5. As staff #5 prepared client #6's medications, she popped the pills out of their containers and initialed the MAR prior to the medications being administered to client #6. At 6:14 AM, client #5 received his medications from staff #5. As staff #5 prepared client #5's medications, she popped the pills out of their containers and initialed the MAR prior to the medications being administered to client #5. On 4/12/16 at 9:49 AM, the Program Director indicated the clients' MARs should be initialed by staff after the client takes the medications. On 4/12/16 at 9:49 AM, the Home Manager indicated staff #5 was trained to dot the MAR and then initial the MAR after the medication was taken.		will be completed three times per week for two weeks, two times per week for two weeks and then one time per week for two weeks and then at least one time per week ongoing to ensure medications are administered according to physicians orders.	

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	On 4/12/16 at 10:43 AM, the Licensed Practical Nurse indicated the staff should initial the MAR after the clients' medications were administered. 9-3-6(a)			
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 4 of 12 medications prescribed to be administered during the morning observation to client #6, the facility failed to ensure staff administered the client's medications/treatments as ordered. Findings include: On 4/12/16 from 6:00 AM to 7:28 AM, an observation was conducted at the group home. At 6:07 AM, client #6 received his medications from staff #5. Staff #5 did not administer Fluticasone nasal spray for allergies, Saline Mist (no diagnosis indicated), Hydrocortisone ointment to affected areas (no diagnosis indicated) and Ketoconazole cream to affected areas (no diagnosis indicated).	W 0369	Staff #5 was retrained on Core A medication administration with the nurse on 4/18/16.Observations will be completed three times per week for two weeks, two times per week for two weeks and then one time per week for two weeks and then at least one time per week ongoing to ensure objectives are being completed, goals are implemented, dining plans and adaptive equipment is used correctly and medications are administered according to physicians orders.	05/14/2016

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	On 4/12/16 at 12:12 PM, a review of client #6's record was conducted. Client #6's 3/29/16 Physician's Orders indicated he was prescribed the following medications: Fluticasone nasal spray at 7:30 AM, Saline Mist at 7:30 AM, Hydrocortisone ointment to affected areas at 7:00 AM and Ketoconazole cream to affected areas at 7:00 AM. On 4/12/16 at 10:38 AM, the Registered Nurse indicated staff not administering client #6's medications as prescribed were medication errors. On 4/12/16 at 10:39 AM, the Licensed Practical Nurse indicated client #6's medications should have been administered as ordered. The LPN indicated client #6 not receiving his medications as ordered were medication errors. 9-3-6(a)			
W 0436 Bldg. 00	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.			

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	Based on observation, record review and interview for 1 of 3 non-sampled clients with adaptive equipment (#5), the facility failed to ensure client #5's adaptive equipment was available to use at the facility-operated day program. Findings include: On 4/11/16 from 12:17 PM to 12:43 PM, an observation was conducted client #5's day program. At 12:26 PM, client #5 was eating lunch. Client #5 did not have a divided plate or utensils to use. Staff #11 was putting bite-sized pieces of sandwich directly into client #5's mouth with her fingers. Staff #11 used a plastic spoon to feed client #5 applesauce. At 12:28 PM, staff #11 indicated client #5 was trying to eat her fingers to the day program supervisor. The day program supervisor told staff #11 to put his food on a plate and client #5 could feed himself. At 12:29 PM, the day program supervisor put a plate on the table for client #5 to use. Client #5 did not have any adaptive equipment (angled spoon or fork) to use. Staff #11 moved client #5's sandwich to the plate and continued to use her fingers to feed client #5. Staff #11 continued to feed client #5 bites of his sandwich using her fingers and a plastic spoon to feed client #5 bites of applesauce and yogurt until he finished	W 0436	Adaptive equipment is currently available and being utilized in the day program for Client #5. Observations will be completed at least weekly for two weeks and then at least monthly ongoing in the day program to ensure the adaptive equipment is available and being utilized correctly for Client #5.The Program Coordinator (HM) for the day program will be retrained to ensure group home staff are notified if the clients have needs for day program plans to be implemented correctly. The communication book between the day program and the group home will be reveiwed daily by home staff to ensure the clients needs are met.	05/14/2016

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	his lunch at 12:42 PM. On 4/12/16 at 9:40 AM, a focused review of client #5's record was conducted. Client #5's 7/14/15 Risk Management Assessment and Plan indicated, "Uses a divided plate to keep food items separate and a 90 degree spoon and fork. Staff should sit beside [client #5] at meals/when eating, assist to eat slowly, and monitor for choking... Assist as needed to use the divided plate and angles (sic) spoon and fork." Client #5's 1/7/16 Dining Plan indicated, "Divided plate, angled spoon & (and) fork...." Client #5's 7/14/15 Individualized Support Plan indicated, "Dining equipment utilized: Divided plate, angled spoon and fork...." On 4/12/16 at 9:34 AM, the Program Director (PD) indicated the day program should have client #5's adaptive equipment. The PD indicated staff should not feed client #5. The PD indicated client #5's plans to use his adaptive equipment should be implemented as written. 9-3-7(a)			
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at			

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	least quarterly for each shift of personnel. Based on record review and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to conduct quarterly evacuation drills for each shift of personnel. Findings include: On 4/11/16 at 3:29 PM, a review of the facility's evacuation drills was conducted. During the day shift (6:00 AM to 2:00 PM), the facility failed to conduct an evacuation drill from 10/13/15 to 4/8/16. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. On 4/11/16 at 3:35 PM, the Home Manager indicated when told an evacuation drill could not be located for the quarterly evacuation drill in January 2016 that January was scheduled to have a tornado drill. On 4/12/16 at 10:22 AM, the Program Director indicated the facility should conduct quarterly evacuation drills for each shift. 9-3-7(a)	W 0440	The Program Coordinator (HM) was retrained on ensuring all evacuation drills are completed at least quarterly for each shift of personnel. The PC will review evacuation drills monthly and follow up with corrective action as needed to ensure each drill is completed according to the monthly schedule implemented by Indiana MENTOR. The Program Director (QIDP) will ensure the drills are completed each month according to the implemented schedule.	05/14/2016
W 0460	483.480(a)(1) FOOD AND NUTRITION SERVICES			

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Bldg. 00	Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview for 2 of 4 clients in the sample (#4 and #6) and one additional client (#7), the facility failed to ensure each client's prescribed diet order was implemented as written. Findings include: On 4/11/16 from 3:29 PM to 5:50 PM, an observation was conducted at the group home. At 5:28 PM, dinner started. Each client received a piece of 8 inches by 4 inches meatloaf. At 5:34 PM, client #4 asked for and received seconds of meat loaf (same size as the original serving). At 5:34 PM, clients #6 and #7 received second helpings of meat loaf (same size as the original serving), potatoes and spinach. On 4/12/16 at 11:38 AM, a review of client #4's record was conducted. Client #4's 3/29/16 Physician's Orders indicated he was prescribed an 1800 calorie, low calorie snacks diet. On 4/12/16 at 12:12 PM, a review of client #6's record was conducted. Client #6's 3/29/16 Physician's Orders indicated he was prescribed a low fat, no	W 0460	Staff in the home were retrained on all client mealtime dining plans. Observations will be completed three times per week for two weeks, two times per week for two weeks and then one time per week for two weeks and then at least one time per week ongoing to ensure dining plans are followed and adaptive equipment is used correctly.	05/14/2016

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	concentrated sweets, no added salt and no caffeine diet. Client #6's 7/2/15 dietary review indicated he weighed 195. The dietician indicated client #6's ideal body weight was 144-176. On 4/12/16 at 10:43 AM, a focused review of client #7's record was conducted. Client #7's 3/29/16 Physician's Orders indicated he was prescribed a regular, high fiber, no concentrated sweets, no added salt, encourage healthy snacks and low calorie fluids diet. On 4/12/16 at 9:50 AM, the Program Director (PD) indicated the clients should be encouraged to follow their diets. On 4/12/16 at 10:43 AM, the Licensed Practical Nurse indicated clients #4 and #7 were on reduced calorie diets. The LPN indicated the clients should be encouraged to not eat second helpings during meals. On 4/12/16 at 10:43 AM, the Registered Nurse indicated the clients should have been encouraged to have seconds of vegetables. The RN indicated the extra food should not be put on the table to reduce the chance of the clients wanting seconds. The RN indicated one serving size of meat would be the size of a			

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	person's palm. 9-3-8(a)			