

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/14/2015
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151
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W 0000 Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Survey Dates: December 8, 9, 10, 11 and 14, 2015</p> <p>Facility Number: 000819 Provider Number: 15G300 AIM Number: 100249100</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/17/15.</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review for 7 of 7 clients (#1, #2, #3, #4, #5, #6 and #7), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to exercise operating direction over the facility by failing to ensure: 1) there was a sufficient amount of dining room chairs, in good condition, for staff and</p>	W 0102	Staff will receive training on completing water temperature log sheet and reporting information to Program Coordinator. Program Coordinator will review water temperature weekly to ensure information has been accurately reported. Program Director will also review log weekly to ensure accurate reporting and that corrective is taken if needed.	01/13/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>clients to sit at the table during meals, 2) the water temperature did not exceed 110 degrees Fahrenheit since 8/16/15, 3) appropriate corrective action was implemented following seven staff documenting on client #5's Medication Administration Record he received a medication he did not receive from 9/5/15 to 9/30/15 due to the medication not being in the group home to administer and 4) the overnight shift staff was monitored following an incident at the group home on 11/8/15 in which staff failed to implement client #6's diet/dining plan, follow and implement client #6's BSP (behavioral support plan) appropriately, follow the on call procedure, try to prevent client to client abuse, and being in the med room/office during a behavioral incident in which physical intervention was deemed necessary for safety.</p> <p>Findings include:</p> <p>1) Please refer to W104. For 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility's governing body failed to exercise operating direction over the facility by failing to ensure: 1) there was a sufficient amount of dining room chairs, in good condition, for staff and clients to sit at the table during meals, 2) the water</p>		<p>Program Coordinator will be trained on completing Home Needs Checklist weekly to ensure equipment is in proper working condition. Program Director will review this information to ensure it is complete and that corrective action is taken. Area Director will review with Program Director weekly using the Program Director Weekly review form to ensure appropriate action in regards to listed concerns have been taken. Staff will trained on all clients Behavioral Support Plans/Individual Support Plans Observations will be conducted 6 times per week for 2 months to include all 3 shifts (6am-2pm) (2pm-10pm)(10pm-6am) to ensure the behavior plans/ISP's are followed consistently. The documentation of these observations will be turned into the Program Director for follow up and corrective action. Area Director will review weekly with Program Director to ensure completion. Staff will be trained on medication administration procedure. Observations will be conducted 6 times per week for 2 months to include all med passes and that all staff are observed administering medications to ensure that medication passes are administered correctly. The documentation of these observations will be turned into the Program Director for follow up and corrective action. Area Director will review weekly with</p>	

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	<p>temperature did not exceed 110 degrees Fahrenheit since 8/16/15, 3) appropriate corrective action was implemented following seven staff documenting on client #5's Medication Administration Record he received a medication he did not receive from 9/5/15 to 9/30/15 due to the medication not being in the group home to administer and 4) the overnight shift staff was monitored following an incident at the group home on 11/8/15 in which staff failed to implement client #6's diet/dining plan, follow and implement client #6's BSP (behavioral support plan) appropriately, follow the on call procedure, try to prevent client to client abuse, and being in the med room/office during a behavioral incident in which physical intervention was deemed necessary for safety.</p> <p>2) Please refer to W122. For 5 of 7 clients living in the group home (#2, #4, #5, #6 and #7), the facility failed to meet the Condition of Participation: Client Protections. The governing body neglected to implement its policies and procedures to conduct a thorough investigation of client #5's injury of unknown origin (fracture), implement appropriate corrective action to address seven staff initialing client #5's Medication Administration Record indicating a medication not in the home</p>		<p>Program Director to ensure completion. Responsible party: Program Coordinator, Program Director and Area Director Date of completion:1/13/2016</p>				

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	<p>was administered from 9/5/15 to 9/30/15, ensure staff implemented the facility's medication policy and procedure to ensure client #5 was not administered another client's medications, ensure staff immediately reported an allegation of abuse to the administrator, prevent client to client abuse, and implement appropriate corrective action to monitor staff during the overnight shift following an incident on 11/8/15 when the staff failed to implement client #6's diet/dining plan, follow and implement client #6's BSP (Behavioral Support Plan) appropriately, follow the on call procedure, try to prevent client to client abuse, and being in the med room/office during a behavioral incident in which physical intervention was deemed necessary for safety.</p> <p>9-3-1(a)</p>			
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility's governing body</p>	W 0104	Staff will receive training on completing water temperature log sheet and reporting information to Program Coordinator. Program Coordinator will review water temperature weekly to ensure	01/13/2016

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	<p>failed to exercise operating direction over the facility by failing to ensure: 1) there was a sufficient amount of dining room chairs, in good condition, for staff and clients to sit at the table during meals, 2) the water temperature did not exceed 110 degrees Fahrenheit since 8/16/15, 3) appropriate corrective action was implemented following seven staff documenting on client #5's Medication Administration Record he received a medication he did not receive from 9/5/15 to 9/30/15 due to the medication not being in the group home to administer and 4) the overnight shift staff was monitored following an incident at the group home on 11/8/15 in which staff failed to implement client #6's diet/dining plan, follow and implement client #6's BSP (behavioral support plan) appropriately, follow the on call procedure, try to prevent client to client abuse, and being in the med room/office during a behavioral incident in which physical intervention was deemed necessary for safety.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 12/8/15 from 3:44 PM to 6:02 PM and 12/9/15 from 6:19 AM to 7:36 AM. During the observations, there were seven wooden dining room chairs.</p>		<p>information has been accurately reported. Program Director will also review log weekly to ensure accurate reporting and that corrective is taken if needed. Program Coordinator will be trained on completing Home Needs Checklist weekly to ensure equipment is in proper working condition. Program Director will review this information to ensure it is complete and that corrective action is taken. Area Director will review with Program Director weekly using the Program Director Weekly review form to ensure appropriate action in regards to listed concerns have been taken. Staff will trained on all clients Behavioral Support Plans/Individual Support Plans Observations will be conducted 6 times per week for 2 months to include all 3 shifts (6am-2pm) (2pm-10pm)(10pm-6am) to ensure the behavior plans/ISP's are followed consistently for 2 months. The documentation of these observations will be turned into the Program Director for follow up and corrective action. Area Director will review weekly with Program Director to ensure completion. Staff will be trained on medication administration procedure. Observations will be conducted 6 times per week for 2 months to include all med passes and that all staff are observed administering medications to ensure that medication passes are administered correctly. The</p>	

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	<p>Two of the seven chairs were damaged. The backs of the two chairs were broken where the back of the chair met the seat. Client #4 and #3's chairs were damaged. The clients could not lean back or rest their backs on the chairs due to the backs of the chairs being broken. There was not a sufficient amount of chairs for seven clients (#1, #2, #3, #4, #5, #6 and #7) and three staff who were working during the evening and morning shifts at the group home.</p> <p>On 12/11/15 at 2:37 PM, a Quote from a furniture company, dated 12/11/15, indicated 12 chairs were ordered. The estimated ship date was 4-6 weeks.</p> <p>On 12/8/15 at 5:37 PM, the Program Coordinator (PC) indicated 12 new chairs had been ordered. The PC indicated the home needed additional chairs.</p> <p>2) Please refer to W426. The governing body failed to ensure the water temperature did not exceed 110 degrees Fahrenheit from 8/16/15 to 12/9/15.</p> <p>3) Please refer to W149. For 5 of 14 incident/investigative reports reviewed affecting clients #2, #4, #5, #6 and #7, the governing body neglected to implement its policies and procedures to conduct a thorough investigation of client</p>		documentation of these observations will be turned into the Program Director for follow up and corrective action. Area Director will review weekly with Program Director to ensure comp Responsible party: Program Coordinator, Program Director and Area Director Date of completion:1/13/2016				

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W 0122 Bldg. 00	<p>#5's injury of unknown origin (fracture), implement appropriate corrective action to address seven staff initialing client #5's Medication Administration Record indicating a medication not in the home was administered from 9/5/15 to 9/30/15, ensure staff implemented the facility's medication policy and procedure to ensure client #5 was not administered another client's medications, ensure staff immediately reported an allegation of abuse to the administrator and implement appropriate corrective action to monitor staff during the overnight shift following an incident on 11/8/15.</p> <p>4) Please refer to W157. For 2 of 14 incident/investigative reports reviewed affecting clients #2, #5, #6 and #7, the governing body failed to implement appropriate corrective actions to monitor/supervise medication administration following client #5 missing a medication for 26 days and failed to monitor/supervise the overnight shift after an incident on 11/8/15.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client</p>				

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	<p>protections requirements are met.</p> <p>Based on record review and interview for 5 of 7 clients living in the group home (#2, #4, #5, #6 and #7), the facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement its policies and procedures to conduct a thorough investigation of client #5's injury of unknown origin (fracture), implement appropriate corrective action to address seven staff initialing client #5's Medication Administration Record indicating a medication not in the home was administered from 9/5/15 to 9/30/15, ensure staff implemented the facility's medication policy and procedure to ensure client #5 was not administered another client's medications, ensure staff immediately reported an allegation of abuse to the administrator, prevent client to client abuse, and implement appropriate corrective action to monitor staff during the overnight shift following an incident on 11/8/15 when the staff failed to implement client #6's diet/dining plan, follow and implement client #6's BSP (Behavioral Support Plan) appropriately, follow the on call procedure, try to prevent client to client abuse, and being in the med room/office during a behavioral incident in which physical intervention was deemed necessary for safety.</p>	W 0122	<p>Program Director will receive investigation training, including corrective actions; this training will include individuals that should be questioned during investigation process. Investigations and corrective actions will be review weekly by Area Director and Program Director. Documentation of this weekly review will be completed on the Program Director Weekly review form. Staff will be trained on medication administration procedure. Observations will be conducted 6 times per week for 2 months to include all med passes and that all staff are observed administering medications to ensure that medication passes are administered correctly. The documentation of these observations will be turned into the Program Director for follow up and corrective action. Area Director will review weekly with Program Director to ensure completion. Staff will be trained on reporting all incidents of abuse and neglect. Responsible party: Program Coordinator, Program Director and Area Director Date of completion:1/13/2016</p>	01/13/2016

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	<p>Findings include:</p> <p>1) Please refer to W149. For 5 of 14 incident/investigative reports reviewed affecting clients #2, #4, #5, #6 and #7, the facility neglected to implement its policies and procedures to conduct a thorough investigation of client #5's injury of unknown origin (fracture), implement appropriate corrective action to address seven staff initialing client #5's Medication Administration Record indicating a medication not in the home was administered from 9/5/15 to 9/30/15, ensure staff implemented the facility's medication policy and procedure to ensure client #5 was not administered another client's medications, ensure staff immediately reported an allegation of abuse to the administrator and implement appropriate corrective action to monitor staff during the overnight shift following an incident on 11/8/15.</p> <p>2) Please refer to W153. For 1 of 14 incident/investigative reports reviewed affecting client #4, the facility failed to ensure staff immediately reported an allegation of verbal abuse to the administrator.</p> <p>3) Please refer to W154. For 1 of 14 incident/investigative reports reviewed</p>						

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W 0149 Bldg. 00	<p>affecting client #5, the facility failed to conduct a thorough investigation of an injury of unknown origin (fracture).</p> <p>4) Please refer to W157. For 2 of 14 incident/investigative reports reviewed affecting clients #2, #5, #6 and #7, the facility failed to implement appropriate corrective actions to monitor/supervise medication administration following client #5 missing a medication for 26 days and failed to monitor/supervise the overnight shift after an incident on 11/8/15.</p> <p>9-3-2(a)</p> <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 5 of 14 incident/investigative reports reviewed affecting clients #2, #4, #5, #6 and #7, the facility neglected to implement its policies and procedures to conduct a thorough investigation of client #5's injury of unknown origin (fracture), implement appropriate corrective action to address seven staff initialing client #5's Medication Administration Record indicating a medication not in the home</p>	W 0149	<p>Program Director will receive investigation training, including corrective actions; this training will include individuals that should be questioned during investigation process. Investigations and corrective actions will be review weekly by Area Director and Program Director. Documentation of this weekly review will be completed on the Program Director Weekly review form. Staff will be trained on medication administration</p>	01/13/2016

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	<p>was administered from 9/5/15 to 9/30/15, ensure staff implemented the facility's medication policy and procedure to ensure client #5 was not administered another client's medications, ensure staff immediately reported an allegation of abuse to the administrator and implement appropriate corrective action to monitor staff during the overnight shift following an incident on 11/8/15.</p> <p>Findings include:</p> <p>On 12/8/15 at 12:33 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 10/1/15 at 12:34 PM, the Bureau of Developmental Disabilities Services (BDDS) incident report, dated 10/2/15, indicated, in part, "[Name of pharmacy] dc'd (discontinued) [client #5's] Acyclovir (for pancytopenia - deficiency of all three cellular components of the blood (red cells, white cells and platelets) instead of Alendronate Sodium (bone loss). Acyclovir was not in September 2015 cycle fill. Staff failed to correctly check in medications and follow the agency medication administration policy. From September 5, 2015 until September 30, 2015 [client #5] failed to receive Acyclovir due to not being in the packet.</p>		<p>procedure. Observations will be conducted 6 times per week for 2 months to include all med passes and that all staff are observed administering medications to ensure that medication passes are administered correctly. The documentation of these observations will be turned into the Program Director for follow up and corrective action. Area Director will review weekly with Program Director to ensure completion. Staff will trained on all clients Behavioral Support Plans/Individual Support Plans Observations will be conducted 6 times per week for 2 months to include all 3 shifts (6am-2pm) (2pm-10pm)(10pm-6am) to ensure the behavior plans/ISP's are followed consistently. The documentation of these observations will be turned into the Program Director for follow up and corrective action. Area Director will review weekly with Program Director to ensure completion. Responsible party: Program Coordinator, Program Director and Area Director Date of completion:1/13/2016</p>	

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	<p>Doctor has been notified of this medication error. [Client #5] will continue to be monitored for health and safety. Staff will be retrained on 10/6/15 on medication administration. Medication administration observations will be completed two times a week for 60 days, after having been retrained, to ensure staff are compliant with our medication administration policy."</p> <p>The 10/7/15 Investigation Summary indicated in the Factual Findings section, "[Nurse] reported that she had received a phone call from [pharmacist's name] at [name of pharmacy] to report that [client #5's] Acyclovir had been dc'd instead of his Alendronate Sodium. [Nurse] reported that [pharmacist] had found this when completing her pharmacy audit in the home. [Nurse] reported that staff had signed that the medication had been given but it was not in the packages to be given. [Nurse] reported that this happened during the period of 9/5/15 - 9/30/15." The Conclusion of the investigation indicated, "Evidence supports staff did not follow med administration procedures." The Recommendations section indicated, "All staff were retrained on 10/6/15 on Mentor's med administration policy and procedure and checking meds in. Staff administering meds during the time of the</p>			

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	<p>incident will be given a record of discussion. Med observations, 2 times a week, for 60 days will be completed."</p> <p>The facility failed to implement appropriate corrective action to address the systemic issue of seven staff documenting a medication as administered when the medication was not in the home to administer. The facility failed to conduct observations of all the staff who was involved.</p> <p>On 12/10/15 at 12:33 PM, a review of client #5's 10/13/15 Physician's Orders indicated client #5 was prescribed Acyclovir 400 milligrams twice a day for pancytopenia.</p> <p>On 12/9/15 at 4:48 PM, the Program Director (PD) sent an email with Records of Discussion indicating the following for staff #1, #2, #3, #8, #9, #11 and #12: "Reason for discussion: Failed to follow Mentor's Medication Administration Procedures and failed to follow proper medication check in procedure. Background information: Has previous training on proper medication administration procedure and proper medication check in procedure."</p> <p>On 12/9/15 at 4:48 PM, the PD sent an email with the medication administration</p>						

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	<p>observations conducted with the staff. Staff #1 was observed to pass medications two times. Staff #3 was observed to pass medications four times. Staff #8 was observed to pass medications three times. Staff #9 was observed to pass medications four times. Staff #5, #11 and #12 were not observed to pass medications.</p> <p>On 12/9/15 at 11:23 AM, the nurse indicated the staff initialed the medication administration record (MAR) as having administered the medication and the medication was not in the home to administer. The nurse indicated the staff was not doing checks of medications with the MAR prior to administering the medications. The nurse indicated the facility discovered the issue when the pharmacist was conducting her quarterly review. The nurse indicated the medication was not discontinued by the physician. The nurse indicated the staff told her they thought the medication was discontinued but continued to initial the MAR as administering the medication. The nurse indicated she retrained staff on how to check medications into the home when dropped off by the pharmacy. The nurse stated she went over the medication administration policy and procedures "once again." The nurse indicated the facility was conducting pop in medication</p>			
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	<p>observations. The nurse indicated the staff should implement the medication administration policy and procedure.</p> <p>On 12/10/15 at 3:29 PM, the PD indicated the nurse, a Program Coordinator from another home and the PD conducted the medication pass observations at the group home following client #5's missed medication from 9/5/15 to 9/30/15. The PD initially indicated supervising two medication passes a week was sufficient. The PD stated the facility should have monitored the staff daily for "at least two to three weeks" until the staff was competently trained on medication administration. The PD indicated staff #11 and #12 were not monitored during medication pass due to working PRN (as needed). The PD indicated the staff who was involved with signing the MAR as administering client #5 his medication when the medication was not in the home should have been monitored. The PD stated the facility "should have planned it (the monitoring of staff) better."</p> <p>2) On 12/3/15 at 7:00 AM, the BDDS incident report, dated 12/4/15, indicated, in part, "[Staff #8] contacted [name], Program Coordinator and [name], Program Nurse, to report that [client #5] had been given another clients (sic)</p>			

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	<p>medications. [Client #5] was taken to the [name of emergency room] where he was checked out. [Client #5's] vitals were taken and his vitals were within normal ranges. [Client #5] was released to go home and rest as the medications would make him drowsy. [Client #5] was instructed to hold some of his medications for the evening and to resume all his medications on 12/4/15. Program Nurse instructed staff at the group home to take [client #5's] blood pressure and pulse in the evening of 12/3/15 and the morning of 12/4/15 and report back to the nurse. [Name], Program Nurse, contacted PD (Program Director), [name] with each reading and each reading fell within normal ranges. [Staff #8] has been suspended from passing medications until she is retrained on proper medication procedures. [Client #5] will continue to be monitored for health and safety."</p> <p>The 12/9/15 Investigation Summary indicated staff #8 reported she put client #5 and client #6's medication in cups and put their initials on the cups. Staff #8 reported she took client #5's medications to him in the living room. Staff #8 indicated after administering client #6's medications to client #5, she contacted the Program Coordinator, Program Director and the nurse. Staff #8 indicated</p>			

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	<p>the clients' medications were supposed to be administered one at a time and she was not supposed to prepare medications ahead of time. The Conclusion of the investigation indicated, "Evidence supports staff did not intervene appropriately. Evidence supports staff did not follow med administration procedures." The Recommendations section indicated, "[Staff #8] has been suspended from med administration until she is able to be retrained on med administration. [Staff #8] will be given corrective action for not follow (sic) agency med administration policy."</p> <p>On 12/9/15 at 11:23 AM, the nurse indicated the staff should implement the facility's medication policy and administer the client's medications as ordered.</p> <p>3) On 12/8/15 at 12:33 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 9/23/15 at 6:00 PM, staff #6 was sitting on the front porch with client #5 and noticed his middle finger on his left hand was bruised and swollen on the inside and outside of his hand. The Program Coordinator asked client #5 what happened and client #5 indicated he did not know what happened. Client #5 was taken to the emergency room. Client</p>			

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	<p>#5 had a fracture to his middle finger.</p> <p>The 9/29/15 Investigation Summary indicated in the Conclusion section, "Evidence does not support abuse/neglect and cause of injury is still unknown." The Recommendations section indicated, "Continue to monitor [client #5] for health and safety and for any injuries of unknown origin."</p> <p>The facility's investigation did not include interviews with client #5's peers (clients #1, #2, #3, #4, #6 and #7). The facility's investigation included one interview with staff from client #5's day program. The facility failed to conduct a thorough investigation. The facility failed to interview client #5's peers and additional staff from client #5's day program.</p> <p>On 12/9/15 at 1:47 PM, the Program Director (PD) indicated she did not interview client #5's peers. The PD stated, "I absolutely should have interviewed his peers." The PD indicated she should have interviewed additional day program staff. The PD indicated the investigation was not thorough. On 12/10/15 at 3:24 PM, the PD indicated she received retraining after the investigation on conducting interviews and who to conduct interviews with. The</p>			

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	<p>PD indicated the retraining she received was not in response to her investigation of client #5's injury of unknown origin. The PD indicated she was retrained following a survey at another group home. The PD indicated the Area Director (AD) provided the training. The PD indicated the AD reviewed her investigation of client #5's injury of unknown origin. The PD indicated the AD did not request additional interviews to be conducted.</p> <p>4) On 12/8/15 at 12:33 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 7/7/15, Indiana Mentor was notified by the Bureau of Quality Improvement Services (BQIS) of an incident on 7/1/15 between 4:30 PM and 5:30 PM involving an allegation of verbal abuse. The 7/10/15 Internal Investigation Summary indicated in the Brief Summary of the incident section, "...During an initial investigation into the allegation, it was determined that the staff involved was [staff #13] and the client was [client #4]. [Staff #13] was immediately suspended pending an investigation."</p> <p>The Factual Findings section indicated in staff #1's interview, "[Staff #1] stated that when they arrived back at the home [client #4] reported that [staff #13] was</p>			

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	<p>yelling and screaming at him and [staff #1] believed [client #4] was upset over not having a cigarette... [Staff #1] stated that when [staff #13] walked into the house she just said that transport was a 'pain in the a--' and she seemed agitated. [Staff #1] stated that he told [staff #13] to document the incident on [client #4's] BPR (Behavior Problem Record) because it was considered a behavior. He stated that he didn't know if she actually documented it or not though and didn't believe she reported the behavior to anyone else."</p> <p>The Factual Findings section indicated in staff #14's interview, "[Staff #14] stated that she was in an appointment with [former client #8] at [name of clinic] and when they came out, [client #4] was out in the parking lot and [staff #13] was pulling the van into a parking spot. [Staff #14] stated that she talked with [client #4] and told him to get into the van and he got into the front seat which is his assigned seat. [Staff #14] stated that as they were driving home, [client #4] was doing everything he could to 'set her off' (meaning set [staff #13] off) but (sic) turning on the radio and reaching over and honking the horn. [Staff #14] stated that [staff #13] was 'exceeding the speed a little' and almost hit a couple of cars or they almost hit them in the van due to</p>			

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	<p>lane changes of both the van and the other cars. She stated that [staff #13] was 'yelling and screaming' at [client #4] and told him to 'shut up.' She stated that [staff #13] was also cussing at [client #4] but couldn't recall what words she used. [Staff #14] stated that [client #4] wasn't really saying anything, he was just trying to aggravate [staff #13]... [Staff #14] stated that when they arrived back home and were coming through the back gate, [client #4] slammed the gate on [staff #13's] arm (she wasn't sure if it was intentional) and bruised [staff #13's] arm and [staff #13] called [client #4] a 'retard.' [Staff #14] stated that she did not report this information to anyone and didn't know if [staff #13] did either. She stated that she knew that [staff #13] should have documented the incident but didn't know if she had done that earlier...."</p> <p>The Factual Findings section indicated in staff #13's interview, "[Staff #13] stated that she had the clients in the van with her while [staff #14] was with [client #8] at an appointment at [name of clinic]. [Staff #13] stated that [client #4] got mad and started hitting the windshield and the van itself because he wanted a cigarette and didn't have one. She stated that he was mad because she wouldn't/couldn't give him one. When asked if she yelled</p>						

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	<p>at [client #4] or cussed at [client #4], [staff #13] stated that she 'didn't cuss at him,' she just 'said stuff under my breath.' She stated that she didn't say anything loud enough for him or anyone else to hear. [Staff #13] stated that when they got on the road to head back to the house, [client #4] was grabbing at the wheel of the van and honking the horn and just 'being obnoxious.' She stated that she and [staff #14] told him that if they (sic) didn't stop they would take the phone away from him for the night and he couldn't talk to his girlfriend. When asked if this was part of his plan, [staff #13] stated that she didn't know but it was [staff #14's] idea and he got to talk on the phone anyway that night... [Staff #13] stated that the 'only thing I said was get in the f**king van.' When asked if she said this to [client #4], she said 'yes, because you can't baby talk him. You have to be firm.'"</p> <p>The Factual Findings section indicated in client #7's interview, "...He stated that [staff #13] was cussing at [client #4] and telling him to get in the van."</p> <p>The Factual Findings section indicated in client #8's interview, "...[Client #8] stated that [client #4] wouldn't get back in the van and was yelling at [staff #13] in the van and cussed at [staff #13] and [staff</p>				

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	<p>#13] yelled back at [client #4] and said 'f**k you....'"</p> <p>The Factual Findings section indicated in client #2's interview, "...[Client #2] stated that [staff #13] was telling him to get back in and was cussing at [client #4]...."</p> <p>The Factual Findings section indicated in client #3's interview, "...When asked if he heard [staff #13] raise her voice or yell at [client #4], [client #3] said 'yes.' When asked if he thought [staff #13] was joking around with [client #4], [client #3] said 'no.' When asked if [staff #13] is nice to [client #4] and jokes around with him, [client #3] said 'no.'"</p> <p>The Factual Findings section of the investigation indicated, "There was no documentation found in the home for [client #4] regarding these behaviors in the Daily Support Records or in his Behavior Plan Narratives."</p> <p>The Conclusion of the investigation indicated, "There is evidence to support that [staff #13] was verbally abusive to [client #4]."</p> <p>On 12/8/15 at 1:45 PM, a review of staff #14's 7/16/15 Termination Notice indicated, in part, "Indiana Mentor is terminating [staff #14's] employment due</p>						

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	<p>to failing to report that a staff was being verbally inappropriate to a client and was exceeding the speed limit, as well as the staff almost hit a couple of cars. On 7/7/15, the Company was notified by BQIS of an allegation occurring around 4:30 to 5:30pm on 7/1/15, where a staff was allegedly verbally abusive to a client who was walking outside the Company van while the van followed the client. An investigation was completed on 7/7/15 and 7/10/15, and during the investigation [staff #14] reported that she was in the van on 7/1/15 and another staff was driving and that the staff was exceeding the speed limit and almost hit a couple of cars and that the staff was yelling and screaming at a client. She reported that the staff told the client to shut up and that the staff was cussing at the client and called the client a retard. [Staff #14] admitted that she did not report this information to anyone... Therefore, we are terminating [staff #14's] employment."</p> <p>On 12/8/15 at 1:45 PM, a review of staff #13's 7/16/15 Termination Notice indicated, in part, "Indiana Mentor is terminating [staff #13's] employment due to being verbally inappropriate to a client. On 7/7/15, the Company was notified by BQIS of an allegation occurring around 4:30 to 5:30pm on 7/1/15, where a staff</p>						

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	<p>was allegedly verbally abusive to a client who was walking outside the Company van while the van followed the client. An investigation was completed on 7/7/15 and 7/10/15, and during the investigation [staff #13] admitted that she was driving the van and that she 'said stuff under her breath' and that she did tell the client to 'get in the f***ing van.' The staff who was riding with her in the van reported that she was in the van on 7/1/15 and [staff #13] was exceeding the speed limit a little and almost hit a couple of cars and that [staff #13] was yelling and screaming at a client. She also reported that the (sic) [staff #13] told the client to shut up and was cussing at the client and called the client a retard. Also during the investigation, three of the clients in the van reported that [staff #13] was cussing at the client and that [staff #13] had told the client 'f**k you.' ...Therefore, we are terminating [staff #13's] employment."</p> <p>On 12/8/15 at 12:54 PM, the Area Director (AD) indicated a community member reported the allegation of staff screaming at client #4 while in the parking lot at a doctor's office. The AD indicated staff #13 and #14 were terminated. The AD indicated staff #13 was terminated for yelling at client #4. The AD indicated staff #14 was</p>						

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	<p>terminated for failing to report the incident. The AD stated, "Staff failed to immediately report the incident." The AD indicated the staff failed to document the incident.</p> <p>On 12/9/15 at 1:47 PM, the Program Director (PD) indicated the staff should immediately report an allegation of abuse to the administrator. The PD indicated 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.</p> <p>5) On 11/8/15 at 6:45 AM, client #6 bit client #7's finger. The 11/9/15 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "... [Staff #4] was reporting that [client #6] had bit (sic) [client #7] on the finger, was being physically aggressive to her and [staff #5] and was attempting to elope since 4:30 AM... [Program Coordinator] looked at [client #7's] finger, which had a puncture wound and [Program Coordinator] instructed [staff #1] to take [client #7] to the ER (emergency room) to have his finger checked out. While discussing the incident it was determined that [client #6] had went up stairs (sic) at one point during the behavior and had attempted to enter [client #4's] room and [client #4] reported that he punched</p>			

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	<p>[client #6]. Staff did not report that [client #4] had punched [client #6] or that [client #6] went upstairs. As a precaution [client #4] was taken to the ER also to have his hand checked out to ensure he did not have any fractures to his hand..."</p> <p>The 11/13/15 Investigation Summary indicated in the Incident Summary section, "[Client #6] was food seeking, having self injurious behavior, property destruction, elopement and being combative. [Client #6] had bit (sic) and hit [client #7] and [client #7] hit and kicked him back and attempted to enter [client #4's] room and [client #6] hit [client #4] and [client #4] hit him back."</p> <p>The Factual Findings section of the investigation indicated in the Program Coordinator's (PC) interview, "[PC] reported that she received a call from [staff #4] at 6:46 AM and [staff #4] was working at [name of group home]. [PC] reported that [staff #4] reported to her that [client #6] was being combative and had bit (sic) [client #7's] finger. [PC] reported that [staff #4] reported to her that 'they' were trapped in the office. [PC] asked who was trapped in the office and [staff #4] reported to her that her (sic) and [staff #5] were trapped in the office. [PC] then asked her where [client #6] was. [PC] reported that [staff #5]</p>				

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	<p>then got on the phone and told her that [client #6] was sitting at the dining room table and that she keeps poking her head out the door and checking on him... [PC] reported that [client #4] came down stairs while [client #7] was getting ready to leave for the ER and [client #4] reported to [PC] that his hand hurt because he punched [client #6]. The [PC] reported that [client #4] said look at my face and [PC] asked him what happened and he said it was from [client #6]... [PC] reported that [staff #1] took [clients #4 and #7] to the hospital ER... [PC] reported that she asked [staff #4 and #5] both how [client #7] got bite (sic) and [staff #5] reported that [client #7] was walking down the stairs and that [client #6] ran up to him and bit him as he got to the bottom of the stairs. [PC] reported that [staff #4] agreed with what [staff #5] said... [PC] reported that when [client #7] returned home she asked [client #7] why [client #6] came after him and bite (sic) his finger and [client #7] reported to her that he didn't know why [client #6] bit him that he was just sitting in [client #5's] chair and [client #6] ran up to him and bit his finger... [PC] reported that [staff #15] told her that [staff #5] was upstairs when she went in the home and that [staff #4] was in the office and refusing to leave the office and that [staff #15] told [staff #4] she can't be like that</p>			
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	<p>and be sacred (sic)...."</p> <p>The Factual Findings section of the investigation indicated in staff #5's interview, "...[Staff #5] reported that he got up about 4:30 (AM) and went to the dining room and sat at the table and was asking for cereal. [Staff #5] reported that she told (sic) no, go lay down for a little bit, [staff #5] said she literally just told him this once and he sprinted in to the kitchen and got a bowel (sic) and spoon out and got the milk out of the fridge and normally if he is wanting cereal he will only pour (sic) enough in his bowel (sic) for just the cereal but this time he poured the whole gallon of milk over the bowel (sic) and it got all over the counter and floor. [Staff #5] reported that he doesn't normally get up and want cereal but there have been times he has got (sic) up about 5 am when her and [staff #3] have been there and he is incessant about having cereal and they will give him the cereal. Normally we try to get him to go lay back down and he will for about 15 minutes or so but he will get back up and down and really want it and if it is close enough to morning they will go ahead and let him have it. [Staff #5] reported that after he poured the milk out he was making a screaming noise and he went back in to the dining room and was asking for cereal again. [Staff #5] told [client #6] that</p>			
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	<p>there was no more milk for cereal and that they would have to get more and unthaw it and he would have to wait for [staff #3] to get there... [Staff #5] reported that [client #6] continued to run back and forth to the kitchen and was trying to grab stuff and was causally (sic) opening the cabinet doors and fridge door but wasn't taking anything out at that point. [Staff #5 reported that [client #6] had taken the empty milk jug and threw it in the trash and then took out the trash bag to the dumpster. [Staff #5] reported that she told [staff #4] to go out after him and make sure he didn't run. [Staff #5] reported that [staff #4] ran out right after him. [Staff #5] reported that [client #6] came back inside and was slamming his bedroom doors. [Staff #5] reported that this happened for about 10 minutes and then he came and sat down in the living room... [Client #6] got up and ran over to [client #7] and started smacking [client #7]. [Staff #5] told [staff #4] to go in to the office to call on call. [Client #7] got up and they started hitting each other, I was trying to get in the middle of them and [client #7] had [client #6] pushed in to the chair that [client #6] was originally sitting in. [Client #7] was trying to hold his head or something and that was when [client #6] bit him...."</p> <p>The Conclusion of the investigation</p>						

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	<p>indicated, "Evidence supports staff did not intervene appropriately. Evidence supports staff did not implement BSP (behavior support plan) appropriately. Evidence supports staff did not follow med administration procedures. Evidence supports staff did not follow protocol(s)." The Recommendations section indicated, "All staff in the home retrained on [client #6's] BSP and diet. Corrective action for [staff #4] and [staff #5] for not following [client #6's] diet/dining plan, not following and implementing [client #6's] BSP appropriately, not following the on call procedure, not trying to prevent a client to client incident, and being in the med room/office during a behavioral incident in which physical intervention was deemed necessary for safety."</p> <p>On 12/11/15 at 10:37 AM, a review of client #6's 6/1/15 Individualized Support Plan (ISP) indicated he was on an 1800 calorie, gastroparesis (characterized by symptoms and the confirmed delay of emptying of food from the stomach where no blockage is evident) diet. The ISP indicated client #6 was to receive 6 small meals a day.</p> <p>On 12/11/15 at 12:27 PM, the PD stated staff #4 and #5 were "negligent." The PD stated, "that's why they received the write</p>			

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	<p>up." The PD indicated the staff initially were not truthful about how client #7 was bitten by client #6 when the Program Coordinator asked the staff what happened. The PD indicated the staff failed to implement client #6's BSP as written. The PD indicated the staff could have prevented the incident by implementing client #6's plans. The PD indicated the incident started when client #6 got up and wanted cereal. The PD indicated the staff did not allow him to have cereal even though his dining plan indicated he could have 6 small meals a day. The PD indicated if the staff allowed him to have the cereal, which staff #5 indicated she had done in the past, the incident may have been avoided. The PD indicated the television may have been on during the overnight shift which could have contributed to the behavior. The PD indicated client #6 targeted the television during behaviors for property destruction. The PD indicated the staff did not use or ensure client #6's weighted vest was accessible (it was in the van). The PD indicated the use of the weighted vest could have deescalated the behavior. The PD indicated the staff failed to try to get client #6 to take a shower which was another therapeutic option in the plan. The PD indicated the two staff did not attempt to restrain client #6 per his BSP. The PD indicated staff #4 stayed in the</p>						

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	<p>office during the behavior. The PD indicated the staff failed to administer client #6's PRN (as needed) medication. The PD indicated the staff failed to follow the proper on-call notifications. The PD indicated the staff could have called after 10 minutes of client #6 exhibiting elopement, physical aggression, self injurious behavior, property destruction and obsessing. The PD indicated a PRN could be administered if two of the targeted behaviors were exhibited. The PD indicated staff #4 and #5 continue to work during the overnight shift but not during the same shift. The PD indicated a Program Coordinator from another group home conducted two pop in checks of the staff (PD was not sure which staff was working and did not have documentation of the pop in checks) following the incident. The PD indicated there was no additional monitoring of the night shift staff. The PD indicated there should have been additional monitoring of the overnight shift staff following the incident. The PD stated of the incident, "It could have been avoided." The PD indicated the staff did not implement client #6's plan to avoid the escalation of the behavior.</p> <p>The facility's policy and procedures related to abuse and neglect were</p>			

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	<p>reviewed on 12/8/15 at 1:17 PM. The facility's Quality and Risk Management policy dated April 2011 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 policy defined neglect as, "e. Failure to provide appropriate supervision, care or training; f. Failure to provide a safe, clean and sanitary environment; g. Failure to provide food and medical services as needed; h. Failure to provide medical supplies or safety equipment as indicated in the ISP." The Human Rights policy, dated April 2011, 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</p>			

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W 0153 Bldg. 00	<p>physical, verbal, sexual, or psychological abuse or punishment."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 14 incident/investigative reports reviewed affecting client #4, the facility failed to ensure staff immediately reported an allegation of verbal abuse to the administrator.</p> <p>Findings include:</p> <p>On 12/8/15 at 12:33 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 7/7/15, Indiana Mentor was notified by the Bureau of Quality Improvement Services (BQIS) of an incident on 7/1/15 between 4:30 PM and 5:30 PM involving an allegation of verbal abuse. The 7/10/15 Internal Investigation Summary indicated in the Brief Summary of the incident section, "...During an initial investigation into the allegation, it</p>	W 0153	<p>Staff will be trained on reporting all incidents of abuse and neglect immediately. Staff will trained on all clients Behavioral Support Plans/Individual Support Plans Observations will be conducted 6 times per week for 2 months to include all 3 shifts (6am-2pm) (2pm-10pm)(10pm-6am) to ensure the behavior plans/ISP's are followed consistently. The documentation of these observations will be turned into the Program Director for follow up and corrective action. Area Director will review weekly with Program Director to ensure completion Responsible party: Program Coordinator, Program Director and Area Director Date of completion:1/13/2016</p>	01/13/2016

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	<p>was determined that the staff involved was [staff #13] and the client was [client #4]. [Staff #13] was immediately suspended pending an investigation."</p> <p>The Factual Findings section indicated in staff #1's interview, "[Staff #1] stated that when they arrived back at the home [client #4] reported that [staff #13] was yelling and screaming at him and [staff #1] believed [client #4] was upset over not having a cigarette... [Staff #1] stated that when [staff #13] walked into the house she just said that transport was a 'pain in the a--' and she seemed agitated. [Staff #1] stated that he told [staff #13] to document the incident on [client #4's] BPR (Behavior Problem Record) because it was considered a behavior. He stated that he didn't know if she actually documented it or not though and didn't believe she reported the behavior to anyone else."</p> <p>The Factual Findings section indicated in staff #14's interview, "[Staff #14] stated that she was in an appointment with [former client #8] at [name of clinic] and when they came out, [client #4] was out in the parking lot and [staff #13] was pulling the van into a parking spot. [Staff #14] stated that she talked with [client #4] and told him to get into the van and he got into the front seat which is his</p>			

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	<p>assigned seat. [Staff #14] stated that as they were driving home, [client #4] was doing everything he could to 'set her off' (meaning set [staff #13] off) but (sic) turning on the radio and reaching over and honking the horn. [Staff #14] stated that [staff #13] was 'exceeding the speed a little' and almost hit a couple of cars or they almost hit them in the van due to lane changes of both the van and the other cars. She stated that [staff #13] was 'yelling and screaming' at [client #4] and told him to 'shut up.' She stated that [staff #13] was also cussing at [client #4] but couldn't recall what words she used. [Staff #14] stated that [client #4] wasn't really saying anything, he was just trying to aggravate [staff #13]... [Staff #14] stated that when they arrived back home and were coming through the back gate, [client #4] slammed the gate on [staff #13's] arm (she wasn't sure if it was intentional) and bruised [staff #13's] arm and [staff #13] called [client #4] a 'retard.' [Staff #14] stated that she did not report this information to anyone and didn't know if [staff #13] did either. She stated that she knew that [staff #13] should have documented the incident but didn't know if she had done that earlier...."</p> <p>The Factual Findings section indicated in staff #13's interview, "[Staff #13] stated</p>						

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	<p>that she had the clients in the van with her while [staff #14] was with [client #8] at an appointment at [name of clinic]. [Staff #13] stated that [client #4] got mad and started hitting the windshield and the van itself because he wanted a cigarette and didn't have one. She stated that he was mad because she wouldn't/couldn't give him one. When asked if she yelled at [client #4] or cussed at [client #4], [staff #13] stated that she 'didn't cuss at him,' she just 'said stuff under my breath.' She stated that she didn't say anything loud enough for him or anyone else to hear. [Staff #13] stated that when they got on the road to head back to the house, [client #4] was grabbing at the wheel of the van and honking the horn and just 'being obnoxious.' She stated that she and [staff #14] told him that if they (sic) didn't stop they would take the phone away from him for the night and he couldn't talk to his girlfriend. When asked if this was part of his plan, [staff #13] stated that she didn't know but it was [staff #14's] idea and he got to talk on the phone anyway that night... [Staff #13] stated that the 'only thing I said was get in the f**king van.' When asked if she said this to [client #4], she said 'yes, because you can't baby talk him. You have to be firm.'"</p> <p>The Factual Findings section indicated in</p>			

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	<p>client #7's interview, "...He stated that [staff #13] was cussing at [client #4] and telling him to get in the van."</p> <p>The Factual Findings section indicated in client #8's interview, "...[Client #8] stated that [client #4] wouldn't get back in the van and was yelling at [staff #13] in the van and cussed at [staff #13] and [staff #13] yelled back at [client #4] and said 'f**k you...'"</p> <p>The Factual Findings section indicated in client #2's interview, "...[Client #2] stated that [staff #13] was telling him to get back in and was cussing at [client #4]...."</p> <p>The Factual Findings section indicated in client #3's interview, "...When asked if he heard [staff #13] raise her voice or yell at [client #4], [client #3] said 'yes.' When asked if he thought [staff #13] was joking around with [client #4], [client #3] said 'no.' When asked if [staff #13] is nice to [client #4] and jokes around with him, [client #3] said 'no.'"</p> <p>The Factual Findings section of the investigation indicated, "There was no documentation found in the home for [client #4] regarding these behaviors in the Daily Support Records or in his Behavior Plan Narratives."</p>						

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	<p>The Conclusion of the investigation indicated, "There is evidence to support that [staff #13] was verbally abusive to [client #4]."</p> <p>On 12/8/15 at 1:45 PM, a review of staff #14's 7/16/15 Termination Notice indicated, in part, "Indiana Mentor is terminating [staff #14's] employment due to failing to report that a staff was being verbally inappropriate to a client and was exceeding the speed limit, as well as the staff almost hit a couple of cars. On 7/7/15, the Company was notified by BQIS of an allegation occurring around 4:30 to 5:30pm on 7/1/15, where a staff was allegedly verbally abusive to a client who was walking outside the Company van while the van followed the client. An investigation was completed on 7/7/15 and 7/10/15, and during the investigation [staff #14] reported that she was in the van on 7/1/15 and another staff was driving and that the staff was exceeding the speed limit and almost hit a couple of cars and that the staff was yelling and screaming at a client. She reported that the staff told the client to shut up and that the staff was cussing at the client and called the client a retard. [Staff #14] admitted that she did not report this information to anyone... Therefore, we are terminating [staff #14's] employment."</p>						

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	<p>On 12/8/15 at 1:45 PM, a review of staff #13's 7/16/15 Termination Notice indicated, in part, "Indiana Mentor is terminating [staff #13's] employment due to being verbally inappropriate to a client. On 7/7/15, the Company was notified by BQIS of an allegation occurring around 4:30 to 5:30pm on 7/1/15, where a staff was allegedly verbally abusive to a client who was walking outside the Company van while the van followed the client. An investigation was completed on 7/7/15 and 7/10/15, and during the investigation [staff #13] admitted that she was driving the van and that she 'said stuff under her breath' and that she did tell the client to 'get in the f***ing van.' The staff who was riding with her in the van reported that she was in the van on 7/1/15 and [staff #13] was exceeding the speed limit a little and almost hit a couple of cars and that [staff #13] was yelling and screaming at a client. She also reported that the (sic) [staff #13] told the client to shut up and was cussing at the client and called the client a retard. Also during the investigation, three of the clients in the van reported that [staff #13] was cussing at the client and that [staff #13] had told the client 'f**k you.' ...Therefore, we are terminating [staff #13's] employment."</p>			
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W 0154 Bldg. 00	<p>On 12/9/15 at 1:47 PM, the Program Director (PD) indicated the staff should immediately report an allegation of abuse to the administrator.</p> <p>On 12/8/15 at 12:54 PM, the Area Director (AD) indicated a community member reported the allegation of staff screaming at client #4 while in the parking lot at a doctor's office. The AD indicated staff #13 and #14 were terminated. The AD indicated staff #13 was terminated for yelling at client #4. The AD indicated staff #14 was terminated for failing to report the incident. The AD stated, "Staff failed to immediately report the incident."</p> <p>9-3-2(a)</p> <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 1 of 14 incident/investigative reports reviewed affecting client #5, the facility failed to conduct a thorough investigation of an injury of unknown origin (fracture).</p> <p>Findings include:</p>	W 0154	<p>Program Director will receive investigation training, including corrective actions; this training will include individuals that should be questioned during investigation process. Investigations and corrective actions will be review weekly by Area Director and Program Director. Documentation of this</p>	01/13/2016

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	<p>On 12/8/15 at 12:33 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 9/23/15 at 6:00 PM, staff #6 was sitting on the front porch with client #5 and noticed his middle finger on his left hand was bruised and swollen on the inside and outside of his hand. The Program Coordinator asked client #5 what happened and client #5 indicated he did not know what happened. Client #5 was taken to the emergency room. Client #5 had a fracture to his middle finger.</p> <p>The 9/29/15 Investigation Summary indicated in the Conclusion section, "Evidence does not support abuse/neglect and cause of injury is still unknown." The Recommendations section indicated, "Continue to monitor [client #5] for health and safety and for any injuries of unknown origin."</p> <p>The facility's investigation did not include interviews with client #5's peers (clients #1, #2, #3, #4, #6 and #7. The facility's investigation included one interview with staff from client #5's day program. The facility failed to conduct a thorough investigation. The facility failed to interview client #5's peer and additional staff from client #5's day program.</p>		<p>weekly review will be completed on the Program Director Weekly review form. Responsible party: Program Director and Area Director Date of completion:1/13/2016</p>				

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W 0157 Bldg. 00	<p>On 12/9/15 at 1:47 PM, the Program Director (PD) indicated she did not interview client #5's peers. The PD stated, "I absolutely should have interviewed his peers." The PD indicated she should have interviewed additional day program staff. The PD indicated the investigation was not thorough. On 12/10/15 at 3:24 PM, the PD indicated she received retraining after the investigation on conducting interviews and who to conduct interviews with. The PD indicated the retraining she received was not in response to her investigation of client #5's injury of unknown origin. The PD indicated she was retrained following a survey at another group home. The PD indicated the Area Director (AD) provided the training. The PD indicated the AD reviewed her investigation of client #5's injury of unknown origin. The PD indicated the AD did not request additional interviews to be conducted.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 14 incident/investigative reports</p>	W 0157	Staff will trained on all clients Behavioral Support Plans/Individual Support Plans	01/13/2016			

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	<p>reviewed affecting clients #2, #5, #6 and #7, the facility failed to implement appropriate corrective actions to monitor/supervise medication administration following client #5 missing a medication for 26 days and failed to monitor/supervise the overnight shift after an incident on 11/8/15.</p> <p>Findings include:</p> <p>1) On 12/8/15 at 12:33 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 10/1/15 at 12:34 PM, the Bureau of Developmental Disabilities Services (BDDS) incident report, dated 10/2/15, indicated, in part, "[Name of pharmacy] dc'd (discontinued) [client #5's] Acyclovir (for pancytopenia - deficiency of all three cellular components of the blood (red cells, white cells and platelets) instead of Alendronate Sodium (bone loss). Acyclovir was not in September 2015 cycle fill. Staff failed to correctly check in medications and follow the agency medication administration policy. From September 5, 2015 until September 30, 2015 [client #5] failed to receive Acyclovir due to not being in the packet. Doctor has been notified of this medication error. [Client #5] will continue to be monitored for health and</p>		<p>Observations will be conducted 6 times per week for 2 months to include all 3 shifts (6am-2pm) (2pm-10pm)(10pm-6am) to ensure the behavior plans/ISP's are followed consistently. The documentation of these observations will be turned into the Program Director for follow up and corrective action. Area Director will review weekly with Program Director to ensure completion. Staff will be trained on medication administration procedure. Observations will be conducted 6 times per week for 2 months to include all med passes and that all staff are observed administering medications to ensure that medication passes are administered correctly. The documentation of these observations will be turned into the Program Director for follow up and corrective action. Area Director will review weekly with Program Director to ensure completion. Program Director will receive investigation training, including corrective actions; this training will include individuals that should be questioned during investigation process. Investigations and corrective actions will be review weekly by Area Director and Program Director. Documentation of this weekly review will be completed on the Program Director Weekly review form. Responsible party: Program Coordinator, Program Director and Area</p>	

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	<p>safety. Staff will be retrained on 10/6/15 on medication administration. Medication administration observations will be completed two times a week for 60 days, after having been retrained, to ensure staff are compliant with our medication administration policy."</p> <p>The 10/7/15 Investigation Summary indicated in the Factual Findings section, "[Nurse] reported that she had received a phone call from [pharmacist's name] at [name of pharmacy] to report that [client #5's] Acyclovir had been dc'd instead of his Alendronate Sodium. [Nurse] reported that [pharmacist] had found this when completing her pharmacy audit in the home. [Nurse] reported that staff had signed that the medication had been given but it was not in the packages to be given. [Nurse] reported that this happened during the period of 9/5/15 - 9/30/15." The Conclusion of the investigation indicated, "Evidence supports staff did not follow med administration procedures." The Recommendations section indicated, "All staff were retrained on 10/6/15 on Mentor's med administration policy and procedure and checking meds in. Staff administering meds during the time of the incident will be given a record of discussion. Med observations, 2 times a week, for 60 days will be completed."</p>		Director Date of completion:1/13/2016		

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	<p>The facility failed to implement appropriate corrective action to address the systemic issue of seven staff documenting a medication as administered when the medication was not in the home to administer. The facility failed to conduct observations of all the staff who was involved.</p> <p>On 12/10/15 at 12:33 PM, a review of client #5's 10/13/15 Physician's Orders indicated client #5 was prescribed Acyclovir 400 milligrams twice a day for pancytopenia.</p> <p>On 12/9/15 at 4:48 PM, the Program Director (PD) sent an email with Records of Discussion indicating the following for staff #1, #2, #3, #8, #9, #11 and #12: "Reason for discussion: Failed to follow Mentor's Medication Administration Procedures and failed to follow proper medication check in procedure. Background information: Has previous training on proper medication administration procedure and proper medication check in procedure."</p> <p>On 12/9/15 at 4:48 PM, the PD sent an email with the medication administration observations conducted with the staff. Staff #1 was observed to pass medications two times. Staff #3 was</p>			

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	<p>observed to pass medications four times. Staff #8 was observed to pass medications three times. Staff #9 was observed to pass medications four times. Staff #5, #11 and #12 were not observed to pass medications.</p> <p>On 12/9/15 at 11:23 AM, the nurse indicated the staff initialed the medication administration record (MAR) as having administered the medication and the medication was not in the home to administer. The nurse indicated the staff was not doing checks of medications with the MAR prior to administering the medications. The nurse indicated the facility discovered the issue when the pharmacist was conducting her quarterly review. The nurse indicated the medication was not discontinued by the physician. The nurse indicated the staff told her they thought the medication was discontinued but continued to initial the MAR as administering the medication. The nurse indicated she retrained staff on how to check medications into the home when dropped off by the pharmacy. The nurse stated she went over the medication administration policy and procedures "once again." The nurse indicated the facility was conducting pop in medication observations. The nurse indicated the staff should implement the medication administration policy and procedure.</p>			

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	<p>On 12/10/15 at 3:29 PM, the PD indicated the nurse, a Program Coordinator from another home and the PD conducted the medication pass observations at the group home following client #5's missed medication from 9/5/15 to 9/30/15. The PD initially indicated supervising two medication passes a week was sufficient. The PD stated the facility should have monitored the staff daily for "at least two to three weeks" until the staff was competently trained on medication administration. The PD indicated staff #11 and #12 were not monitored during medication pass due to working PRN (as needed). The PD indicated the staff who was involved with signing the MAR as administering client #5 his medication when the medication was not in the home should have been monitored. The PD stated the facility "should have planned it (the monitoring of staff) better."</p> <p>2) On 11/8/15 at 6:45 AM, client #6 bit client #7's finger. The 11/9/15 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "... [Staff #4] was reporting that [client #6] had bit (sic) [client #7] on the finger, was being physically aggressive to her and [staff #5] and was attempting to elope since 4:30 AM... [Program Coordinator]"</p>				

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	<p>looked at [client #7's] finger, which had a puncture wound and [Program Coordinator] instructed [staff #1] to take [client #7] to the ER (emergency room) to have his finger checked out. While discussing the incident it was determined that [client #6] had went up stairs (sic) at one point during the behavior and had attempted to enter [client #4's] room and [client #4] reported that he punched [client #6]. Staff did not report that [client #4] had punched [client #6] or that [client #6] went upstairs. As a precaution [client #4] was taken to the ER also to have his hand checked out to ensure he did not have any fractures to his hand...."</p> <p>The 11/13/15 Investigation Summary indicated in the Incident Summary section, "[Client #6] was food seeking, having self injurious behavior, property destruction, elopement and being combative. [Client #6] had bit (sic) and hit [client #7] and [client #7] hit and kicked him back and attempted to enter [client #4's] room and [client #6] hit [client #4] and [client #4] hit him back."</p> <p>The Factual Findings section of the investigation indicated in the Program Coordinator's (PC) interview, "[PC] reported that she received a call from [staff #4] at 6:46 AM and [staff #4] was working at [name of group home]. [PC]</p>			

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	<p>reported that [staff #4] reported to her that [client #6] was being combative and had bit (sic) [client #7's] finger. [PC] reported that [staff #4] reported to her that 'they' were trapped in the office. [PC] asked who was trapped in the office and [staff #4] reported to her that her (sic) and [staff #5] were trapped in the office. [PC] then asked her where [client #6] was. [PC] reported that [staff #5] then got on the phone and told her that [client #6] was sitting at the dining room table and that she keeps poking her head out the door and checking on him... [PC] reported that [client #4] came down stairs while [client #7] was getting ready to leave for the ER and [client #4] reported to [PC] that his hand hurt because he punched [client #6]. The [PC] reported that [client #4] said look at my face and [PC] asked him what happened and he said it was from [client #6]... [PC] reported that [staff #1] took [clients #4 and #7] to the hospital ER... [PC] reported that she asked [staff #4 and #5] both how [client #7] got bite (sic) and [staff #5] reported that [client #7] was walking down the stairs and that [client #6] ran up to him and bit him as he got to the bottom of the stairs. [PC] reported that [staff #4] agreed with what [staff #5] said... [PC] reported that when [client #7] returned home she asked [client #7] why [client #6] came after him and bite</p>			

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	<p>(sic) his finger and [client #7] reported to her that he didn't know why [client #6] bit him that he was just sitting in [client #5's] chair and [client #6] ran up to him and bit his finger... [PC] reported that [staff #15] told her that [staff #5] was upstairs when she went in the home and that [staff #4] was in the office and refusing to leave the office and that [staff #15] told [staff #4] she can't be like that and be sacred (sic)..."</p> <p>The Factual Findings section of the investigation indicated in staff #5's interview, "...[client #6] got up and ran over to [client #7] and started smacking [client #7]. [Staff #5] told [staff #4] to go in to the office to call on call. [Client #7] got up and they started hitting each other, I was trying to get in the middle of them and [client #7] had [client #6] pushed in to the chair that [client #6] was originally sitting in. [Client #7] was trying to hold his head or something and that was when [client #6] bit him...."</p> <p>The Conclusion of the investigation indicated, "Evidence supports staff did not intervene appropriately. Evidence supports staff did not implement BSP (behavior support plan) appropriately. Evidence supports staff did not follow med administration procedures. Evidence supports staff did not follow</p>			

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	<p>protocol(s)." The Recommendations section indicated, "All staff in the home retrained on [client #6's] BSP and diet. Corrective action for [staff #4] and [staff #5] for not following [client #6's] diet/dining plan, not following and implementing [client #6's] BSP appropriately, not following the on call procedure, not trying to prevent a client to client incident, and being in the med room/office during a behavioral incident in which physical intervention was deemed necessary for safety."</p> <p>On 12/11/15 at 10:37 AM, a review of client #6's 6/1/15 Individualized Support Plan (ISP) indicated he was on an 1800 calorie, gastroparesis (characterized by symptoms and the confirmed delay of emptying of food from the stomach where no blockage is evident) diet. The ISP indicated client #6 was to receive 6 small meals a day.</p> <p>On 12/11/15 at 12:27 PM, the PD stated staff #4 and #5 were "negligent." The PD stated, "that's why they received the write up." The PD indicated the staff initially were not truthful about how client #7 was bitten by client #6 when the Program Coordinator asked the staff what happened. The PD indicated the staff failed to implement client #6's BSP as written. The PD indicated the staff could</p>						

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	<p>have prevented the incident by implementing client #6's plans. The PD indicated the incident started when client #6 got up and wanted cereal. The PD indicated the staff did not allow him to have cereal even though his dining plan indicated he could have 6 small meals a day. The PD indicated if the staff allowed him to have the cereal, which staff #5 indicated she had done in the past, the incident may have been avoided. The PD indicated the television may have been on during the overnight shift which could have contributed to the behavior. The PD indicated client #6 targeted the television during behaviors for property destruction. The PD indicated the staff did not use or ensure client #6's weighted vest was accessible (it was in the van). The PD indicated the use of the weighted vest could have deescalated the behavior. The PD indicated the staff failed to try to get client #6 to take a shower which was another therapeutic option in the plan. The PD indicated the two staff did not attempt to restrain client #6 per his BSP. The PD indicated staff #4 stayed in the office during the behavior. The PD indicated the staff failed to administer client #6's PRN (as needed) medication. The PD indicated the staff failed to follow the proper on-call notifications. The PD indicated the staff could have called after 10 minutes of client #6</p>			

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W 0203 Bldg. 00	<p>exhibiting elopement, physical aggression, self injurious behavior, property destruction and obsessing. The PD indicated a PRN could be administered if two of the targeted behaviors were exhibited. The PD indicated staff #4 and #5 continue to work during the overnight shift but not during the same shift. The PD indicated a Program Coordinator from another group home conducted two pop in checks of the staff (PD was not sure which staff was working and did not have documentation of the pop in checks) following the incident. The PD indicated there was no additional monitoring of the night shift staff. The PD indicated there should have been additional monitoring of the overnight shift staff following the incident. The PD stated of the incident, "It could have been avoided." The PD indicated the staff did not implement client #6's plan to avoid the escalation of the behavior.</p> <p>9-3-2(a)</p> <p>483.440(b)(5)(i) ADMISSIONS, TRANSFERS, DISCHARGE At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status.</p>			

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	<p>Based on record review and interview for 1 client who was discharged from the group home (#8) since 12/8/14, the facility failed to ensure client #8's final summary included developmental, social, health and nutritional status information as well as his strengths, needs, required services, social relationships and preferences.</p> <p>Findings include:</p> <p>On 12/9/15 at 12:52 PM, the Program Director (PD) provided a copy of client #8's Discharge Summary, dated 9/1/15. The Developmental Summary indicated, "New goals have been developed by this IDT (interdisciplinary team). [Client #8] will follow a chore schedule. [Client #8] will develop a weekly budget. [Client #8] will cook a healthy meal." The Behavioral Summary indicated, "Behavior services have been requested on the waiver to support [client #8] with his transition." The Health Summary section indicated, "[Client #8] is current on all medical appts (appointments)." The Nutritional Summary section indicated, "[Client #8] will need support with making good nutritional choices when making food purchases." The Social Services section indicated, "[Client #8] is very social. [Client #8] is able to access the community</p>	W 0203	Program Director will be trained on completion of discharge summaries, including information that is to be included in summary. Area Director will review future discharge summaries for completeness. Responsible party: Program Director and Area Director Date of completion: 1/13/2016	01/13/2016			

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	<p>independently. [Client #8] will be living in a rural area and transportation could be a barrier and he will need support with transportation." The Vocational Summary section indicated, "[Client #8] will continue to be employed with [name of sheltered workshop] in the workshop." The Future Recommendations section indicated, "[Client #8] will move to [name of city]. [Client #8] will work on opening a VR (Vocational Rehabilitation) case for community employment once he moves to [name of city]."</p> <p>The Discharge Summary did not address client #8's strengths, needs, required services, social relationships and preferences. There was no documentation the client #8's current plans (Individual Support Plan, Behavior Support Plan, Risk Management Plans, list of current medications, copies of recent medical appointments and quarterly dietary review were provided to the new staff for review.</p> <p>On 12/9/15 at 1:31 PM, the Program Director indicated client #8's discharge summary should contain the required information.</p> <p>9-3-4(a)</p>			

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W 0248 Bldg. 00	<p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN</p> <p>A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 2 of 2 clients (#2 and #4) who attended day program #2, the facility failed to ensure a copy of each clients' individual plans was available to all relevant staff.</p> <p>Findings include:</p> <p>On 12/8/15 at 2:41 PM, a review of client #2 and #4's records at day program #2 was conducted. Client #2's Individual Support Plan (ISP) at day program #2 was dated 7/26/13. Client #2's Behavior Support Plan (BSP) was dated 8/22/13. Client #4's ISP was dated 3/14/14 and his BSP was dated 4/1/14. The facility failed to ensure day program #2 had the clients' current program plans.</p> <p>On 12/9/15 at 11:36 AM, a review of client #2's group home record was conducted. Client #2's current ISP was dated 7/20/15 and his BSP was dated 5/18/15.</p> <p>On 12/9/15 at 12:43 PM, a review of client #4's group home record was conducted. Client #4's current ISP was</p>	W 0248	<p>Program Director will be trained on providing current plans to outside provider of services. Program Director will provide new plans to providers and complete a day program observation monthly that will include signature of outside provider staff ensuring they have updated plans. Area Director will review monthly document sheet by the 10th of next month to ensure documentation is completed and accurate. Responsible party: Program Director and Area Director Date of completion:1/13/2016</p>	01/13/2016

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W 0262 Bldg. 00	<p>dated 3/12/15 and his BSP was dated 3/23/15.</p> <p>On 12/9/15 at 1:44 PM, the Program Director indicated client #2 and #4's day program should have the clients' current plans.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & 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.</p> <p>Based on record review and interview for 4 of 4 clients (#2, #3, #4 and #7) in the sample with restrictive plans, the facility's specially constituted committee (Human Rights Committee - HRC) failed to review, approve and monitor the use of the clients' restrictive plans.</p> <p>Findings include:</p> <p>On 12/9/15 at 11:36 AM, a review of client #2's record was conducted. Client #2's 5/18/15 Behavioral Support Plan (BSP) did not include the use of psychotropic medications. Client #2's BSP indicated, "Due to a house mates</p>	W 0262	<p>Program Director will be trained on receiving appropriate approvals before a plan is to be put in place. The Area Director will review weekly with Program Director and this will be documented on the Program Director Weekly review forms, which include whether HRC and guardian approvals have been obtained Responsible party: Program Director and Area Director Date of completion:1/13/2016</p>	01/13/2016			

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	<p>(sic) inappropriate food seeking, food in the house is under lock and key which is a restriction in place that affects [client #2]." There was no documentation in client #2's record indicating the HRC reviewed, approved and monitored his restrictive BSP.</p> <p>On 12/9/15 at 12:06 PM, the nurse indicated client #2 was prescribed Latuda and Buspar as psychotropic medications.</p> <p>Client #2's 7/20/15 Individualized Support Plan (ISP) indicated he needed 24 hours a day supervision. The ISP indicated due to two housemate's plans, the sharps in the home (knives, scissors, etc.) were locked up. Client #2's ISP indicated due to a housemate's plan, the exit doors had alarms. Client #2's ISP indicated due to a housemate's plan, the basement door was locked due to elopement and property destruction. The ISP indicated, "HRC approval has been obtained." There was no documentation in client #2's record indicating the HRC reviewed, approved and monitored his restrictive ISP.</p> <p>On 12/9/15 at 12:19 PM, a review of client #3's record was conducted. Client #3's 1/16/15 ISP indicated he had a guardian. The ISP indicated client #3 needed 24 hours a day supervision.</p>				

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	<p>Client #3's ISP indicated due to a housemate's plan, the sharps in the home (knives, scissors, etc.) were locked up.</p> <p>Client #3's ISP indicated due to a housemate's plan, the exit doors had alarms. Client #3's ISP indicated due to a housemate's plan, the basement door was locked due to elopement and property destruction. The ISP indicated, "HRC approval has been obtained." There was no documentation in client #3's record indicating the HRC reviewed, approved and monitored his restrictive ISP.</p> <p>On 12/9/15 at 12:43 PM, a review of client #4's record was conducted. Client #4's 3/23/15 Behavior Support Plan's Medication Management Plan indicated he was prescribed Fanapt and Naltrexone (both for anxiety) as psychotropic medications. Client #4's BSP indicated, "Due to a house mates (sic) inappropriate food seeking, food in the house is under lock and key which is a restriction in place that affects [client #4]." Client #4's BSP indicated, "Due to [client #4] having issues with Property Destruction he saves 10% of his income and his it put away (sic) if he goes a certain amount of time with no incident of property destruction he can use that money for something else such as an outing or to buy something he wants." The Property Destruction section of his BSP indicated, "If blocking is not</p>			

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	<p>effective, then apply the agency approved containment techniques and continue to contain [client #4] until he is calm...."</p> <p>The plan indicated, in part, "[Client #4] will need to be in line of sight during episodes of him threatening to hurt himself... If behavior can not be redirected, take [client #4] to ER (emergency room) immediately for an evaluation." There was no documentation in client #4's record indicating the HRC reviewed, approved and monitored his restrictive BSP.</p> <p>Client #4's 3/12/15 ISP indicated he had a guardian and needed 24 hours a day supervision. The ISP indicated due to his and another housemate's plans, the sharps in the home (knives, scissors, etc.) were locked up. Client #4's ISP indicated due to a housemate's plan, the exit doors had alarms. Client #4's ISP indicated due to a housemate's plan, the basement door was locked due to elopement and property destruction. The ISP indicated, "HRC approval has been obtained." There was no documentation in client #4's record indicating the HRC reviewed, approved and monitored his restrictive ISP.</p> <p>On 12/9/15 at 1:02 PM, a review of client #7's record was conducted. Client #7's 1/29/15 BSP included the use of psychotropic medications (Celexa, Invega</p>			

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	<p>and Depakote). Client #7's BSP indicated he had a targeted behavior of property destruction. The plan indicated, "If blocking is ineffective, apply agency approved crisis intervention containment techniques and continue the containment until [client #7] is calm." In the physical assault section, the plan indicated, "If he pursues and reinitiates physical assault, use the minimum amount of physical guidance necessary to stop the aggression (use the agency approved crisis intervention techniques)." The plan indicated in the inappropriate sexual behavior section, "[Client #7] should be kept in line of sight when he and his previously targeted housemate are not in common areas where staff can see them in order to assure the safety of his housemate... If he pursues and reinitiates inappropriate sexual behavior, use the minimum amount of physical guidance necessary to stop the behavior (use the agency approved physical management techniques)." There was no documentation in client #7's record indicating the HRC reviewed, approved and monitored his restrictive BSP.</p> <p>Client #7's 1/22/15 ISP indicated client #7 had a guardian. The ISP indicated client #7 needed 24 hours a day supervision. Client #7's ISP indicated due to a housemate's plan, the sharps in</p>			

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W 0312 Bldg. 00	<p>the home (knives, scissors, etc.) were locked up. Client #7's ISP indicated due to a housemate's plan, the exit doors had alarms. Client #7's ISP indicated due to a housemate's plan, the basement door was locked due to elopement and property destruction. The ISP indicated, "HRC approval has been obtained." There was no documentation in client #7's record indicating the HRC reviewed, approved and monitored his restrictive ISP.</p> <p>On 12/10/15 at 3:04 PM, the Program Director indicated the facility's HRC should review, approve and monitor the clients' restrictive plans at least annually or as their plans were updated.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 2 of 3 clients (#2 and #4) in the sample with psychotropic medications, the facility failed to ensure the clients had plans to reduce the use of psychotropic medications.</p>	W 0312	Program Director will be trained on ensuring that medication reduction plans have accurate and obtainable information. Program Director will be trained on receiving appropriate approvals before a plan is to be	01/13/2016

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	<p>Findings include:</p> <p>On 12/9/15 at 11:36 AM, a review of client #2's record was conducted. Client #2's 5/18/15 Behavior Support Plan (BSP) did not indicate the use of psychotropic medications. The Medications for Behavior section was blank. There was no psychotropic medication reduction plan in the BSP.</p> <p>On 12/9/15 at 12:06 PM, the nurse indicated client #2 was prescribed Latuda and Buspar as psychotropic medications.</p> <p>On 12/9/15 at 12:43 PM, a review of client #4's record was conducted. Client #4's 3/23/15 Behavior Support Plan's Medication Management Plan indicated he was prescribed Fanapt and Naltrexone (both for anxiety) as psychotropic medications. The Medication Management Plan, dated 11/19/15, was blank (no information or criteria for reducing the use of the psychotropic medications) in the Criteria for reduction section.</p> <p>On 12/9/15 at 1:08 PM, the Program Director indicated the clients should have medication reduction plans to reduce their use of psychotropic medications.</p>		<p>put in place. The Area Director will review weekly with Program Director and this will be documented on the Program Director Weekly review forms, which include whether HRC and guardian approvals have been obtained Responsible party: Program Director and Area Director Date of completion:1/13/2016</p>				

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W 0318 Bldg. 00	<p>9-3-5(a)</p> <p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on record review and interview for 1 of 3 non-sampled clients (#5), the facility failed to meet the Condition of Participation: Health Care Services. The facility's nursing services failed to ensure staff administered client #5's medications as ordered by the physician. The facility's nursing services failed to ensure seven staff did not document administering client #5 a medication that was not in the home to administer from 9/5/15 to 9/30/15. The facility's nursing services failed to ensure staff did not administer client #5 another client's medications. The facility's nursing services failed to implement appropriate corrective action to address the on-going, systemic issue of seven staff documenting a medication was administered to client #5 when the medication was not in the home to administer. The facility's nursing services failed to ensure staff #8 prepared and then administered the clients' medications, one at a time, following the facility's policies and procedures.</p>	W 0318	<p>Program nurse will review Medication Administration records and medications weekly to ensure that correct dosages are given and available. Program Nurse will review this documentation with Area Director weekly. Staff will be trained on medication administration procedure. Observations will be conducted 6 times per week for 2 months to include all med passes and that all staff are observed administering medications to ensure that medication passes are administered correctly. The documentation of these observations will be turned into the Program Director for follow up and corrective action. Area Director will review weekly with Program Director to ensure completion. Responsible party: Program Nurse, Program Director and Area Director Date of completion:1/13/2016</p>	01/13/2016

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W 0331 Bldg. 00	<p>Findings include:</p> <p>Please refer to W331. For 1 of 3 non-sampled clients living in the group home (#5), the facility's nursing services failed to ensure staff administered client #5's medications as ordered by the physician.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 3 non-sampled clients living in the group home (#5), the facility's nursing services failed to ensure staff administered client #5's medications as ordered by the physician.</p> <p>Findings include:</p> <p>On 12/8/15 at 12:33 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 10/1/15 at 12:34 PM, the Bureau of Developmental Disabilities Services (BDDS) incident report, dated 10/2/15, indicated, in part, "[Name of pharmacy]</p>	W 0331	<p>Program nurse will review Medication Administration records and medications weekly to ensure that correct dosages are given and available. Program Nurse will review this documentation with Area Director weekly. Staff will be trained on medication administration procedure. Observations will be conducted 6 times per week for 2 months to include all med passes and that all staff are observed administering medications to ensure that medication passes are administered correctly. The documentation of these observations will be turned into the Program Director for follow up and corrective action. Area Director will review weekly with Program Director to ensure completion. Responsible party:</p>	01/13/2016			

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	<p>dc'd (discontinued) [client #5's] Acyclovir (for pancytopenia - deficiency of all three cellular components of the blood (red cells, white cells and platelets)) instead of Alendronate Sodium (bone loss). Acyclovir was not in September 2015 cycle fill. Staff failed to correctly check in medications and follow the agency medication administration policy. From September 5, 2015 until September 30, 2015 [client #5] failed to receive Acyclovir due to not being in the packet. Doctor has been notified of this medication error. [Client #5] will continue to be monitored for health and safety. Staff will be retrained on 10/6/15 on medication administration. Medication administration observations will be completed two times a week for 60 days, after having been retrained, to ensure staff are compliant with our medication administration policy."</p> <p>The 10/7/15 Investigation Summary indicated in the Factual Findings section, "[Nurse] reported that she had received a phone call from [pharmacist's name] at [name of pharmacy] to report that [client #5's] Acyclovir had been dc'd instead of his Alendronate Sodium. [Nurse] reported that [pharmacist] had found this when completing her pharmacy audit in the home. [Nurse] reported that staff had signed that the medication had been</p>		<p>Program Nurse, Program Coordinator, Program Director and Area Director Date of completion:1/13/2016</p>		

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	<p>given but it was not in the packages to be given. [Nurse] reported that this happened during the period of 9/5/15 - 9/30/15." The Conclusion of the investigation indicated, "Evidence supports staff did not follow med administration procedures." The Recommendations section indicated, "All staff were retrained on 10/6/15 on Mentor's med administration policy and procedure and checking meds in. Staff administering meds during the time of the incident will be given a record of discussion. Med observations, 2 times a week, for 60 days will be completed."</p> <p>The facility failed to implement appropriate corrective action to address the systemic issue of seven staff documenting a medication as administered when the medication was not in the home to administer. The facility failed to conduct observations of all the staff who was involved.</p> <p>On 12/10/15 at 12:33 PM, a review of client #5's 10/13/15 Physician's Orders indicated client #5 was prescribed Acyclovir 400 milligrams twice a day for pancytopenia.</p> <p>On 12/9/15 at 4:48 PM, the Program Director (PD) sent an email with Records of Discussion indicating the following for</p>			

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	<p>staff #1, #2, #3, #8, #9, #11 and #12: "Reason for discussion: Failed to follow Mentor's Medication Administration Procedures and failed to follow proper medication check in procedure. Background information: Has previous training on proper medication administration procedure and proper medication check in procedure."</p> <p>On 12/9/15 at 4:48 PM, the PD sent an email with the medication administration observations conducted with the staff. Staff #1 was observed to pass medications two times. Staff #3 was observed to pass medications four times. Staff #8 was observed to pass medications three times. Staff #9 was observed to pass medications four times. Staff #5, #11 and #12 were not observed to pass medications.</p> <p>On 12/9/15 at 11:23 AM, the nurse indicated the staff initialed the medication administration record (MAR) as having administered the medication and the medication was not in the home to administer. The nurse indicated the staff was not doing checks of medications with the MAR prior to administering the medications. The nurse indicated the facility discovered the issue when the pharmacist was conducting her quarterly review. The nurse indicated the</p>			

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	<p>medication was not discontinued by the physician. The nurse indicated the staff told her they thought the medication was discontinued but continued to initial the MAR as administering the medication. The nurse indicated she retrained staff on how to check medications into the home when dropped off by the pharmacy. The nurse stated she went over the medication administration policy and procedures "once again." The nurse indicated the facility was conducting pop in medication observations. The nurse indicated the staff should implement the medication administration policy and procedure.</p> <p>On 12/10/15 at 3:29 PM, the PD indicated the nurse, a Program Coordinator from another home and the PD conducted the medication pass observations at the group home following client #5's missed medication from 9/5/15 to 9/30/15. The PD initially indicated supervising two medication passes a week was sufficient. The PD stated the facility should have monitored the staff daily for "at least two to three weeks" until the staff was competently trained on medication administration. The PD indicated staff #11 and #12 were not monitored during medication pass due to working PRN (as needed). The PD indicated the staff who was involved with signing the MAR as administering client</p>			

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	<p>#5 his medication when the medication was not in the home should have been monitored. The PD stated the facility "should have planned it (the monitoring of staff) better."</p> <p>2) On 12/3/15 at 7:00 AM, the BDDS incident report, dated 12/4/15, indicated, in part, "[Staff #8] contacted [name], Program Coordinator and [name], Program Nurse, to report that [client #5] had been given another clients (sic) medications. [Client #5] was taken to the [name of emergency room] where he was checked out. [Client #5's] vitals were taken and his vitals were within normal ranges. [Client #5] was released to go home and rest as the medications would make him drowsy. [Client #5] was instructed to hold some of his medications for the evening and to resume all his medications on 12/4/15. Program Nurse instructed staff at the group home to take [client #5's] blood pressure and pulse in the evening of 12/3/15 and the morning of 12/4/15 and report back to the nurse. [Name], Program Nurse, contacted PD (Program Director), [name] with each reading and each reading fell within normal ranges. [Staff #8] has been suspended from passing medications until she is retrained on proper medication procedures. [Client #5] will continue to be monitored for</p>			

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	<p>health and safety."</p> <p>The 12/9/15 Investigation Summary indicated staff #8 reported she put client #5 and client #6's medication in cups and put their initials on the cups. Staff #8 reported she took client #5's medications to him in the living room. Staff #8 indicated after administering client #6's medications to client #5, she contacted the Program Coordinator, Program Director and the nurse. Staff #8 indicated the clients' medications were supposed to be administered one at a time and she was not supposed to prepare medications ahead of time. The Conclusion of the investigation indicated, "Evidence supports staff did not intervene appropriately. Evidence supports staff did not follow med administration procedures." The Recommendations section indicated, "[Staff #8] has been suspended from med administration until she is able to be retrained on med administration. [Staff #8] will be given corrective action for not follow (sic) agency med administration policy."</p> <p>The facility's nursing services failed to ensure staff administered client #5's medications according to his physician's orders.</p> <p>On 12/9/15 at 11:23 AM, the nurse</p>			

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W 0368 Bldg. 00	<p>indicated the staff should implement the facility's medication policy and administer the client's medications as ordered.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 1 of 3 non-sampled clients (#5), the facility failed to ensure client #5's medications were administered as ordered by the physician.</p> <p>Findings include:</p> <p>On 12/8/15 at 12:33 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 10/1/15 at 12:34 PM, the Bureau of Developmental Disabilities Services (BDDS) incident report, dated 10/2/15, indicated, in part, "[Name of pharmacy] dc'd (discontinued) [client #5's] Acyclovir (for pancytopenia - deficiency of all three cellular components of the blood (red cells, white cells and</p>	W 0368	<p>Program nurse will review Medication Administration records and medications weekly to ensure that correct dosages are given and available. Program Nurse will review this documentation with Area Director weekly. Staff will be trained on medication administration procedure. Observations will be conducted 6 times per week for 2 months to include all med passes and that all staff are observed administering medications to ensure that medication passes are administered correctly. The documentation of these observations will be turned into the Program Director for follow up and corrective action. Area Director will review weekly with Program Director to ensure completion. Responsible party: Program Nurse, Program Coordinator, Program Director and Area Director Date of completion:1/13/2016</p>	01/13/2016

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	<p>platelets)) instead of Alendronate Sodium (bone loss). Acyclovir was not in September 2015 cycle fill. Staff failed to correctly check in medications and follow the agency medication administration policy. From September 5, 2015 until September 30, 2015 [client #5] failed to receive Acyclovir due to not being in the packet. Doctor has been notified of this medication error. [Client #5] will continue to be monitored for health and safety. Staff will be retrained on 10/6/15 on medication administration. Medication administration observations will be completed two times a week for 60 days, after having been retrained, to ensure staff are compliant with our medication administration policy."</p> <p>2) On 12/3/15 at 7:00 AM, the BDDS incident report, dated 12/4/15, indicated, in part, "[Staff #8] contacted [name], Program Coordinator and [name], Program Nurse, to report that [client #5] had been given another clients (sic) medications. [Client #5] was taken to the [name of emergency room] where he was checked out. [Client #5's] vitals were taken and his vitals were within normal ranges. [Client #5] was released to go home and rest as the medications would make him drowsy. [Client #5] was instructed to hold some of his medications for the evening and to</p>				

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	<p>resume all his medications on 12/4/15. Program Nurse instructed staff at the group home to take [client #5's] blood pressure and pulse in the evening of 12/3/15 and the morning of 12/4/15 and report back to the nurse. [Name], Program Nurse, contacted PD (Program Director), [name] with each reading and each reading fell within normal ranges. [Staff #8] has been suspended from passing medications until she is retrained on proper medication procedures. [Client #5] will continue to be monitored for health and safety."</p> <p>On 12/9/15 at 11:23 AM, the nurse indicated the staff should implement the facility's medication policy and administer the client's medications as ordered.</p> <p>9-3-6(a)</p>						
W 0426 Bldg. 00	<p>483.470(d)(3) CLIENT BATHROOMS</p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>Based on observation, interview and record review for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6</p>	W 0426	Staff will receive training on completing water temperature log sheet and reporting information to Program Coordinator. Program	01/13/2016			

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	<p>and #7), the facility failed to ensure the water temperature did not exceed 110 degrees Fahrenheit.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 12/8/15 from 3:44 PM to 6:02 PM. At 4:34 PM, the kitchen sink and downstairs bathroom shower/tub water temperature was 132 degrees Fahrenheit.</p> <p>An observation was conducted at the group home on 12/9/15 from 6:19 AM to 7:36 AM. At 7:20 AM, the kitchen sink and downstairs bathroom shower/tub water temperature was 120 degrees Fahrenheit.</p> <p>On 12/8/15 at 4:34 PM, the Program Director (PD) indicated the water temperature should be less than 110 degrees Fahrenheit.</p> <p>On 12/8/15 at 4:56 PM, staff #1 indicated clients #1, #2, #3, #4, #5, #6 and #7 could adjust the water temperature independently.</p> <p>On 12/8/15 at 5:01 PM, client #2 indicated, at times, the water temperature was too hot. Client #2 indicated he turned the hot water down when it was</p>		<p>Coordinator will review water temperature weekly to ensure information has been accurately reported. Program Director will also review log weekly to ensure accurate reporting and that corrective is taken if needed. Responsible party: Program Coordinator, Program Director and Area Director Date of completion:1/13/2016</p>				

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	<p>too hot.</p> <p>On 12/8/15 at 5:01 PM, client #4 indicated the water temperature was too hot, at times. Client #4 indicated he could adjust the water temperature.</p> <p>On 12/8/15 at 4:35 PM, a review of the Water Temperature documentation was conducted. From 8/16/15 to 9/30/15, the water temperature was recorded consistently as 120 degrees Fahrenheit in the kitchen sink, and two bathrooms (including the sink and shower/tubs). There was no documentation the group home tested the water temperature from 10/1/15 to 11/30/15. The 12/1/15 to 12/7/15 Water Temperature form indicated the water temperatures were consistently 120 degrees Fahrenheit. On 12/6/15, the kitchen and bathroom sinks temperature were 125 degrees Fahrenheit and the shower/tubs were documented as 122 degrees Fahrenheit. On 12/7/15, the kitchen sink temperature was 132 degrees Fahrenheit. The laundry room and bathrooms were documented as 125 degrees Fahrenheit. The form indicated at the bottom, "If the water temperature exceeds 110 degrees Fahrenheit, it needs to be adjusted. If it cannot be immediately adjusted, staff must directly supervise all individuals who cannot independently adjust water temperature.</p>						

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	<p>Notify your supervisor immediately if temperature exceeds 120 degrees Fahrenheit. The supervisor will ensure that water temperature is adjusted."</p> <p>There was no documentation the staff adjusted the water temperature. There was no documentation the supervisor was notified. There was no documentation the supervisor ensured the water temperature was adjusted.</p> <p>On 12/9/15 at 1:33 PM, the PD indicated the water temperature should not exceed 110 degrees Fahrenheit. The PD indicated she did not review the Water Temperature documentation. The PD stated there "needs to be a better monitoring system." The PD indicated the staff should follow the directions on the form.</p> <p>On 12/9/15 at 1:33 PM, the Program Coordinator (PC) indicated the water temperature should not exceed 110 degrees Fahrenheit. The PC indicated she did not review the form. The PC indicated the staff complete the form and the form remains in a binder at the group home.</p> <p>9-3-7(a)</p>			

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W 0475 Bldg. 00	<p>483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils.</p> <p>Based on observation and interview for 6 of 7 clients living in the group home (#1, #2, #4, #5, #6 and #7), the facility failed to ensure the clients were provided knives during dinner.</p> <p>Findings include:</p> <p>On 12/8/15 from 3:44 PM to 6:02 PM, an observation was conducted at the group home. At 5:03 PM, dinner started. Clients #1, #2, #4, #5, #6 and #7 were not provided knives to cut the ham slices. Clients #1, #2, #4, #5 and #7 picked up the ham slices with their fingers to take bites. At 5:15 PM, client #6 stuck the whole slice of ham into his mouth. On 12/8/15 at 5:15 PM, the Program Director (PD) indicated to staff #1, #3 and #6 that client #6's meat needed to be cut up in the future. The PD indicated there were no knives on the table. None of the clients was provided knives during the meal.</p> <p>On 12/9/15 at 1:36 PM, the Program Director (PD) indicated knives should have been provided during the meal to the clients. The PD indicated she should have asked the clients or staff to get knives when she noticed it during the</p>	W 0475	Staff will receive training on ensuring appropriate utensils are available during meal times. Observations will be conducted 3 times a week for a month to ensure utensils are available for client use. These observations will be reviewed by Program Coordinator and Program Director. Responsible party: Program Coordinator, Program Director and Area Director Date of completion:1/13/2016	01/13/2016

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W 9999 Bldg. 00	meal. On 12/9/15 at 1:37 PM, the PC indicated knives should have been provided to the clients. 9-3-8(a) State Findings The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: 460 IAC 9-3-1(a) Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 14. A significant injury to an individual that includes but is not limited to: g. any injury requiring more than first aid; h. any puncture wound penetrating the skin, including human or animal bites. This state rule was not met as evidenced by:	W 9999	Staff will be trained on reporting all reportable incidents to supervisor or on call. Program Director will be trained on reportable incidents. Responsible party: Program Coordinator, Program Director and Area Director Date of completion:1/13/2016	01/13/2016	

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	<p>Based on record review and interview for 1 of 14 incident/investigative reports reviewed affecting client #3, the facility failed to submit an incident report to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours of an incident in which a fish hook went into client #3's skin, requiring a visit to his primary care physician, in accordance with state law.</p> <p>Findings include:</p> <p>On 12/9/15 at 12:19 PM, a review of client #3's record was conducted. An Indiana Mentor/TSI Medical Appointment Form, dated 11/6/15, indicated, "Reason for visit: look at where fish hook went into skin on foot as [client #3] is diabetic." The results section indicated, "foot looks fine - no further treatment needed. Tdap (tetanus, diphtheria and pertussis shot) given today."</p> <p>On 12/8/15 at 12:33 PM, a review of the facility's incident reports was conducted. There was no documentation the facility reported client #3's incident to BDDS.</p> <p>On 12/9/15 at 1:47 PM, the Program Director (PD) indicated she did not recall the incident. The PD indicated the</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G300	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 12/14/2015
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 W PIKE ST MARTINSVILLE, IN 46151		
(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	
	incident should have been reported to BDDS. 9-3-1(b)				