STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	2715 ROCKFORD LN KOKOMO, IN 46902

(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
W000000	This visit was for a recertification and state licensure survey. This visit included the investigations of complaint #IN00148709 and complaint #IN00149476. Complaint #IN00148709: SUBSTANTIATED, Federal and state deficiency related to the allegation was cited at W407. Complaint #IN00149476: SUBSTANTIATED, Federal and State deficiencies related to the allegation were cited at W149, W192, W318, and W331. Dates of Survey: 5/27, 5/28, 5/29, 5/30, 6/2, 6/3, and 6/6/2014. Provider Number: 15G282 AIM Number: 100243610 Facility Number: 000802 Surveyor: Susan Eakright, QIDP The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/16/14 by Ruth Shackelford, QIDP.	W000000		

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

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

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W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, for 2 of 4 sampled clients (clients A and B), the governing body failed to exercise operating direction over the facility to complete maintenance and repairs for clients A and B's stained carpet. Findings include: On 5/27/14 from 3:15pm until 5:05pm, and on 5/28/14 from 5:55am until 7:55am, client A and B's shared bedroom carpet was observed to have stains and dark spots throughout the room. On 5/28/14 at 6:00am, Group Home Staff #1 stated the carpet looked "dirty" and "dingy." On 5/29/14 at 11:00am, an interview was conducted with the Residential Manager (RM). The RM stated client A and B's shared bedroom carpet was "dirty" and needed to be cleaned. On 6/6/14 at 9:00am, an interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted. The PD/QIDP indicated client A and B's	W000104	Indiana Mentor has policies and procedures in place in regards to facility maintenance and operations. The DSP's, house manager, and program directors are trained on facility practices and cleanliness in the homes. The agency also has on staff a maintenance man who helps facilitates needed repairs to house items. The agency has contacted and scheduled a carpet cleaning agency to clean the affected carpets. The staff have been retrained on program maintenance and cleanliness. Part of training included when to contact maintenance to report needed facility repairs. On going routine carpet cleaning has been scheduled for preventive maintenance and cleanliness in the home. Area checks for the house have been added to the checklists for the home manager and program director which will be turned into and reviewed by the area director. Responsible Party: Home Manager and Program Director Complete Date: 7/5/2014	07/05/2014

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	shared bedroom carpet needed to be cleaned. 9-3-1(a)			
W000125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review, and interview, the facility failed to obtain consent for 1 of 4 sampled clients (client C) regarding locked sharps and utensils. The facility failed to ensure consent for locked sharps and unimpeded access to sharps for 3 of 4 sampled clients (clients A, B, and D) and 4 additional clients (clients E, F, G, and H) who did not require restricted access to sharps and utensils. Findings include: On 5/27/14 from 3:15pm until 5:05pm, and on 5/28/14 from 5:55am until 7:55am, clients A, B, C, D, E, F, G, and H were observed at the group home. During both observation periods GHS (Group Home Staff) #1, #2, #3, and the Residential Manager (RM) had the key	W000125	All staff at Indiana Mentor are trained on clients rights upon hire and annually there after. Indiana Mentor also has policies in procedures in place in restrictions to client's right which include HRC consents and approvals. The QMRP are trained on obtaining these consents prior to restrictions going in place. The QMRP and Home Manager completed assessments for all clients for the locks. The Area Director put the completed formal assessments in each clients files and the QMRP developed formal goals for clients who could not successfully manage the locks. The QMRP sent out a revised HRC request and guardian approval to all members and received approval for the necessary restrictions. The agency has revised the HRC form to provide better clarity and accuracy for requests. Manager	07/05/2014

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	secured on their person for the locked sharps container kept on the counter in the kitchen. On 5/27/14 from 3:15pm until 5:05pm, clients C and D were prompted by GHS #4 to assist with cooking in the kitchen. GHS #4 accessed the locked sharps container on the kitchen counter, removed a knife, and GHS #4 cut vegetables and opened packages of hamburger. From 3:30pm until 4:05pm, GHS #4 washed the knife and replaced it each time into the secured sharps container on the kitchen counter. From 3:15pm until 4:40pm, clients C and D stirred pots on the stove, client B made macaroni and cheese on the stove, and client D flipped hamburgers on an electric grill on the kitchen counter. Clients C and D were not prompted or taught to use a knife to cut or prepare foods. On 5/27/14 at 4:40pm, the RM indicated the facility had locked sharps and knives because of client C's continued threats of harm toward staff and other clients. The RM indicated clients A, B, D, E, F, G, and H did not have access to locked sharps and were not taught how or when to access locked sharps. On 6/6/14 at 9:00am, an interview with the PD/QIDP (Program		had training on use of form and to ensuring assessments completed for each individual prior to household restrictions being put in place. QMRP is sending future HRC requests and as needed assessments to Area Director prior to implementation. Responsible Party: QMRP Completion Date: 7/5/2014	

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	Director/Qualified Intellectual Disabilities Professional) was conducted. The PD/QIDP indicated the practice of locked sharp objects was not addressed in the clients' plans. The PD/QIDP indicated client C had a history of misusing sharp objects. The PD/QIDP indicated clients A, B, D, E, F, G, and H did not have identified needs for the locked sharp objects and that sharps were restricted for the clients who lived in the group home. The PD/QIDP indicated the practice of locked sharp objects was not addressed in client A, B, D, E, F, G, and H's plans. The QIDP indicated clients A, B, C, D, E, F, G, and H would need to gain access to the sharps via staff. On 5/29/14 at 12:45pm, client C's 11/2013 BSP (Behavior Support Plan) and 7/2/13 ISP (Individual Support Plan) indicated client C's behaviors included SIB (Self Injurious Behavior), aggressive outburst (physical aggression and verbal aggression), Story Telling/False accusations, Inappropriate Sexual Comments, Inappropriate Sexual Behavior, Refusals to complete daily hygiene and tasks, Vacating (leaving a specific environment, and Suicidal Threats/attempt. Client C's 7/2/2013 Comprehensive Functional Assessment did not indicate the identified need for locked sharps at the group home. Client			

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	C's BSP did not indicate the need for locked sharps at the group home. Client C's record did not indicate consent for locked sharps. Client C's plans failed to include an objective/goal to teach her responsible methods to utilize locked sharp objects. Client A's record was reviewed on 5/29/14 at 11:30am. Client A's 10/15/13 ISP (Individual Support Plan) and 10/13 Comprehensive Functional Assessment (CFA) did not indicate an identified need to lock sharp objects. Client A's record did not indicate consent for locked sharps. Client B's record was reviewed on 5/29/14 at 12noon. Client B's 10/18/13 ISP and 10/2013 CFA did not indicate an identified need to lock sharp objects. Client B's record did not indicate consent for locked sharps. Client D's record was reviewed on 5/29/14 at 1:45pm. Client D's 9/10/13 ISP and 9/2013 CFA did not indicate an identified need to lock sharp objects. Client D's record did not indicate consent for locked sharps. 9-3-2(a)			

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W000137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation, interview, and record review, for 1 additional client (client F), the facility failed to ensure client F had direct access to her own clothing. Findings include: On 5/27/14 from 3:15pm until 5:05pm, and on 5/28/14 from 5:55am until 7:55am, client F's personal clothing was kept inside the medication room/office/laundry area of the group home. During both observation periods clients A, B, C, D, E, F, G, and H had access to client F's personal clothing and chest of drawers kept inside the medication room/office/laundry area and client F was not encouraged to access her personal belongings. On 5/28/14 at 5:55am, Group Home Staff (GHS) #1 stated client F's clothing and chest of drawers "were kept" inside the secured medication room/office/laundry area.	W000137	All staff are trained on clients rights and responsibilities upon hire and annually thereafter. Staff are given a list of examples of clients rights which is gone through with them. Management is trained on restrictions to these rights need to have prior HRC approval prior to implementation. The clothes that were kept in the laundry room were returned to storage in clients F room. Staff have been retrained on clients rights and responsibilities including storing possessions. Management has been retrained on client restrictions and on going need Area Director approval along with HRC approval prior to implementing any restrictions. When Area Director conducts house checks he will check to ensure improper restrictions or rights violations are not in place Responsible Party: QMRP Completion Date: 7/5/2014	07/05/2014

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	GHS #1 indicated he selected client F's clothing. GHS #1 selected a pair of slacks, underwear, and a top from the secured clothing, and GHS #1 took the selected clothing to client F's bedroom. Client F's record was reviewed on 6/2/14 at 8am. Client F's record indicated a 5/2014 ISP (Individual Support Plan) and 5/2014 BSP (Behavior Support Plan) and both plans did not indicate a reason for client F's secured clothing. On 6/6/14 at 9:00am, an interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted. The PD/QIDP indicated client F's plans did not include a reason for her secured clothing inside the medication room/office/laundry area. The PD/QIDP indicated clients A, B, C, D, E, F, G, and H along with facility staff had access to client F's clothing and chest of drawers inside the secured medication room/office/ laundry room. The PD/QIDP stated client F had a history of tearing up her clothing "a few years ago" and indicated she was unsure if client F			

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	still had the behavior. 9-3-2(a)			
W000149	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 observation, record review, and interview, for 2 of 4 sampled clients (clients A and B), the facility neglected to implement their policy and procedure to prevent abuse, neglect, and/or mistreatment to provide nursing services according to client A and B's identified medical needs. Findings include: 1. On 5/27/14 from 3:15pm until 5:05pm, and on 5/28/14 from 5:55am until 7:55am, client A was observed to have her right arm in a sling. Client A was assisted to stand and/or to walk by Group Home Staff (GHS) #1, GHS #2, GHS #3, and the Residential Manager (RM) by the staff person pulling client A up by her left arm, pulling client A up by the waist band of client A's slacks, assisting client A to walk by grasping client A's left arm with their hand, and/or walking beside client A. During both observation periods client A did not use a	W000149	Indiana Mentor has policies and procedures in place in regards to abuse and neglect and healthcare coordination for individuals. These policies and procedures are trained upon hire and annually thereafter. All staff are being retrained on the abuse/neglect policy. Staff are being trained on signs and treatment for wound, side effect monitoring, and skin integrity. The nursing supervisor has retrained the nurse on reviewing physician orders and mars, discharge consulting and staff training, client assessments, and follow ups. IDT has followed up with guardian for client A who has agreed to bed railing. Nurse has revised protocols for clients A and trained staff on those protocols which includes seizures, falls, ambulation and transfers, and wound care and for client B would the staff have been trained on the skin integrity protocol. For next 6 months management (home manager, qmrp, area director, or nursing) has been trained to monitor serfs for accuracy 3x a	07/05/2014

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	walker and wore a seizure helmet that moved on her head (was not secured in place) and the helmet had three separate tears in the protective foam held together with tape. During both observation periods client A swayed back and forth when she walked with the facility staff and client A was repeatedly unsteady with each step she took while walking. Client A wore a sling with her right arm and wrist which hung lower than her waist and client A's arm was not positioned into place. During both observation periods client A's right wrist, lower right arm, and fingers were swollen, bluish/white in color, and client A stated during both observations her fingers and wrist were "tight" feeling. On 5/27/14 at 1:40pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 09/01/2013 through 05/27/14 for client A. -A 5/23/14 BDDS report for an incident on 5/23/14 at 2:00pm indicated client A was admitted to the hospital for surgery and "due to the orthopedic surgeon deciding to do surgery on her broken right humerus." -A 5/17/14 BDDS report for an incident		month. After six months this will be checked on every month to ensure proper completion. Nurse and management have additionally been trained on discharge and follow up procedures including revising protocols and staff training for clients with medical concerns. A system has been put in place to track staff training for new medical concerns and these trainings will be sent to the Area Director to be reviewed and filed to ensure medical compliance. The Program Director will note medical changes and concerns in their monthly summary as well. A person of management will also conduct pop ins on staff 6x month for the next 6 months to ensure procedures being implemented properly.A person of management will also conduct pop ins on staff 6x month for the next 6 months to ensure procedures being implemented properly. Responsible Party: Nurse, QMRP Complete Date: 7/5/2014	

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	on 5/17/14 at 6:30am indicated client A "woke up and staff noticed that she was wincing when moving her right arm." The report indicated at 7:00am, client A "was getting dressed and attempting to move her arm and she started complaining that it hurt." The report indicated client A was taken to the Emergency Room (ER) later that morning and client A "told staff, her mom, and the ER Doctor that she had a seizure and had fallen out of bed during the night and got back into bed and went to sleep." The report indicated the ER indicated client A's "Right Humerus is broken, they put it in a sling, and said for staff to call the Orthopedic surgeon on Monday to make an appt. (appointment). The ER Doctor said for that kind of break they just keep it in a sling and let gravity realign the break." -A 5/9/14 BDDS report for an incident on 5/8/14 at 11:30am indicated client A was "walking through the cafeteria when she fell. [Client A] fell backwards due to having a seizure," the Residential Manager (RM) was present and "swiped [client A's] VNS (Vagus Nerve Stimulator- a magnetic device to control the seizure)," and client A sustained a bruise on the outside of her right upper knee "about 2 inches" long and "1 1/2 inches wide."			

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	-A 9/21/13 BDDS report for an incident on 9/20/13 at 9:35pm indicated client A "was in bed and went to get up to use the restroom and slipped, sliding down the side of her bed hitting her head on the end of the bed." Client A's records were reviewed on 5/29/14 at 11:30am. Client A's records indicated she returned home from the hospital on Sunday 5/25/14 after surgery to repair her "fractured right Humerus (arm)." Client A's records included the following: -Client A's record included an undated "Seizure Protocol" which indicated what staff were to do once client A had a seizure. The seizure protocol did not indicate safety information for how staff were to prevent possible injuries during a seizure. Client A's seizure plan did not include the use of her seizure helmet or her VNS magnet. Client A's seizure plan did not include her night time safety. -Client A's record included an undated "Fall Protocol" which indicated client A "has seizures that could cause a fall that could result in an injury. At times walks to (sic) fast and leans slightly forward. She needs to be reminded to slow down. She has a walker with brakes with rollers			

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	on the front, tennis balls on the back to help slow her down. Walker also has a seat so if she gets tired she can sit." Client A's Fall Protocol had not been updated to address client A's falls out of bed and did not include how staff were to prevent falls since client A's right arm fracture after she was unable to use her walker to prevent falls. -Client A's 2/4/2013 "Balance Assessment for PT (Physical Therapy)" indicated "Please get a rolling walker for pt. (patient) with 2 wheels...." Client A's balance assessment did not include client A changing positions from the seated position to standing position and/or her night time positions of sitting, standing, and/or laying in bed. -Client A's records indicated a 5/29/13 "Clinic Interim Review" from her physician which indicated client A had the potential for "falls and unsteadiness" since 5/29/13. -Client A's 10/15/2013 "Annual Healthcare Assessment" indicated she had seizure activity, used a "Vagel (sic) Nerve Stimulator to stop seizures 1-5 seizures per week," and "wears a helmet at all times while up." -Client A's records indicated the			

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	following falls in which no BDDS reports were generated: -On 4/3/14 at 5:45am, fell after laying down and "a small cut 1/8 inch long, L (Left) eyebrow." -On 1/12/14 at no time documented, was "brushing teeth, unsteady" fell during a seizure in the bathroom. -On 5/22/13 at no time documented, client A fell, cut her right elbow open, and had her right elbow wound "glued" closed at the ER. -Client A's 5/22/13 "ER Visit for Busted L (Left) elbow," indicated client A had suffered a cut to her left elbow. -Client A's undated "Medical Appointment Form" from the home healthcare agency indicated "Add protein to faster healing. Boost ensure good for this...Change dressing daily, clean with saline, pat dry, apply dry gauze, and a BDs (Band-Aid) tape in place (sic). Notify doctor for signs increased redness, drainage, swelling, pain, Signs of infection (sic)." On 5/29/14 at 10:54am, an interview with the facility's LPN and the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted. The LPN indicated client A's nursing plans had not been updated since her fall,			

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	hospitalization, surgery, and 5/25/14 (Sunday) return from the hospitalization for her right arm fracture. The LPN indicated client A had a history of falls with injuries from her bed, when client A walked, and from a seated position. The LPN indicated client A's nursing plans did not indicate the proper position the staff were to use for client A's right arm and sling, what signs and symptoms staff were to watch for regarding client A's fracture and surgery, the care and treatment for client A's injury, and how staff were to assist client A to walk, sit, and/or stand. The LPN and the PD/QIDP indicated the facility neglected to update client A's plans and neglected to train the facility staff on client A's identified nursing needs. The PD/QIDP and the LPN both indicated no documented staff training for client A's nursing needs was available for review. 2. On 5/27/14 from 3:15pm until 5:05pm, and on 5/28/14 from 5:55am until 7:55am, client B was observed to have a boot on her left foot and heel with a plastic bag wrapped inside the boot between client B's skin of her left foot and the protective boot. Client B sat in a wheel chair. On 5/28/14 at 7:15am, GHS (Group Home Staff) #1 wheeled client B's wheel chair into the front room of the home. GHS #1 tilted client B's wheel			

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	chair backwards to elevate client B's left foot. At 7:15am, GHS #1 removed client B's protective boot and indicated client B had an open sore to the bottom of client B's left foot. GHS #1 removed a baggie which had been sealed around client B's foot. Upon removal of the protective boot, the baggie contained bloody fluid in the baggie which continued to drip from the gauze dressing partially taped to client B's left foot. GHS #1 stated client B's open draining sore was "red" and "weepy" with drainage. GHS #1 stated there was a "two inch (2") white area of skin around the "half (1/2) dollar size" open draining skin area. GHS #1 stated "It's (the dressing and gauze) changed twice a day. It's changed to me since yesterday, maybe bigger" and stated "It (client B's wound) looked worse." GHS #1 applied client B's treatment of a barrier cream to "remove moisture" to client B's wound, applied a plastic wrap over a four by four inch gauze pad, and reapplied her protective boot. GHS #1 stated the staff used the plastic wrap over client B's wound to "keep [client B's] clothing clean, her bed sheets clean, and the protective boot clean." GHS #1 indicated he had not received training specific to client B's identified nursing needs for her wound care. GHS #1 indicated he needed to call the nurse later to tell her about client B's wound			

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	changing. On 5/29/14 at 9:45am, client B was observed at the workshop and had a protective boot on her left foot. At 9:45am, an interview with the workshop Registered Nurse (RN) was conducted. The RN indicated she assisted client B with toileting and changing at the workshop during work hours. The RN indicated client B needed to be changed because of soiling her clothing on 5/7/14 and the open draining sore was noticed on client B's left heel at that time. The RN indicated she immediately contacted the group home. Client B's records were reviewed on 5/29/14 at 12:00noon. Client B's record included an undated "Impaired Skin Integrity Protocol" which indicated client B's skin was to be monitored for "Disruption of skin surface and may include discoloration, open wound, drainage, and itching pain and/or decreased sensation...checked daily with bath, clothing change, and toileting." Client B's record did not indicate an updated plan to include the treatment of her 5/7/14 open/draining wound on her left foot. Client B's record indicated diagnoses which included but were not limited to: Cerebral Palsy and Muscle Spasticity. Client B's "Skin Assessment			

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	Checklist" indicated the following: "Side Effect Recording Form" to be completed by the 10th of each month" on 5/10/14, 4/10/14, 3/12/14, 2/7/14, 1/8/14, 12/10/13, 11/7/13, 10/3/13, 9/10/13, and 8/4/13 which did not indicate client B had an open draining wound on her left foot. Client B's 5/10/14, 4/10/14, and 3/12/14 "Skin Assessment Checklist" did not indicate client B had an open draining wound on her left foot. On 5/29/14 at 10:54am, an interview with the facility's LPN and the PD/QIDP was conducted. The LPN indicated client B's nursing plans had not been updated since her open sore developed. The LPN stated she had not seen client B's open sore until "today." The LPN indicated client B went to her physician after the open sore was noticed by the workshop on 5/7/14. The LPN stated "No" when asked if client B's records indicated an open/draining sore on her left heel before the workshop notified the group home on 5/7/14. The LPN stated she was unaware of "any" skin issue with client B before the 5/7/14 notification. The LPN indicated there was not documented staff training for providing client B with skin treatment to her open draining sore. The LPN indicated client B did have a history of open areas on her skin. The LPN indicated client B's open wound should			

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	not have been covered with a plastic bag/wrap. The LPN indicated the plastic would have sealed in the moisture of the wound to keep the wound moist and client B's treatment cream was a barrier cream to dry the wound to promote healing. The LPN indicated client B's nursing plans did not indicate the proper positioning of client B's protective boot, what signs and symptoms staff were to watch for regarding client B's open area, and the care and treatment for client B's open draining sore. The LPN and the PD/QIDP indicated the facility neglected to update client B's plans and neglected to train the facility staff on client B's identified nursing needs. The PD/QIDP and the LPN both indicated no documented staff training for client B's nursing needs was available for review. The PD/QIDP indicated the facility followed the BDDS reportable guidelines for incidents and the definitions of abuse, neglect, and/or mistreatment. On 5/27/14 at 1:30pm, a review of the 4/2011 "Quality and Risk Management" policy and procedure was conducted. The policy and procedure indicated the facility prohibited abuse, neglect, and/or mistreatment of clients. The policy and procedure indicated the facility followed the BDDS reportable policy and procedures. The policy and procedure			

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	indicated the facility "seeks to protect individuals receiving Indiana Mentor services through oversight of management and procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating, and reducing the risk to which individuals are exposed." The policy and procedure indicated "g. Failure to provide food and medical services as needed. 4. j. A Significant injury to an individual including...5.) Any occurrence of skin breakdown related to a decubitus ulcer regardless of severity...p. Inadequate staff support for an individual, including inadequate supervision, with the potential for: 1) significant harm or injury to an individual...." On 5/27/14 at 1:40pm, a record review was completed of the 6/11/2002 BDDS "Incident Reporting" policy and procedure which indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...." This federal tag relates to complaint #IN00149476. 9-3-2(a)			

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W000192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients A and B), the facility failed to ensure staff displayed knowledge and competence related to client A and B's identified medical needs. Findings include: 1. On 5/27/14 from 3:15pm until 5:05pm, and on 5/28/14 from 5:55am until 7:55am, client A was observed to have her right arm in a sling. Client A was assisted to stand and/or to walk by Group Home Staff (GHS) #1, GHS #2, GHS #3, and the Residential Manager (RM) by the staff person pulling client A up by her left arm, pulling client A up by the waist band of client A's slacks, assisting client A to walk by grasping client A's left arm with their hand, and/or walking beside client A. During both observation periods client A did not use a walker and wore a seizure helmet that moved on her head (was not secured in place) and the helmet had three separate tears in the protective foam held together with tape. During both observation periods client A swayed back and forth	W000192	Indiana Mentor has policies and procedures in place in regards to healthcare coordination for individuals. These policies and procedures are trained upon hire and annually thereafter. Additionally prior to working in homes staff must go through client specific training on each individual in the home to ensure they are knowledgeable on all aspects of the client. Staff are being trained on signs and treatment for wound, side effect monitoring, and skin integrity. The nursing supervisor has retrained the nurse on reviewing physician orders and mars, discharge consulting and staff training, client assessments, and follow ups. IDT has followed up with guardian for client A who has agreed to bed railing. Nurse has revised protocols for clients A and staff have been trained on seizures, falls, ambulation and transfers, and wound care and for client B staff have been trained on the skin integrity protocol. Nurse and management have been trained on discharge and follow up procedures including revising protocols and staff training for clients with medical concerns. A system has been put in place to track staff	07/05/2014

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	when she walked with the facility staff and client A was repeatedly unsteady with each step she took while walking. Client A wore a sling with her right arm and wrist which hung lower than her waist and client A's arm was not positioned into place. During both observation periods client A's right wrist, lower right arm, and fingers were swollen, bluish/white in color, and client A stated during both observations her fingers and wrist were "tight" feeling. On 5/27/14 at 1:40pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 09/01/2013 through 05/27/14 for client A. -A 5/23/14 BDDS report for an incident on 5/23/14 at 2:00pm indicated client A was admitted to the hospital for surgery and "due to the orthopedic surgeon deciding to do surgery on her broken right humerus." -A 5/17/14 BDDS report for an incident on 5/17/14 at 6:30am indicated client A "woke up and staff noticed that she was wincing when moving her right arm." The report indicated at 7:00am, client A "was getting dressed and attempting to move her arm and she started		training for new medical concerns and these training will be sent to the Area Director to be reviewed and filed to ensure medical compliance. The management continues to ensure all staff are client specific trained on each individual prior to working as well. The Program Director will note medical changes and concerns in their monthly summary as well.A person of management will also conduct pop ins on staff 6x month for the next 6 months to ensure procedures being implemented properly. Responsible Party: Nurse, QMRP Complete Date: 7/5/2014	

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	complaining that it hurt." The report indicated client A was taken to the Emergency Room (ER) later that morning and client A "told staff, her mom, and the ER Doctor that she had a seizure and had fallen out of bed during the night and got back into bed and went to sleep." The report indicated the ER indicated client A's "Right Humerus is broken, they put it in a sling, and said for staff to call the Orthopedic surgeon on Monday to make an appt. (appointment). The ER Doctor said for that kind of break they just keep it in a sling and let gravity realign the break." -A 5/9/14 BDDS report for an incident on 5/8/14 at 11:30am indicated client A was "walking through the cafeteria when she fell. [Client A] fell backwards due to having a seizure," the Residential Manager (RM) was present and "swiped [client A's] VNS (Vagus Nerve Stimulator- a magnetic device to control the seizure)," and client A sustained a bruise on the outside of her right upper knee "about 2 inches" long and "1 1/2 inches wide." -A 9/21/13 BDDS report for an incident on 9/20/13 at 9:35pm indicated client A "was in bed and went to get up to use the restroom and slipped, sliding down the side of her bed hitting her head on the			

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	end of the bed." Client A's records were reviewed on 5/29/14 at 11:30am. Client A's records indicated she returned home from the hospital on Sunday 5/25/14 after surgery to repair her "fractured right Humerus (arm)." Client A's records included the following: -Client A's record included an undated "Seizure Protocol" which indicated what staff were to do once client A had a seizure. The seizure protocol did not indicate safety information for how staff were to prevent possible injuries during a seizure. Client A's seizure plan did not include the use of her seizure helmet or her VNS magnet. Client A's seizure plan did not include her night time safety. -Client A's record included an undated "Fall Protocol" which indicated client A "has seizures that could cause a fall that could result in an injury. At times walks to (sic) fast and leans slightly forward. She needs to be reminded to slow down. She has a walker with brakes with rollers on the front, tennis balls on the back to help slow her down. Walker also has a seat so if she gets tired she can sit." Client A's Fall Protocol had not been updated to address client A's falls out of bed and did not include how staff were to			

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	prevent falls since client A's right arm fracture after she was unable to use her walker to prevent falls. -Client A's 2/4/2013 "Balance Assessment for PT (Physical Therapy)" indicated "Please get a rolling walker for pt. (patient) with 2 wheels...." Client A's balance assessment did not include how staff were to assist client A changing positions from the seated position to standing position and/or her night time positions of sitting, standing, and/or laying in bed. -Client A's records indicated a 5/29/13 "Clinic Interim Review" from her physician which indicated client A had the potential for "falls and unsteadiness" since 5/29/13. -Client A's 10/15/2013 "Annual Healthcare Assessment" indicated she had seizure activity, used a "Vagel (sic) Nerve Stimulator to stop seizures 1-5 seizures per week," and "wears a helmet at all times while up." -Client A's records indicated the following falls in which no BDDS reports were generated: -On 4/3/14 at 5:45am, fell after laying down and "a small cut 1/8 inch long, L (Left) eyebrow."			

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	-On 1/12/14 at no time documented, was "brushing teeth, unsteady" fell during a seizure in the bathroom. -On 5/22/13 at no time documented, client A fell, cut her right elbow open, and had her right elbow wound "glued" closed at the ER. -Client A's 5/22/13 "ER Visit for Busted L (Left) elbow," indicated client A had suffered a cut to her left elbow. -Client A's undated "Medical Appointment Form" from the home healthcare agency indicated "Add protein to faster healing. Boost ensure good for this...Change dressing daily, clean with saline, pat dry, apply dry gauze, and a BDs (Band-Aid) tape in place (sic). Notify doctor for signs increased redness, drainage, swelling, pain, Signs of infection (sic)." On 5/29/14 at 10:54am, an interview with the facility's LPN and the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted. The LPN indicated client A's nursing plans had not been updated since her fall, hospitalization, surgery, and 5/25/14 (Sunday) return from the hospitalization for her right arm fracture. The LPN indicated client A had a history of falls with injuries from her bed, when client A			

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	walked, and from a seated position. The LPN indicated client A's nursing plans did not indicate the proper position the staff were to use for client A's right arm and sling, what signs and symptoms staff were to watch for regarding client A's fracture and surgery, the care and treatment for client A's injury, and how staff were to assist client A to walk, sit, and/or stand. The LPN and the PD/QIDP indicated the facility failed to update client A's plans and failed to train the facility staff on client A's identified nursing needs. The PD/QIDP and the LPN both indicated no documented staff training for client A's nursing needs were available for review. 2. On 5/27/14 from 3:15pm until 5:05pm, and on 5/28/14 from 5:55am until 7:55am, client B was observed to have a boot on her left foot and heel with a plastic bag wrapped inside the boot between client B's skin of her left foot and the protective boot. Client B sat in a wheel chair. On 5/28/14 at 7:15am, GHS (Group Home Staff) #1 wheeled client B's wheel chair into the front room of the home. GHS #1 tilted client B's wheel chair backwards to elevate client B's left foot. At 7:15am, GHS #1 removed client B's protective boot and indicated client B had an open sore to the bottom of client B's left foot. GHS #1 removed a baggie			

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	which had been sealed around client B's foot. Upon removal of the protective boot, the baggie contained a bloody fluid which continued to drip from the gauze dressing partially taped to client B's left foot. GHS #1 stated client B's open draining sore was "red" and "weepy" with drainage. GHS #1 stated there was a "two inch (2") white area of skin around the "half (1/2) dollar size" open draining skin area. GHS #1 stated "It's (the dressing and gauze) changed twice a day. It's changed to me since yesterday, maybe bigger" and stated "It (client B's wound) looked worse." GHS #1 applied client B's treatment of a barrier cream to "remove moisture" to client B's wound, applied a plastic wrap over a four by four inch gauze pad, and reapplied her protective boot. GHS #1 stated the staff used the plastic wrap over client B's wound to "keep [client B's] clothing clean, her bed sheets clean, and the protective boot clean." GHS #1 indicated he had not received training specific to client B's identified nursing needs for her wound care. GHS #1 indicated he needed to call the nurse later to tell her about client B's wound changing. On 5/29/14 at 9:45am, client B was observed at the workshop, sat in a wheel chair, and had a protective boot on her left foot. At 9:45am, an interview with			

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	the workshop Registered Nurse (RN) was conducted. The RN indicated she assisted client B with toileting and changing at the workshop during work hours. The RN indicated client B needed to be changed because of soiling her clothing on 5/7/14 and the open draining sore was noticed on client B's left heel at that time. The RN indicated she immediately contacted the group home. Client B's records were reviewed on 5/29/14 at 12:00noon. Client B's record included an undated "Impaired Skin Integrity Protocol" which indicated client B's skin was to be monitored for "Disruption of skin surface and may include discoloration, open wound, drainage, and itching pain and/or decreased sensation...checked daily with bath, clothing change, and toileting." Client B's record did not indicate an updated plan to include the treatment of her 5/7/14 open/draining wound on her left foot. Client B's record indicated diagnoses which included but were not limited to: Cerebral Palsy and Muscle Spasticity. Client B's "Skin Assessment Checklist" indicated the following: "Side Effect Recording Form" to be completed by the 10th of each month" on 5/10/14, 4/10/14, 3/12/14, 2/7/14, 1/8/14, 12/10/13, 11/7/13, 10/3/13, 9/10/13, and 8/4/13 which did not indicate client B			

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	had an open draining wound on her left foot. Client B's 5/10/14, 4/10/14, and 3/12/14 "Skin Assessment Checklist" did not indicate client B had an open draining wound on her left foot. On 5/29/14 at 10:54am, an interview with the facility's LPN and the PD/QIDP was conducted. The LPN indicated client B's nursing plans had not been updated since her open sore developed. The LPN stated she had not seen client B's open sore until "today." The LPN indicated client B went to her physician after the open sore was noticed by the workshop on 5/7/14. The LPN stated "No" when asked if client B's records indicated an open/draining sore on her left heel before the workshop notified the group home on 5/7/14. The LPN stated she was unaware of "any" skin issue with client B before the 5/7/14 notification. The LPN indicated there was not documented staff training for providing client B with skin treatment to her open draining sore. The LPN indicated client B did have a history of open areas on her skin. The LPN indicated client B's open wound should not have been covered with a plastic bag/wrap. The LPN indicated the plastic would have sealed in the moisture of the wound to keep the wound moist and client B's treatment cream was a barrier cream to dry the wound to promote			

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	healing. The LPN indicated client B's nursing plans did not indicate the proper positioning of client B's protective boot, what signs and symptoms staff were to watch for regarding client B's open area, and the care and treatment for client B's open draining sore. The LPN and the PD/QIDP indicated the facility failed to update client B's plans and neglected to train the facility staff on client B's identified nursing needs. The PD/QIDP and the LPN both indicated no documented staff training for client B's nursing needs was available for review. This federal tag relates to complaint #IN00149476. 9-3-3(a)			
W000240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review, and interview, the facility failed to develop criteria for 4 of 4 sampled clients (clients A, B, C, and D) and four additional clients (clients E, F, G, and H) the facility failed to include how and when clients A, B, C, D, E, F, G, and H were to access locked sharps and utensils.	W000240	All staff at Indiana Mentor are trained on clients rights upon hire and annually there after. Indiana Mentor also has policies in procedures in place in restrictions to client's right which include HRC consents and approvals. The QMRP are trained on obtaining these consents prior to restrictions going in place. The QMRP and Home Manager completed assessments for all	07/05/2014

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	Findings include: On 5/27/14 from 3:15pm until 5:05pm, and on 5/28/14 from 5:55am until 7:55am, clients A, B, C, D, E, F, G, and H were observed at the group home. During both observation periods GHS (Group Home Staff) #1, #2, #3, and the Residential Manager (RM) had the key secured on their person for the locked sharps container kept on the counter in the kitchen. On 5/27/14 from 3:15pm until 5:05pm, clients C and D were prompted by GHS #4 to assist with cooking in the kitchen. GHS #4 accessed the locked sharps container on the kitchen counter, removed a knife, and GHS #4 cut vegetables and opened packages of hamburger. From 3:30pm until 4:05pm, GHS #4 washed the knife and replaced it each time into the secured sharps container on the kitchen counter. From 3:15pm until 4:40pm, clients C and D stirred pots on the stove, client B made macaroni and cheese on the stove, and client D flipped hamburgers on an electric grill on the kitchen counter. Clients C and D were not prompted or taught to use a knife to cut or prepare foods. On 5/27/14 at 4:40pm, the RM indicated the facility had locked sharps and knives because of client C's		clients for the locks. The Area Director put the completed formal assessments in each clients files and the QMRP developed formal goals for clients who could not successfully manage the locks. The QMRP sent out a revised HRC request and guardian approval to all members and got approval for the necessary restrictions. The agency has revised the HRC form to provide better clarity and accuracy for requests. Manager had training on use of form and to ensure assessments are completed for each individual prior to household restrictions being put in place. QMRP is sending future HRC requests and as needed assessments to Area Director prior to implementation. Responsible Party: Dana Langley Completion Date: 7/5/2014	

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	continued threats of harm toward staff and other clients. The RM indicated clients A, B, C, D, E, F, G, and H did not have access to locked sharps and were not taught how or when to access locked sharps. On 6/6/14 at 9:00am, an interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted. The PD/QIDP indicated the practice of locked sharp objects was not addressed in the clients' plans. The PD/QIDP indicated client C had a history of misusing sharp objects. The PD/QIDP indicated clients A, B, D, E, F, G, and H did not have identified safety needs for the locked sharp objects and that sharps were restricted for the clients who lived in the group home. The PD/QIDP indicated the practice of locked sharp objects was not addressed in client A, B, D, E, F, G, and H's plans. The PD/QIDP indicated clients A, B, C, D, E, F, G, and H would need to gain access to the sharps via staff. The PD/QIDP both indicated clients A, B, C, D, E, F, G, and H's program plans did not include methodology to teach clients to access locked sharps and utensils. On 5/29/14 at 12:45pm, client C's 11/2013 BSP (Behavior Support Plan)			

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	and 7/2/13 ISP (Individual Support Plan) indicated client C's behaviors included SIB (Self Injurious Behavior), aggressive outburst (physical aggression and verbal aggression), Story Telling/False accusations, Inappropriate Sexual Comments, Inappropriate Sexual Behavior, Refusals to complete daily hygiene and tasks, Vacating (leaving a specific environment, and Suicidal Threats/attempt. Client C's 7/2/2013 Comprehensive Functional Assessment did not indicate the identified need for locked sharps at the group home. Client C's BSP did not indicate the identified need for locked sharps at the group home. Client C's plans failed to include an objective/goal to teach her responsible methods to utilize locked sharp objects. Client C's "Quarterly Review(s)" completed by the PD/QIDP indicated the following: -On 4/30/2014 "Quarterly Review" indicated client C's "behaviors have increased greatly this past quarter. She had 20 episodes of verbal abuse, 6 runs/wanders away, 14 physical assaults, 12 SIB's...and 4 suicidal threats...." -On 1/31/2014 "Quarterly Review" indicated client C's "behaviors have increased greatly this past quarter. She had 20 episodes of verbal abuse, 4 runs/wanders away, 12 physical assaults, 10 SIB's...and 2 suicidal threats...."			

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	-On 10/31/2013 "Quarterly Review" indicated client C's "behaviors have increased this past quarter. She had 15 episodes of verbal abuse, 2 runs/wanders away, 4 physical assaults, 3 SIB's, 1 inappropriate sexual behavior...and 0 suicidal threats...." Client A's record was reviewed on 5/29/14 at 11:30am. Client A's 10/15/13 ISP (Individual Support Plan) and 10/13 Comprehensive Functional Assessment (CFA) did not indicate an identified need to lock sharp objects and did not teach client A how or when to access locked sharps and utensils. Client B's record was reviewed on 5/29/14 at 12noon. Client B's 10/18/13 ISP and 10/2013 CFA did not indicate an identified need to lock sharp objects. Client B's plans did not include a plan to teach how or when to access locked sharps and utensils. Client D's record was reviewed on 5/29/14 at 1:45pm. Client D's 9/10/13 ISP and 9/2013 CFA did not indicate an identified need to lock sharp objects. Client D's plans did not include a plan to teach how or when to access locked sharps and utensils. 9-3-4(a)			

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W000318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on interview and record review for 2 of 4 sampled clients (clients A and B), the facility failed to meet the Condition of Participation: Health Care Services. The facility's health care services failed to ensure nursing services met client A and B's medical needs in regard to completing accurate assessments, development of nursing care plans, and monitoring of client A and B's skin integrity, dressing care, mobility needs, body positioning, and clients A and B's health status. Findings include: The facility's nursing services failed to assess, to develop plans, and to provide oversight of the facility staff to care for client A's right arm fracture, surgical site dressing care, identified mobility needs, and identified safety need for falls and seizures. The facility's nursing services failed to assess, to develop a plan, and to provide oversight of the facility staff to care for client B's open and draining foot wound; and failed to provide nursing services according to client A and B's	W000318	Indiana Mentor has policies and procedures in place in regards to abuse and neglect and healthcare coordination for individuals. These policies and procedures are trained upon hire and annually thereafter. All staff are being retrained on the abuse/neglect policy. Staff are being trained on signs and treatment for wound, side effect monitoring, and skin integrity. The Nursing Supervisor has retrained the nurse on reviewing physician orders and mars, discharge consulting and staff training, client assessments, and follow ups. IDT has followed up with guardian for client A who has agreed to bed railing. Nurse has revised protocols for clients A and staff have been trained on seizures, falls, ambulation and transfers, and wound care and for client B staff have been trained on the skin integrity protocol. Nurse and management have additionally been trained on discharge and follow up procedures including revising protocols and staff training for clients with medical concerns. A system has been put in place to track staff training for new medical concerns	07/05/2014

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	identified medical needs for 2 of 4 sampled clients (clients A and B). Please see W331. This federal tag relates to complaint #IN00149476. 9-3-6(a)		and these training will be sent to the Area Director to be reviewed and filed to ensure medical compliance. The Program Director will note medical changes and concerns in their monthly summary as well. The nurses care plans have been reviewed by management for clients A-F to ensure they meet the needs of the clients. Future plans and monthly progress notes are being checked by a member of management monthly for the next 3 months then quarterly thereafter. A person of management will also conduct pop ins on staff 6x month for the next 6 months to ensure procedures being implemented properly. Responsible Party: Nurse, QMRP Complete Date: 7/5/2014	
W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients A and B), the facility's nursing services failed to assess, to develop plans, and to provide oversight of the facility staff to care for client A's right arm fracture, surgical site dressing care, identified mobility needs, and identified safety needs for falls and seizures. The facility's nursing services failed to assess, to develop a plan, and to provide	W000331	Indiana Mentor has policies and procedures in place in regards to healthcare coordination and medical oversight for individuals. These policies and procedures are trained upon hire and annually thereafter. All group homes have a nurse who helps coordinate and oversee the healthcare coordination for the programs and is overseen by a nursing director. The Nursing Supervisor has retrained the nurse on reviewing physician	07/05/2014

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	oversight of the facility staff to care for client B's open and draining foot wound; and failed to provide nursing services according to client A and B's identified medical needs. Findings include: 1. On 5/27/14 from 3:15pm until 5:05pm, and on 5/28/14 from 5:55am until 7:55am, client A was observed to have her right arm in a sling. Client A was assisted to stand and/or to walk by Group Home Staff (GHS) #1, GHS #2, GHS #3, and the Residential Manager (RM) by the staff person pulling client A up by her left arm, pulling client A up by the waist band of client A's slacks, assisting client A to walk by grasping client A's left arm with their hand, and/or walking beside client A. During both observation periods client A did not use a walker and wore a seizure helmet that moved on her head (was not secured in place) and the helmet had three separate tears in the protective foam held together with tape. During both observation periods client A swayed back and forth when she walked with the facility staff and client A was repeatedly unsteady with each step she took while walking. Client A wore a sling with her right arm and wrist which hung lower than her waist and client A's arm was not		orders and mars, discharge consulting and staff training, client assessments, and follow ups. The nurse has revised clients A's and B's health care plans and plans were developed on trained on for both clients wound care. For client A additional plans and training were done for ambulation and positioning in general and with arm, falls, and seizures. Nurse and management have additionally been trained on discharge and follow up procedures including revising protocols and staff training for clients with medical concerns. A system has been put in place to track staff training for new medical concerns and these training will be sent to the Area Director to be reviewed and filed to ensure medical compliance. The Program Director will note medical changes and concerns in their monthly summary as well. The nurses care plans have been reviewed by management for clients A-F to ensure they meet the needs of the clients. Future plans and monthly progress notes are being checked by a member of management monthly for the next 3 months then quarterly thereafter. A person of management will also conduct pop ins on staff 6x month for the next 6 months to ensure procedures being implemented properly. Responsible Party: Nurse, QMRP	

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	positioned into place. During both observation periods client A's right wrist, lower right arm, and fingers were swollen, bluish/white in color, and client A stated during both observations her fingers and wrist were "tight" feeling. On 5/27/14 at 1:40pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 09/01/2013 through 05/27/14 for client A. -A 5/23/14 BDDS report for an incident on 5/23/14 at 2:00pm indicated client A was admitted to the hospital for surgery and "due to the orthopedic surgeon deciding to do surgery on her broken right humerus." -A 5/17/14 BDDS report for an incident on 5/17/14 at 6:30am indicated client A "woke up and staff noticed that she was wincing when moving her right arm." The report indicated at 7:00am, client A "was getting dressed and attempting to move her arm and she started complaining that it hurt." The report indicated client A was taken to the Emergency Room (ER) later that morning and client A "told staff, her mom, and the ER Doctor that she had a seizure and had fallen out of bed during			

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	the night and got back into bed and went to sleep." The report indicated the ER indicated client A's "Right Humerus is broken, they put it in a sling, and said for staff to call the Orthopedic surgeon on Monday to make an appt. (appointment). The ER Doctor said for that kind of break they just keep it in a sling and let gravity realign the break." -A 5/9/14 BDDS report for an incident on 5/8/14 at 11:30am indicated client A was "walking through the cafeteria when she fell. [Client A] fell backwards due to having a seizure," the Residential Manager (RM) was present and "swiped [client A's] VNS (Vagus Nerve Stimulator- a magnetic device to control the seizure)," and client A sustained a bruise on the outside of her right upper knee "about 2 inches" long and "1 1/2 inches wide." -A 9/21/13 BDDS report for an incident on 9/20/13 at 9:35pm indicated client A "was in bed and went to get up to use the restroom and slipped, sliding down the side of her bed hitting her head on the end of the bed." Client A's records were reviewed on 5/29/14 at 11:30am. Client A's records indicated she returned home from the hospital on Sunday 5/25/14 after surgery			

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	to repair her "fractured right Humerus (arm)." Client A's records included the following: -Client A's record included an undated "Seizure Protocol" which indicated what staff were to do once client A had a seizure. The seizure protocol did not indicate safety information for how staff were to prevent possible injuries during a seizure. Client A's seizure plan did not include the use of her seizure helmet or her VNS magnet. Client A's seizure plan did not include her night time safety. -Client A's record included an undated "Fall Protocol" which indicated client A "has seizures that could cause a fall that could result in an injury. At times walks to (sic) fast and leans slightly forward. She needs to be reminded to slow down. She has a walker with brakes with rollers on the front, tennis balls on the back to help slow her down. Walker also has a seat so if she gets tired she can sit." Client A's Fall Protocol had not been updated to address client A's falls out of bed and did not include how staff were to prevent falls since client A's right arm fracture after she was unable to use her walker to prevent falls. -Client A's 2/4/2013 "Balance Assessment for PT (Physical Therapy)"			

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	indicated "Please get a rolling walker for pt. (patient) with 2 wheels...." Client A's balance assessment did not include client A changing positions from the seated position to standing position and/or her night time positions of sitting, standing, and/or laying in bed. -Client A's records indicated a 5/29/13 "Clinic Interim Review" from her physician which indicated client A had the potential for "falls and unsteadiness" since 5/29/13. -Client A's 10/15/2013 "Annual Healthcare Assessment" indicated she had seizure activity, used a "Vagel (sic) Nerve Stimulator to stop seizures 1-5 seizures per week," and "wears a helmet at all times while up." -Client A's records indicated the following falls in which no BDDS reports were generated: -On 4/3/14 at 5:45am, fell after laying down and "a small cut 1/8 inch long, L (Left) eyebrow." -On 1/12/14 at no time documented, was "brushing teeth, unsteady" fell during a seizure in the bathroom. -On 5/22/13 at no time documented, client A fell, cut her right elbow open, and had her right elbow wound "glued" closed at the ER.			

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	-Client A's 5/22/13 "ER Visit for Busted L (Left) elbow," indicated client A had suffered a cut to her left elbow. -Client A's undated "Medical Appointment Form" from the home healthcare agency indicated "Add protein to faster healing. Boost ensure good for this...Change dressing daily, clean with saline, pat dry, apply dry gauze, and a BDs (Band-Aid) tape in place (sic). Notify doctor for signs increased redness, drainage, swelling, pain, Signs of infection (sic)." On 5/29/14 at 10:54am, an interview with the facility's LPN and the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted. The LPN indicated client A's nursing plans had not been updated since her fall, hospitalization, surgery, and 5/25/14 (Sunday) return from the hospitalization for her right arm fracture. The LPN indicated client A had a history of falls with injuries from her bed, when client A walked, and from a seated position. The LPN indicated client A's nursing plans did not indicate the proper position the staff were to use for client A's right arm and sling, what signs and symptoms staff were to watch for regarding client A's fracture and surgery, the care and			

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	treatment for client A's injury, and how staff were to assist client A to walk, sit, and/or stand. The LPN and the PD/QIDP indicated the facility failed to update client A's plans and failed to train the facility staff on client A's identified nursing needs. The PD/QIDP and the LPN both indicated no documented staff training for client A's nursing needs was available for review. 2. On 5/27/14 from 3:15pm until 5:05pm, and on 5/28/14 from 5:55am until 7:55am, client B was observed to have a boot on her left foot and heel with a plastic bag wrapped inside the boot between client B's skin of her left foot and the protective boot. Client B sat in a wheel chair. On 5/28/14 at 7:15am, GHS (Group Home Staff) #1 wheeled client B's wheel chair into the front room of the home. GHS #1 tilted client B's wheel chair backwards to elevate client B's left foot. At 7:15am, GHS #1 removed client B's protective boot and indicated client B had an open sore to the bottom of client B's left foot. GHS #1 removed a baggie which had been sealed around client B's foot. Upon removal of the protective boot, the baggie contained a bloody fluid in the baggie which continued to drip from the gauze dressing partially taped to client B's left foot. GHS #1 stated client B's open draining sore was "red" and			

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	"weepy" with drainage. GHS #1 stated there was a "two inch (2") white area of skin around the "half (1/2) dollar size" open draining skin area. GHS #1 stated "It's (the dressing and gauze) changed twice a day. It's changed to me since yesterday, maybe bigger" and stated "It (client B's wound) looked worse." GHS #1 applied client B's treatment of a barrier cream to "remove moisture" to client B's wound, applied a plastic wrap over a four by four inch gauze pad, and reapplied her protective boot. GHS #1 stated the staff used the plastic wrap over client B's wound to "keep [client B's] clothing clean, her bed sheets clean, and the protective boot clean." GHS #1 indicated he had not received training specific to client B's identified nursing needs for her wound care. GHS #1 indicated he needed to call the nurse later to tell her about client B's wound changing. On 5/29/14 at 9:45am, client B was observed at the workshop, sat in a wheel chair, and had a protective boot on her left foot. At 9:45am, an interview with the workshop Registered Nurse (RN) was conducted. The RN indicated she assisted client B with toileting and changing at the workshop during work hours. The RN indicated client B needed to be changed because of soiling her			

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	clothing on 5/7/14 and the open draining sore was noticed on client B's left heel at that time. The RN indicated she immediately contacted the group home. Client B's records were reviewed on 5/29/14 at 12:00noon. Client B's record included an undated "Impaired Skin Integrity Protocol" which indicated client B's skin was to be monitored for "Disruption of skin surface and may include discoloration, open wound, drainage, and itching pain and/or decreased sensation...checked daily with bath, clothing change, and toileting." Client B's record did not indicate an updated plan to include the treatment of her 5/7/14 open/draining wound on her left foot. Client B's record indicated diagnoses which included but were not limited to: Cerebral Palsy and Muscle Spasticity. Client B's "Skin Assessment Checklist" indicated the following: "Side Effect Recording Form" to "be completed by the 10th of each month" on 5/10/14, 4/10/14, 3/12/14, 2/7/14, 1/8/14, 12/10/13, 11/7/13, 10/3/13, 9/10/13, and 8/4/13 which did not indicate client B had an open draining wound on her left foot. Client B's 5/10/14, 4/10/14, and 3/12/14 "Skin Assessment Checklist" did not indicate client B had an open draining wound on her left foot.			

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	On 5/29/14 at 10:54am, an interview with the facility's LPN and the PD/QIDP was conducted. The LPN indicated client B's nursing plans had not been updated since her open sore developed. The LPN stated she had not seen client B's open sore until "today." The LPN indicated client B went to her physician after the open sore was noticed by the workshop on 5/7/14. The LPN stated "No" when asked if client B's records indicated an open/draining sore on her left heel before the workshop notified the group home on 5/7/14. The LPN stated she was unaware of "any" skin issue with client B before the 5/7/14 notification. The LPN indicated there was not documented staff training for providing client B with skin treatment to her open draining sore. The LPN indicated client B did have a history of open areas on her skin. The LPN indicated client B's open wound should not have been covered with a plastic bag/wrap. The LPN indicated the plastic would have sealed in the moisture of the wound to keep the wound moist and client B's treatment cream was a barrier cream to dry the wound to promote healing. The LPN indicated client B's nursing plans did not indicate the proper positioning of client B's protective boot, what signs and symptoms staff were to watch for regarding client B's open area, and the care and treatment for client B's			

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	open draining sore. The LPN and the PD/QIDP indicated the facility failed to update client B's plans and neglected to train the facility staff on client B's identified nursing needs. The PD/QIDP and the LPN both indicated no documented staff training for client B's nursing needs was available for review. This federal tag relates to complaint #IN00149476. 9-3-6(a)			
W000407	483.470(a)(1) CLIENT LIVING ENVIRONMENT The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together. Based on observation, record review, and interview, for 1 of 4 sampled clients (client C), the facility failed to ensure the housing environment met client C's developmental, social, and behavioral needs. Findings include: On 5/27/14 from 3:15pm until 5:05pm, and on 5/28/14 from 5:55am until 7:55am, clients A, B, C, D, E, F, G, and H were observed at the group home.	W000407	Indiana Mentor works in conjunction with BDDS and the rest of the individuals IDT to ensure proper placement is met for individuals receiving services. When individuals require alternative placement Indiana Mentor works with these agencies to ensure the individual recieves qualitity care while alternative placement is sought. For client C the agency and IDT had requested an emergency CIH waiver five weeks prior to survey. Agency had been actively checking with BDDS on progress	07/05/2014

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	During both observation periods GHS (Group Home Staff) #1, #2, #3, and the Residential Manager (RM) had the key secured on their person for the locked sharps container kept on the counter in the kitchen. On 5/27/14 from 3:15pm until 5:05pm, GHS #4 accessed the locked sharps container on the kitchen counter, removed a knife, and GHS #4 cut vegetables and opened packages of hamburger. From 3:30pm until 4:05pm, GHS #4 washed the knife and replaced it each time into the secured sharps container on the kitchen counter. On 5/27/14 at 4:40pm, the RM indicated the facility had locked sharps and knives because of client C's continued threats of harm toward staff and other clients. The RM indicated clients A, B, C, D, E, F, G, and H did not have access to locked sharps and were not taught how or when to access locked sharps. On 5/27/14 at 4:15pm, an interview with client C was conducted. Client C stated she "wanted" to live in a different group home or apartment with "a waiver." Client C stated "I am too high functioning for this group home." Client C indicated the plexi glass in her bedroom windows was because she had broken the windows trying to hurt herself		of waiver placement. BDDS has come to the group home and spoken to client C about the waiver process and procedures for placement. The QMRP has revised clients C plan to include the sharp restriction and has sent out HRC approvals for them. IDT has communicated in regards to clients Cs placement and spoken with BDDS on waiver status. IDT is continuing to meet until placement is secured. BDDS is working on expediting process and agency continues to send in any necessary paperwork for process. Agency is having client C tour waiver sites and prep transition items for clients C waivers. Complete Date: 7/5/2014 Responsible Party: QMRP, IDT	

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	with the glass in past years. Client C stated she "did attack" her workshop supervisors on a "regular" basis and stated she was on medication "to help with that." Client C stated she was placed in the group home in 2010 after she "attacked" her family, was in the hospital, and "it was here or jail I guess." On 5/29/14 at 10:30am, and on 6/6/14 at 9:00am, an interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted. The PD/QIDP indicated the practice of locked sharp objects was not addressed in the client C's plans and/or assessments. The PD/QIDP indicated client C had a history of misusing sharp objects. The PD/QIDP indicated client C was admitted in 2010 from the behavioral hospital after a failed suicide attempt. The PD/QIDP indicated client C was a twenty-three year old female living in a group home with other clients whose ages range from fifty-one to seventy-nine years old. The PD/QIDP indicated the facility was evaluating other placement for client C because of her age, behavioral needs, and of the other clients' functional levels. The PD/QIDP stated client C was "smart" and could "possibly" be independent but did not display independent skills for hygiene, medications, dressing, cooking, and appropriate social interaction.			

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	Client C's record was reviewed on 5/29/14 at 12:45pm. Client C's date of birth was 12/20/1991. Client C's 11/2013 BSP (Behavior Support Plan) and 7/2/13 ISP (Individual Support Plan) indicated client C's behaviors included SIB (Self Injurious Behavior), aggressive outburst (physical aggression and verbal aggression), Story Telling/False accusations, Inappropriate Sexual Comments, Inappropriate Sexual Behavior, Refusals to complete daily hygiene and tasks, Vacating (leaving a specific environment, and Suicidal Threats/attempt. Client C's 7/2/2013 Comprehensive Functional Assessment did not indicate the identified need for locked sharps at the group home. Client C's plans failed to include an objective/goal to teach her responsible methods to utilize locked sharp objects. Client C's record indicated she was admitted from the behavioral hospital on 6/17/2010 after a suicide attempt. Client C's record indicated she had "attacked" her family and supervisors in the past before placement. Client C's record indicated "Quarterly Review(s)" completed by the PD/QIDP indicated the following: -On 4/30/2014 "Quarterly Review" indicated client C's "behaviors have			

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	increased greatly this past quarter. She had 20 episodes of verbal abuse, 6 runs/wanders away, 14 physical assaults, 12 SIB's...and 4 suicidal threats...." -On 1/31/2014 "Quarterly Review" indicated client C's "behaviors have increased greatly this past quarter. She had 20 episodes of verbal abuse, 4 runs/wanders away, 12 physical assaults, 10 SIB's...and 2 suicidal threats...." -On 10/31/2013 "Quarterly Review" indicated client C's "behaviors have increased this past quarter. She had 15 episodes of verbal abuse, 2 runs/wanders away, 4 physical assaults, 3 SIB's, 1 inappropriate sexual behavior...and 0 suicidal threats...." Client C's 7/2/13 ISP indicated "a verbal IQ of 65, a performance IQ of 54 and a full scale IQ of 56 suggesting mild" mental retardation. Client C "functions between the 2nd and 4th grade in academic functioning The IDT (Interdisciplinary Team) agrees that this assessment remains valid. [Client C] cannot manage her own financial affairs, give sexual consent or medical consent. [Client C] has a guardian, [name of guardian services] that would make those decisions for her. [Client C] can follow one and two step directions with no difficulty. She can recognize her own name, write in cursive, spell many words,			

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	and read some words. [Client C] knows how to use the telephone." Client C's ISP indicated client C "is very smart and can comprehend anything that you say to her or that she overhears." Client C's ISP indicated goals/objectives for personal hygiene skills objective with 2 verbal prompts client C will apply deodorant 100% of the time for 2 consecutive reviews. Grooming skills objective with 2 verbal prompts and 2 physical prompts client C will assist fixing her hair 100% of the time for 2 consecutive. Housekeeping skills objective with 2 verbal prompts client C will complete a house chore that is requested of her 100% of the time for 2 consecutive reviews. Money skills objective with 3 verbal prompts client C will make 50 cents out of a variety of coins 100% of the time for 2 consecutive reviews. Medication Administration objective client C will increase self medication skills from being dependent on staff to being more independent. Objective with 1 verbal prompt when shown a pill card, client C will state the name and why she takes the medication 100% of the time for 2 consecutive reviews. This federal tag relates to complaint #IN00148709.			

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	9-3-7(a)			
W000436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 1 of 4 sampled clients (client A) with adaptive equipment, the facility failed to provide client A's seizure helmet in good repair. Findings include: On 5/27/14 from 3:15pm until 5:05pm, and on 5/28/14 from 5:55am until 7:55am, client A wore a seizure helmet that moved on her head (was not secured in place) and the helmet had three separate tears in the protective foam held together with tape. During both observation periods client A swayed back and forth when she walked with the facility staff and client A was repeatedly unsteady with each step she took while walking. Client A's records were reviewed on 5/29/14 at 11:30am. Client A's records	W000436	Indiana Mentor has policies and procedures in place in regards to clients health care and well being including monitoring of adaptive equipment. For client A mentor had contacted her specialist prior to order a new helmet and one was ordered. However the helmet caused an allergic reaction in client A and facility had been instructed that all helmets of that line had some foam causing reaction. Mentor has contacted specialist to get a new order for helmet for client A or adaptation to current one to ensure client A safety. Nurse and QMRP are monitoring progress of new helmet order to ensure it meets needs of client A. Client A current helmet has had tear repaired to ensure safety of client. QMRP is monitoring all adaptative equipment on monthly basis to ensure qualitity standards met on equipment. QMRP and nurse did check on current equipment in the house to ensure all met safety needs of individuals. Every	07/05/2014

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	included an undated "Seizure Protocol" which indicated what staff were to do once client A had a seizure and did not indicate safety information for how staff were to prevent possible injuries during a seizure. Client A's seizure plan did not include the use of her seizure helmet. Client A's records indicated a 5/29/13 "Clinic Interim Review" from her physician which indicated client A had the potential for "falls and unsteadiness" since 5/29/13. Client A's 10/15/2013 "Annual Healthcare Assessment" indicated she had seizure activity, used a "Vagel (Vagus) Nerve Stimulator to stop seizures 1-5 seizures per week," and "wears a helmet at all times while up." On 5/29/14 at 10:54am, an interview with the facility's LPN and the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted. The LPN stated client A had a history of falls with injuries from her bed, when client A walked, and from a seated position. The LPN indicated client A wore a seizure helmet to prevent injuries from falling during a seizure. The PD/QIDP indicated client A's seizure helmet had been replaced in 10/2013 with a pink seizure helmet, client A developed an allergic reaction to the helmet, and the pink helmet was altered. The PD/QIDP indicated client A continued to have an		quarter a health and safety assessment is being conducted in the program. Responsible Party: QMRPComplete Date: 7/5/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/06/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902	

(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
	allergic reaction to the helmet in 2/13/2014 and client A began wearing her old helmet with the taped repairs to the helmet. The PD/QIDP indicated the facility was in the process of replacing client A's damaged seizure helmet. 9-3-7(a)			