

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2015
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
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W000000	<p>This visit was for an annual recertification and state licensure survey.</p> <p>Dates of survey: January 13, 14, 15 and 16, 2015.</p> <p>Facility Number: 001113 AIM Number: 100245610 Provider Number: 15G599</p> <p>Surveyor: Christine Colon, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/29/15 by Dotty Walton, QIDP and Ruth Shackelford, QIDP.</p>	W000000		
W000125	<p>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.</p> <p>Based on observation, record review and interview, the facility failed for 7 of 8 clients residing at the group home (clients #2, #3, #4, #5, #6, #7 and #8) to provide</p>	W000125	The facility is committed to making sure that client rights are adhered to at all times. All staff is trained upon hire and annually in client's rights. The facility	02/15/2015

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>assistance to exercise their rights by restricting access to knives.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/13/15 from 5:25 P.M. until 7:15 P.M.. At 6:55 P.M., Client #5 stated "I need a knife." Direct Support Professional (DSP) #4 went to the locked hall closet, unlocked the door, retrieved a steak knife and began cutting client #5's meat. DSP #4 then walked around the table and assisted clients #6 and #7 with cutting their meat. DSP #4 then washed the knife and put it back in the closet and locked the closet door.</p> <p>A review of client #2's records was conducted on 1/14/15 at 1:20 P.M.. The review failed to indicate the need for the restriction to knives for client #2. Further review of the record failed to indicate measures in place to teach the client to access the knives.</p> <p>A review of client #3's records was conducted on 1/14/15 at 1:45 P.M.. The review failed to indicate the need for the restriction to knives for client #3. Further review of the record failed to indicate measures in place to teach the client to access the knives.</p>		<p>coordinates and implements the client goals and objectives with the client and team input as well as using the comprehensive functional assessment which is completed to determine the level of skills the client is capable of in a particular area. The PD will review and update the ISPs and CFA CFA for client's 2,3,4,5,6, 7 and 8 ISP determine the level of skill regarding the use of knives. After the assessments are completed all staff will be trained in any new goals so they can implement at all opportunities available when there is a need to use a knife. Additionally, staff will be trained in client rights. The Home Manager will complete a daily observation on various shifts for 30 days to ensure all staff is implementing any new goals. If at the end of 30 days it is determined that there is compliance with implementation, the Home Manager will complete observations at various times twice a week during different mealtimes to make sure knives are accessible to the clients. The Program Director will complete observations weekly on various shifts for the next 30 days and then monthly during different mealtimes to make sure knives are accessible to the clients.</p>		

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	<p>A review of client #4's records was conducted on 1/14/15 at 2:30 P.M.. The review failed to indicate the need for the restriction to knives for client #4. Further review of the record failed to indicate measures in place to teach the client to access the knives.</p> <p>A review of client #5's records was conducted on 1/14/15 at 2:15 P.M.. The review failed to indicate the need for the restriction to knives for client #5. Further review of the record failed to indicate measures in place to teach the client to access the knives.</p> <p>A review of client #6's records was conducted on 1/14/15 at 3:00 P.M.. The review failed to indicate the need for the restriction to knives for client #6. Further review of the record failed to indicate measures in place to teach the client to access the knives.</p> <p>A review of client #7's records was conducted on 1/14/15 at 2:45 P.M.. The review failed to indicate the need for the restriction to knives for client #7. Further review of the record failed to indicate measures in place to teach the client to access the knives.</p> <p>A review of client #8's records was conducted on 1/14/15 at 3:15 P.M.. The</p>			

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W000153	<p>review failed to indicate the need for the restriction to knives for client #8. Further review of the record failed to indicate measures in place to teach the client to access the knives.</p> <p>An interview with the Area Director (AD) was conducted on 1/15/15 at 2:45 P.M.. The AD indicated the restriction of knives was approved due to client #1 requiring a restriction to the access to knives. The AD further indicated there were no measures in place to teach each client to access the knives.</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.</p> <p>Based on record review and interview, the facility failed for 1 additional client (client #7), to report an allegation of staff abuse immediately to the administrator and to the Bureau of Developmental</p>	W000153	The facility ensures that all allegations of mistreatment, neglect or abuse as well as injuries of unknown origin are reported immediately to the administrator or to other officials in accordance with state law. All	02/15/2015

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	<p>Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/13/15 at 12:35 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-Investigation record dated 12/29/14 involving client #7 indicated: "On 12/29/14, [client #7] approached Program Director (PD) with allegation of being physically and verbally abused by staff [Facility owned Day Program Staff #13] at Day Programs (sic). [Day Program Staff #13] was suspended pending the outcome of the investigation.</p> <p>Interview with [Day Program Staff #14]: [Day Program Staff #14] was asked if she had ever witnessed any abuse from staff/co-worker [Day Program Staff #13] to [client #7], her reply was that she had and she stated that she talked to the staff about what she was witnessing and told her that was inappropriate behavior and that she was going to report her. [Day Program Staff #14] was asked, what exactly she witnessed and she stated that</p>		<p>staff is trained upon hire and annually on the abuse, neglect and exploitation policy along with the timeframes in which incidents should be reported. All day program staff will be trained on the abuse, neglect and exploitation policy. This training will include timeliness of the reporting process in which an incident occurs. The Home Manager will be trained to review the documentation daily at the day program for 30 days to monitor for any incidents that would require reporting. The Program Director will be trained to review the documentation on a weekly basis to monitor for any incidents that have occurred which would require reporting during that time frame. After 30 days the monitoring frequency and compliance with reporting will be reviewed to determine if the frequency can be lowered to the Home Manager monitoring 3 times per week and the Program Director's monitoring to be lowered to bi weekly and then to monthly once compliance in reporting incidents timely has been achieved. If for any reason after reviewing the documentation an incident is found to have not been reported, staff will be immediately retrained and subject to corrective action by not completing the required reporting process.</p>	

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	<p>staff [Day Program Staff #13] does things to aggravate [client #7], like take her purse so that the client can chase her, or [Day Program Staff #13] will tell [client #7] that [Day Program client #4] (another client and client #7's son) is not her son he is her (Day Program Staff #13's) son and she rubs [Day Program Client #4]'s head because that makes [client #7] mad. [Day Program Staff #14] stated that she removed the (sic) [client #7] and began to calm her down, but as soon as she was calm and then [Day Program Staff #13] will start to aggravate her again. [Day Program Staff #14] stated that she witnessed the incident on Tuesday, December 23, 2014. [Day program Staff #14] was asked why didn't she report this, her reply was that she was going to bring it up in her meeting with the PD on 12/29/14. [Day Program Staff #14] was asked if she has been trained on the policy for abuse and neglect, her reply was yes.</p> <p>Interview with [Day Program Staff #15]: [Day Program Staff #15] was asked if she had witnessed any abuse from [Day Program Staff #13] to [client #7], [Day Program Staff #15] stated yes, on the day in question which was 12/23/14, she heard the (sic) [Day Program Staff #13] tell the client that [Day Program Client #4] was not her son and she called [client</p>			

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	<p>#7] bipolar. [Day Program Staff #15] was asked if she had witnessed any kind of 'rough playing' between [Day Program Staff #13] and [client #7], [Day Program Staff #15] stated that what she witnessed was abuse and not playing....[Day Program Staff #15] was asked if she had witnessed this behavior before between the staff and the client and her reply was that [Day program Staff #13] aggravates [client #7] every day on purpose to get a rise out of her and when the other staff gets (sic) involved, [Day Program Staff #13] will leave her alone.... [Day Program Staff #15] was asked why didn't she report this, she replied that she knew that it would be taking (sic) care of based on a conversation with co-workers telling her that she had a scheduled meeting with the PD to discuss this. [Day Program Staff #15] was asked if she was trained on the policy for reporting abuse, her reply was yes....Conclusion: Evidence supports that [Day program Staff #13] did grab [client #7] on her arm and her face as well as teasing her. Evidence supports that [Day Program Staff #13]'s interactions with [client #7] have not been appropriate. Evidence supports the allegation of abuse. Evidence supports that staff did not report their concerns in a timely manner."</p> <p>An interview with the Program Director</p>			

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W000154	<p>(PD) was conducted on 1/13/15 at 1:45 P.M.. The PD indicated there was no written documentation to indicate the administrator was immediately notified of the allegation of abuse. The PD further indicated the administrator should have been immediately notified and BDDS should have been notified within 24 hours of the the mentioned allegation of abuse.</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 2 of 2 incidents, involving 1 of 4 sampled clients and 1 additional client (clients #2 and #7), the facility failed to provide written evidence thorough investigations were conducted in regard to allegations of staff abuse.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative</p>	W000154	The facility ensures that all allegations of mistreatment, neglect or abuse as well as injuries of unknown origin are investigated thoroughly. All staff is trained upon hire and annually on the abuse, neglect and exploitation policy along with the timeframes in which incidents should be reported. The Program Director will be trained to ensure that when investigating an allegation or incident that all potential witnesses are interviewed or the reason for not having interviewed them be	02/15/2015

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	<p>office on 1/13/15 at 12:35 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-Investigation record dated 12/29/14 involving client #7 indicated: "On 12/29/14, [client #7] approached Program Director (PD) with allegation of being physically and verbally abused by staff [Facility owned Day Program Staff #13] at Day Programs (sic). [Day Program Staff #13] was suspended pending the outcome of the investigation.</p> <p>Interview with [Day Program Staff #14]: [Day Program Staff #14] was asked if she had ever witnessed any abuse from staff/co-worker [Day Program Staff #13] to [client #7], her reply was that she had and she stated that she talked to the staff about what she was witnessing and told her that was inappropriate behavior and that she was going to report her. [Day Program Staff #14] was asked, what exactly she witnessed and she stated that staff [Day Program Staff #13] does things to aggravate [client #7], like take her purse so that the client can chase her, or [Day Program Staff #13] will tell [client #7] that [Day Program client #4] (another client and client #7's son) is not her son he is her (Day Program Staff #13's) son</p>		<p>indicated within the summary. The Area Director or Quality Assurance Specialist will review investigations to ensure that all of the required information is present in the investigation summary and that all the appropriate people have been interviewed during the time of the investigation.</p>	

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	<p>and she rubs [Day Program Client #4]'s head because that makes [client #7] mad. [Day Program Staff #14] stated that she removed the (sic) [client #7] and began to calm her down, but as soon as she was calm and then [Day Program Staff #13] will start to aggravate her again. [Day Program Staff #14] stated that she witnessed the incident on Tuesday, December 23, 2014. [Day program Staff #14] was asked why didn't she report this, her reply was that she was going to bring it up in her meeting with the PD on 12/29/14. [Day Program Staff #14] was asked if she has been trained on the policy for abuse and neglect, her reply was yes.</p> <p>Interview with [Day Program Staff #15]: [Day Program Staff #15] was asked if she had witnessed any abuse from [Day Program Staff #13] to [client #7], [Day Program Staff #15] stated yes, on the day in question which was 12/23/14, she heard the (sic) [Day Program Staff #13] tell the client that [Day Program Client #4] was not her son and she called [client #7] bipolar. [Day Program Staff #15] was asked if she had witnessed any kind of 'rough playing' between [Day Program Staff #13] and [client #7], [Day Program Staff #15] stated that what she witnessed was abuse and not playing....[Day Program Staff #15] was asked if she had</p>			

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	<p>witnessed this behavior before between the staff and the client and her reply was that [Day program Staff #13] aggravates [client #7] every day on purpose to get a rise out of her and when the other staff gets (sic) involved, [Day Program Staff #13] will leave her alone.... [Day Program Staff #15] was asked why didn't she report this, she replied that she knew that it would be taking (sic) care of based on a conversation with co-workers telling her that she had a scheduled meeting with the PD to discuss this. [Day Program Staff #15] was asked if she was trained on the policy for reporting abuse, her reply was yes....Conclusion: Evidence supports that [Day program Staff #13] did grab [client #7] on her arm and her face as well as teasing her. Evidence supports that [Day Program Staff #13]'s interactions with [client #7] have not been appropriate. Evidence supports the allegation of abuse. Evidence supports that staff did not report their concerns in a timely manner." Review of the record failed to indicate clients at the facility owned day program were interviewed in regard to this allegation of abuse.</p> <p>-Investigation record dated 3/20/14 involving client #2 indicated: "A report was made to [Day Program Director] by the Fire Watch Volunteer on 3/20/14 that [Day Program Staff #21] had not handled</p>			

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	[client #2] appropriately when assisted (sic) her from the couch. In addition, there was a concern that the client and the staff were in the bathroom for an extended period of time. [Day Program Staff #21] was suspended on 3/20/14 pending the outcome of the investigation. [Fire Watch Volunteer] stated that he was assigned to remain at our day service location as the fire watch volunteer on 3/20/14....[Fire Watch Volunteer] stated he doesn't know how she knew that the client needed to use the restroom but the staff person grabbed the client by her shirt at the top of her shoulder to get her off the couch. [Fire Watch Volunteer] stated that the staff took the client into the restroom holding her by the shirt still and walking her to the restroom. Once in the restroom, the client was in the restroom for approximately 7-10 minutes. [Fire Watch Volunteer] stated that the staff brought the clients (sic) dirty diaper out to throw it away and then got a clean one and went back in the restroom. [Fire Watch Volunteer] stated that some of the other firefighters who have been assigned to the Day Service for fire watch have mentioned that this particular staff person doesn't speak (sic) very respectful tone to the clients or to the other workers. [Fire Watch Volunteer] stated that there has not been any concern with any of the other staff....Conclusion:...Evidence does			

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W000210	<p>support that [Day Program Staff #21] did not assist [client #2] using the least restrictive means necessary when assisting her to the restroom." Further review of the record failed to indicate all clients at the facility owned day program were interviewed in regard to this allegation of staff abuse.</p> <p>An interview with the Program Director (PD) was conducted on 1/13/15 at 1:45 P.M.. The PD indicated there was no written documentation to indicate the facility interviewed all clients in regard to both allegations of staff abuse.</p> <p>9-3-2(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, record review and interview for 2 of 2 clients who used wheelchairs (clients #6 and #7), the</p>	W000210	The facility coordinates and implements the clients goals and objectives on client and team input as well as comprehensive functional assessments which are	02/15/2015

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	<p>facility failed to assess/reassess the clients' use of a wheelchair.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 1/13/15 from 6:10 A.M. until 7:45 A.M.. During the entire observation, clients #6 and #7 were observed sitting in standard wheelchairs.</p> <p>An evening observation was conducted at the group home on 1/13/15 from 5:25 P.M. until 7:15 P.M.. During the entire observation, clients #6 and #7 were observed sitting in standard wheelchairs.</p> <p>A facility owned day program observation was conducted on 1/14/15 from 11:00 A.M. until 12:15 P.M.. During the entire observation client #6 sat in a standard wheelchair. Client #7 was observed sitting in a different wheelchair than she was observed sitting in during both group home observations.</p> <p>A review of client #6's records was conducted on 1/14/15 at 3:00 P.M.. Review of client #6's record failed to indicate an assessment was completed for the use of a wheelchair.</p> <p>A review of client #7's records was conducted on 1/14/15 at 2:45 P.M..</p>		<p>completed to determine the level of skills the client is capable of in a particular area. Included in the assessments is sensorimotor development assessment. The PD will update client#6 and # 7 ISP to include the CFA and sensorimotor development assessment. The Area Director will review and monitor the next 4 ISP/CFA to make sure they have the required information under the state guidelines. In addition to the facility will seek an outside OT specialist to do an assesement on the wheelchair for client #6 and #7. The facility nurse will be retrained to use the information gathered from the OT specialist recommendations and the ISP/ CFA assessment to make sure the appropriate medical care is given to client#6 and #7. The home manager , program director along with the facility nurse will be retrained to get a doctor's appointment for client #6 and 7 for a physical therapy assessment. The facility nurse will be retrained that all doctor's recommendations should be adhered to according to the orders that are prescribed. The program director will monitor the facility nurse's medical charts which include doctor's orders weekly for the next 30 days and then monthly. The Area director will review the facility nurse's medical charts which include doctor's orders bi weekly and then monthly. Residential and day</p>	

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W000249	<p>Review of client #7's record failed to indicate an assessment was completed for the use of a wheelchair.</p> <p>An interview with the facility's nurse was conducted on 1/15/15 at 2:45 P.M.. The nurse indicated clients #6 and #7's wheelchair assessments could not be located. No documentation was available for review to indicate clients #6 and #7 had assessments completed for the use of wheelchairs.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (clients #1, #2, #3 and #4), the facility failed to implement the clients' Individual Support Plan (ISPs) objectives when</p>	W000249	<p>program staff will be retrained by the facility nurse on any new orders or updates regarding client 6 and 7 wheelchairs. The home manger will be retrained to do observations on the use of adaptive equipment for client 6 and 7 daily for the next 30 days and then weekly. The PD will be retrained to do observation weekly for the next 30 days on the use of adaptive equipment and then monthly.</p> <p>The facility currently trains staff upon hire and annually on the importance of implementation of the client's goals and objectives as well as providing consistent and continuous active treatment to support the achievement of objectives in the ISP. The</p>	02/15/2015

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	<p>formal and/or informal opportunities for training existed.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/13/15 from 6:10 A.M. until 7:45 A.M.. During the entire observation period, clients #2 and #3 were non-verbal in communication in that the clients did not speak. No communication training was provided and/or encouraged. Client #1 only used 1 word answers during the entire observation. No communication training was provided and/or encouraged. Beginning at 6:35 A.M., Direct Support Professional (DSP) #2 began administering medications to clients #2, #3 and #4. DSP #2 popped each client's medication into paper souffle cups and handed the medications to each client. There was no teaching or training during the medication administration. From 6:50 A.M. until 7:45 A.M., client #4 stayed in his bedroom with no activity. Clients #1 and #2 sat in the living room with no activity and client #3 slept on the living room couch.</p> <p>An observation was conducted at the group home on 1/13/15 from 5:25 P.M. until 7:15 P.M.. During the entire observation period, clients #2 and #3</p>		<p>Program Director will train all staff on each of the client's goals and objectives including the need to implement the objectives at all opportunities available. The home manager will complete observations at various times twice a week during mealtimes to ensure the staff is providing consistent and continuous active treatment and that objectives are being implemented at all available opportunities. The Program Director will complete observations weekly on various mealtimes to ensure the staff is providing consistent and continuous active treatment and that objectives are being implemented at all available opportunities.</p>	

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	<p>were non-verbal in communication in that the clients did not speak. No communication training was provided and/or encouraged. Client #1 only used 1 word answers during the entire observation. No communication training was provided and/or encouraged. From 5:30 P.M. until 6:45 P.M., client #4 stayed in his room with no activity.</p> <p>A review of client #1's record was conducted on 1/14/15 at 12:17 P.M.. The Individual Support Plan (ISP) dated 3/20/14 indicated the following training objectives which could have been implemented during both observations: "Med Administration: Daily [client #1] will get his cup of (sic) water...Will write his name...Will engage in some form of exercise...Staff will show [client #1] pictures and ask him to tell staff what each picture is."</p> <p>A review of client #2's records was conducted on 1/14/15 at 1:20 P.M.. The ISP dated 12/20/14 indicated the following training objectives which could have been implemented during both observations: "Every med pass will dispose of her cup...Will learn new site (sic) words...Will press the blender button...Will engage in meaningful activity...Will engage in some form of exercise."</p>			

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	<p>A review of client #3's records was conducted on 1/14/15 at 1:45 P.M.. The ISP dated 11/14/14 indicated the following training objectives which could have been implemented during both observations: "Will punch put one of her medications...Will exercise...Staff will show and sign pictures to [client #3]."</p> <p>A review of client #4's records was conducted on 1/14/15 at 2:30 P.M.. The ISP dated 8/24/14 indicated the following training objectives which could have been implemented during both observations: "Medication Administration: Daily [client #4] will get his cup of water...Will engage in some form of exercise..."</p> <p>An interview with the Area Director (AD) was conducted on 1/15/15 at 2:45 P.M.. The AD indicated the facility staff should implement clients #1, #2, #3 and 4's communication training and training objectives at all times of opportunity.</p> <p>9-3-4(a)</p>			

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W000259	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p> <p>Based on record review and interview, the facility failed to assure a Comprehensive Functional Assessment (CFA) was completed for 2 of 4 sampled clients and 1 additional client (clients #3, #4 and #5).</p> <p>Findings include:</p> <p>A review of client #3's record was conducted on 1/14/15 at 11:55 A.M.. The review indicated a CFA had not been completed for client #3.</p> <p>A review of client #4's record was conducted on 1/14/15 at 1:30 P.M.. The review indicated a CFA was not completed for client #4.</p> <p>A review of client #5's record was conducted on 1/14/15 at 2:00 P.M.. The review indicated a CFA was not completed for client #5.</p> <p>An interview with the Area Director (AD) was conducted on 1/15/15 at 2:45 P.M.. The AD indicated the facility did</p>	W000259	<p>The facility currently does a series of assessments to include the needs and ability of the clients. The Program director is trained that an assessment is done upon admission and annually of the client to determine the client's skills, progress and areas of improvement. The Program Director will be retrained on the process of completing CFAs by the Area Director. CFAs will be completed for client's 3, 4 and 5 to determine the clients' skills, progress and areas of improvement. A copy of the assessment will be maintained in the home. The collaboration of the assessments will be given to other outside agencies such as day program in the form of a plan in order to use as a tool to support the client. Periodically assessments can be admended based on the needs of the client's ability or the need for the client to have additional supports. This will be monitored by the Program Director and Home Manager on a weekly basis. If for any reason the needs of the client have changed the assement will be revised toadd changes. The Program Director will train all staff</p>	02/15/2015

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W000268	<p>not have documentation of CFAs being conducted for clients #3, #4 and #5. When asked when CFAs should be completed, the AD stated "CFAs should be completed annually."</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, record review and interview, the facility failed for 2 of 4 sampled clients (clients #2 and #3) who lived in the group home, to promote dignity by not ensuring client #2 had a hair cut and client #3 had appropriately fitted clothing.</p> <p>Findings include: A morning observation was conducted at the group home on 1/13/15 from 6:10 A.M. until 7:45 P.M.. During the entire the observation period, client #2 was observed squinting her eyes. Client #2's bangs reached to the middle of her eye lids. At 6:20 A.M., client #3 stood up</p>	W000268	<p>of the changes and how to implement the new needs of the client. In addition to the program director will be retrained by the area director to meet with the outside agencies monthly to make sure the client's needs are being implemented and followed. The Area Director will monitor the next 4 CFA's to make sure they have all the required information included and that if there are changes training is being held and changes are implemented appropriately.</p> <p>The facility is committed to treating all the clients we serve with dignity and respect. The facility is also committed to maintaining the health and safety of all the clients Staff is trained upon hire and annually on the clients' rights and to adhere to them at all times. Staff will be trained in client rights and treating the clients with dignity and respect. Staff will be trained to make sure all the clients clothing is fitting properly. Staff will also be trained to implement formal and informal training to prompt a client to ensure proper coverage of the client's body is being maintained. The home manager will complete a daily observation on various shifts for 30 days to</p>	02/15/2015

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	<p>and walked from the dining table to the living room couch. Client #3's shirt came above her navel and her pants were under her stomach exposing her stomach and buttocks. Client #3 did not and was not prompted or assisted in pulling her pants up and shirt down.</p> <p>An evening observation was conducted at the group home on 1/13/15 from 5:25 P.M. until 7:15 P.M.. During the entire the observation period, client #2 was observed squinting her eyes. Client #2's bangs reached to the middle of her eye lids. At 5:55 P.M., client #3 stood up and walked from the living room to the kitchen. Client #3's shirt came above her navel and her pants were under her stomach. At 6:05 P.M., client #3 walked from the living room into the kitchen and then into the dining room. Client #3's shirt came above her navel and her pants were under her stomach, exposing her stomach and buttocks. Client #3 did not and was not prompted or assisted in pulling her pants up and shirt down.</p> <p>A review of client #3's record was conducted on 1/14/15 at 1:45 P.M.. Review of client #3's dietary assessment dated 9/30/14 indicated she had weight gain in the past 6 months and was currently off one of her medications due to excessive weight gain.</p>		<p>ensure the clients are dressed appropriately. If at the end of 30 days it is determined that there is compliance the home manager will complete observations 3 times a week routinely to make sure the clients are dressed appropriately. Staff will be retrained that all clients should be provided with a choice as to what style they would like their hair and what place they would like to receive hair cut services. The client will receive haircuts on a regular basis at least every six weeks or if the client's length of hair is interfering with the ability to see because of covering the eyes. The Home Manager will complete a daily observation on various shifts for 30 days to ensure all staff are insuring the dignity of the clients. If at the end of 30 days it is determined that there is compliance the Home Manager will complete observations at various times three times a week. The Program Director will complete observations weekly on various shifts for the next 30 days and then monthly to ensure the dignity of the clients.</p>	

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W000331	<p>An interview was conducted with the Area Director (AD) on 1/15/15 at 2:45 P.M.. The AD indicated she wasn't sure when the last time client #2 had her hair cut. The AD indicated clients should at least go monthly to get their haircut. The AD indicated client #3 should have proper fitting clothing at all times. The AD further indicated client #3 had gained weight.</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview for 2 of 4 sampled clients (clients #1 and #4), the facility's nursing staff failed to ensure facility staff were adequately trained and showed competency in regard to documenting/tracking clients #1 and #4's bowel movements and implementing the clients' constipation protocols. The facility's nursing staff failed to ensure staff documented clients #1 and #4's weights as ordered by their physician. The facility's nursing staff failed to</p>	W000331	<p>The facility is committed to maintaining the health and safety of the clients. Staff will be retrained on client #1 and 4 's constipation protocol and how to document on the required forms as ordered by the physician. Staff will also be retrained on checking and documenting the weights for client 1 and 4. The facility nurse will be retrained by the Area Director to follow the doctor's orders as prescribed. The facility nurse will be retrained to monitor the client's medication charts weekly to make sure documentation is current and</p>	02/15/2015

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	<p>monitor each client's constipation to prevent blockage on a more frequent basis.</p> <p>Findings include:</p> <p>1. A review of client #1's record was conducted on 1/14/15 at 12:17 P.M.. Review of client #1's "Constipation Protocol" dated 3/20/14 indicated:</p> <p>"Incontinent of bowel/bladder. Staff toilet [client #1]. Usually has BM (Bowel Movement) daily. Document BMs? Yes If yes, where? MAR (Medication Administration Record). If document BMs, how/ Observed....PRN (as needed) bowel medications: If no BM for 3 days or hard stools noted, Give Milk of Magnesia, 2 tbs (tablespoons) every 4 hours as needed. Notify nurse of use. If no BM after 8 hours after receiving Milk of Magnesia notify nurse....After following PRN order, if no stool by the end of 1st day, call supervisor and R.N. (Registered Nurse)...If person has 'no' or only small stool in 3 days, call Supervisor and R.N....Document incident in Medical notes, Incident Report and DSR (Daily Service Report)."</p> <p>A review of client #1's record was</p>		<p>complete. The nurse will notify the home manager and/or Program Director id documentation is not current and complete. The home manager and Program Director will be trained to provide additional oversight by monitoring the client's charts on a bi weekly bases to make sure documentation is current and complete.</p>	

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	<p>conducted on 1/14/15 at 12:17 P.M.. A review of client #1's MARs for the months of 4/1/14 to 1/16/15 indicated no administration of client #1's PRN Milk of Magnesia during those months.</p> <p>A review of client #1's bowel tracking sheets indicated: No documented bowel movement on 4/14, 4/15, 4/16, 4/17, 4/18, 4/19, 4/20, 4/21, 4/22, 4/23, 4/24, 4/25, 4/28, 4/29, 4/30/14, no documented bowel movements during the month of June 2014, no documented bowel movement on 9/1 through 9/18/14, no bowel movement 11/10, 11/11, 11/12, 11/13, 11/16, 11/17, 11/18, 11/19, 11/20, 11/21/14. There was no documentation to indicate the supervisor or RN was contacted as directed in his "Constipation Protocol" dated 3/20/14. Review of the documentation failed to indicate staff noted the shape, size, consistency, and color of client #1's BMs as noted in his protocol.</p> <p>A review of client #1's Physician Orders (PO) dated 1/14 to 1/15 indicated: "Weight...Weight to be done every Sunday morning, initial and record on MAR chart." Review of client #1's MAR dated 5/14 indicated no weight documentation on 5/4/14 and 5/18/14. Review of client #1's MAR dated 8/1/14 indicated no weight documentation for</p>			

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	<p>8/24/14. Review of client #1's MAR dated 11/14 indicated no weight documentation on 11/16/14. Review of the record failed to indicate client #1 was weighed every Sunday as ordered by his physician.</p> <p>2. A review of client #4's record was conducted on 1/14/15 at 2:30 P.M.. Review of client #4's "Constipation Protocol" dated 8/24/14 indicated:</p> <p>"Incontinent of bowel/bladder. Staff toilet [client #4]. Usually has BM (Bowel Movement) daily. Document BMs? Yes If yes, where? MAR (Medication Administration Record). If document BMs, how/ Observed....PRN (as needed) bowel medications: If no BM for 3 days or hard stools noted, Give Milk of Magnesia, 2 tbs (tablespoons) every 4 hours as needed. Notify nurse of use. If no BM after 8 hours after receiving Milk of Magnesia notify nurse....After following PRN order, if no stool by the end of 1st day, call supervisor and R.N. (Registered Nurse)...If person has 'no' or only small stool in 3 days, call Supervisor and R.N....Document incident in Medical notes, Incident Report and DSR (Daily Service Report)."</p>			

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	<p>A review of client #4's record was conducted on 1/14/15 at 2:30 P.M.. A review of client #4's MARs for the months of 4/1/14 to 1/16/15 indicated no administration of client #4's PRN Milk of Magnesia during those months.</p> <p>A review of client #4's bowel tracking sheets for 2014 indicated: No documented bowel movement on 4/1, 4/2, 4/3, 4/4, no documented bowel movement on 4/8 through 4/25, 4/28, 4/29, 4/30, no documented bowel movement on 6/1 through 6/8, 6/10, 6/11, 6/12, 6/13, no documented bowel movement on 6/15 through 6/29, no documented bowel movement on 8/1 through 8/5, no documented bowel movement on 8/21 through 8/29, no documented bowel movement on 9/1 through 9/19. There was no documentation to indicate the supervisor or RN was contacted as directed in his "Constipation Protocol" dated 8/24/14. Review of the documentation failed to indicate staff noted the shape, size, consistency, and color of client #4's BMs as noted in his protocol.</p> <p>A review of client #4's Physician Orders (PO) dated 1/14 to 1/15 indicated: "Weight...Weight to be done every Sunday morning, initial and record on MAR chart." Review of client #4's MAR</p>			

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W000436	<p>dated 5/14 indicated no weight documentation on 5/4/14. Review of the record failed to indicate client #4 was weighed every Sunday as ordered by his physician.</p> <p>An interview with the facility's nurse was conducted on 1/15/15 at 2:45 P.M.. The nurse indicated all staff are to document clients #1 and #4's bowel movements as indicated in their protocols. The nurse indicated there was no written documentation to indicate the facility notified the physician of clients #1 and #4's lack of bowel movements. The nurse indicated there was no documentation available for review to indicate the facility's nursing services monitored clients #1 and #4's bowel movements and weights.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p>			

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	<p>Based on observation, record review and interview, the facility failed to assure the repair of adaptive equipment for 2 of 2 clients (clients #6 and #7) who used a wheelchair for mobility.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 1/13/15 from 6:10 A.M. until 7:45 A.M.. During the observation periods clients #6 and #7 sat in wheelchairs. Clients #6 and #7's left and right arm rests were torn and broken, exposing the yellow colored stuffing and metal.</p> <p>An evening observation was conducted at the group home on 1/13/15 from 5:25 P.M. until 7:15 P.M.. During the observation periods clients #6 and #7 sat in wheelchairs. Clients #6 and #7's left and right arm rests were torn and broken, exposing the yellow colored stuffing and metal.</p> <p>An interview with clients #6 and #7 was conducted at the group home on 1/13/15 at 5:45 P.M.. Clients #6 and #7 stated their arm rests had been torn for a "long" time.</p> <p>A review of client #6's record was conducted on 1/14/15 at 3:30 P.M..</p>	W000436	<p>The facility is committed to making sure the health and safety of the clients are maintained at all times. The program director and home manager will be retrained by the Area director to provide and maintain adaptive equipment for all the clients we serve. The home manager will contact a wheelchair repair company and request a loaner wheelchair if needed client #6 and 7 while the wheelchair arms are repaired. The home manager will be retrained to monitor the clients adaptive equipment weekly to make sure it is in good working order. The program director will be retrained to monitor the clients adaptive equipment at least bi weekly to make sure it is in good working order. The home manager and program director will be trained to provide the Area director with weekly updates as to the progress of getting the chair repaired.</p>	02/15/2015

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W000440	<p>Review of client #6's record indicated she used a wheelchair at all times for mobility.</p> <p>A review of client #7's record was conducted on 1/14/15 at 3:45 P.M.. Review of client #7's record indicated she used a wheelchair at all times for mobility.</p> <p>An interview with the Area Director (AD) was conducted on 1/15/15 at 2:45 P.M.. The AD indicated clients #6 and #7's wheelchair arm rests should be repaired. When asked when the wheelchairs would be repaired, the AD indicated she did not know.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills which affected 8 of 8 clients living in the facility (clients #1, #2, #3, #4, #5, #6, #7 and #8).</p> <p>Findings include:</p>	W000440	<p>The facility is committed to treating all the clients with dignity and respect. The facility is also committed to maintain the health and safety of all the clients. The staff will be retrained to complete a fire drill according to the evacuation schedule which designates rotating shifts each month for a drill to be completed</p>	02/15/2015

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W000455	<p>The facility's records were reviewed on 1/13/15 at 6:50 A.M.. The review failed to indicate the facility held an evacuation drill for clients #1, #2, #3, #4, #5, #6, #7 and #8 during the morning shift (8:00 A.M. to 4:00 P.M.) for the first quarter (January 1st through March 31st), during the morning shift (8:00 A.M. to 4:00 P.M.) and overnight shift (12:00 A.M. to 8:00 A.M.) for the second quarter (April 1st through June 30th), no evacuation drills during the third quarter (July 1st through September 30th) and for the evening shift (4:00 P.M. to 12:00 A.M.) for the fourth quarter of 2014.</p> <p>The Area Director (AD) was interviewed on 1/15/15 at 2:55 P.M.. The AD indicated evacuation drills are to be conducted during each quarter for each shift of personnel. The AD further indicated there was no written documentation to indicate the facility conducted evacuation drills during each quarter for each staff shift.</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL There must be an active program for the</p>		<p>in accordance with the regulations. The home manager and program director will be retrained by the area director to make sure that the fire drills are done and that adequate documentation is kept in the home. For the next 3 months the area director will monitor the documentation in the home to make sure all the correct information is recorded and that the documents are in the home for review.</p>	

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	<p>prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation and interview, the facility failed to maintain proper hygiene practices and prevent cross contamination, for 4 of 4 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5, #6 and #7) observed during meal time.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/13/15 from 5:25 P.M. until 7:15 P.M.. From 5:25 P.M. until 6:00 P.M., client #3 lay on the living room couch, coughed, wiped her nose with her hand and ran her hands through her hair. Client #1 sat on the couch, wiped his face, picked his nose and picked up his cup from the floor. At 6:00 P.M., Direct Support Professional (DSP) #4 prompted client #1 to set the cups on the dining table. Client #1 walked to the kitchen cabinet with her bare, unwashed hands, retrieved 7 cups and set them on the dining table in front of clients #1, #2, #3, #4, #5, #6 and #7's individual place setting. Client #3 did not and was not prompted to wash her hands. At 6:05 P.M., DSP #4 prompted client #1 to set the plates on the dining table. DSP #4 handed a stack of dining</p>	W000455	<p>The facility is committed to maintaining the health and safety of all the clients we serve. Staff have been trained upon hire and annually on universal precautions. Staff will be retrained on universal precaution and to have the clients wash their hands prior to setting tables, food preparation, eating , taking medicines and during restroom visits. In addition staff will be retrained if at any point the client's hands become contaminated in anyway staff will prompt the client to wash hands again. The home manager will be retrained to do daily observation for the next 30 days and then weekly. The program director will do observations weekly for the next 30 days and then monthly on progress of implementing universal precautions.</p>	02/15/2015

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W000474	<p>plates to client #1 in his bare, unwashed hands. Client #1 placed each plate in front of each client's place setting. Client #1 did not and was not prompted to wash his hands.</p> <p>An interview with the facility's nurse was conducted on 1/15/15 at 2:45 P.M.. The nurse indicated staff should have prompted clients #1 and #3 to wash their hands before handling the cups and plates.</p> <p>9-3-7(a)</p> <p>483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (client #2), to ensure food was served in a manner that allowed the client to enjoy the taste of each individual item.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/13/15 from 5:25 P.M. until 7:15 P.M.. At 6:50 P.M., Direct Support Professional (DSP) #5 was observed putting client #2's entire meal into the blender and blending</p>	W000474	<p>The facility is committed to treating the clients we serve with dignity and respect at all times. Staff will be retrained to prepare the food for client #2 to the textured described in the dietary assessment. Staff will also be trained that each food item should be prepared separately and placed in the divided bowl provided for client #2. The home manger will be trained to do an observation of food preparation daily for the next 30 days and then 3 times a week routinely during various shifts. The program director will do observations of meal time preparation twice a week for the</p>	02/15/2015

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W000484	<p>everything together. DSP #5 then poured all of the contents into a bowl and placed the contents in front of client #2 and prompted client #2 to serve the food into her divided bowl. The meal consisted of roast, carrots, potatoes and bread sticks. Client #2's food was of a baby food consistency. Her meat was not of a ground consistency. Client #2's food was not blended individually and was not served into her divided bowl individually.</p> <p>A review of client #2's record was conducted on 1/14/15 at 1:30 P.M.. Review of client #2's dietary assessment dated 12/12/14 indicated she was on a mechanical soft diet with ground meats.</p> <p>An interview with the Area Director (AD) was conducted on 1/15/15 at 2:45 P.M.. The AD indicated client #2's food should have been blended individually.</p> <p>9-3-8(a)</p> <p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each</p>		next 30 days and then weekly on a routine bases various shifts to ensure the client's dietary plan is being adhered to by staff.				

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	<p>client.</p> <p>Based on observation and interview, the facility failed for 7 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7 and #8) observed eating breakfast, to provide condiments at the dining table.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 1/13/15 from 6:10 A.M. until 7:45 A.M.. Beginning at 6:10 A.M., clients #1, #2, #3, #4, #5, #6 and #7 began eating their breakfast which consisted of hot wheat cereal, toasted bread and juice. No sugar/sugar substitute, jelly, butter/margarine or milk were on the table for clients #1, #2, #3, #4, #5, #6 and #7's use.</p> <p>A review of the group home menu was conducted at the group home on 1/13/15 at 5:30 P.M.. Review of the menu indicated: "Week 2 Regular Menu Winter...Breakfast 1/2 cup Orange Juice, 3/4 cup assorted cold cereal, 1-2 slices raisin toast, 1 teaspoon margarine/jelly and 1 cup Skim milk/coffee/tea."</p> <p>An interview with the Area Director (AD) was conducted on 1/15/15 at 2:45 P.M.. The AD indicated sugar/sugar substitute, butter/margarine, jelly and</p>	W000484	The facility is committed to make sure that the individuals are provided with all the condiments needs during mealtime preparation. Staff will be retrained that condiments should be provided to all the clients during mealtimes. The home manager will be retrained to do various observations daily for the next 30 days and then weekly during different meal times to make sure condiments are being provided . The program director will be retrained to do various observations weekly for the next 30 days and then monthly to make sure condiments are being provided during mealtimes.	02/15/2015

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W000488	<p>milk should be put on the table for the clients to use.</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview, the facility failed for 1 of 4 sampled clients (client #2) to ensure she assisted with her meal preparation.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/13/15 from 5:25 P.M. until 7:15 P.M.. At 6:50 P.M., Direct Support Professional (DSP) #5 was observed putting client #2's entire meal into the blender and blending everything together as client #2 sat at the dining table with no activity. DSP #5 then poured all of the contents into a bowl and placed the contents in front of</p>	W000488	<p>The facility is committed to making sure that all clients are participating during mealtime preparation. Staff will be retrained to implement client#2 ISP goals and objectives formally and informally during mealtimes along with the other clients in the facility. The home manger will be retrained to conduct an observation daily during various shifts of meal times for the next 30 days and then 3 times a week routinely during various meal times to make sure goals and objectives are being implemented by staff for all the clients. The program director will do an observation 2 times a week at various meal times and then weekly to make sure goals and objectives are being implemented by staff with all the</p>	02/15/2015

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W009999	<p>client #2 and prompted client #2 to serve the food into her divided bowl. The meal consisted of roast, carrots, potatoes and bread sticks. Client #2 did not and was not prompted to push the button on the blender.</p> <p>A review of client #2's records was conducted on 1/14/15 at 1:20 P.M.. The Individual Support Plan (ISP) dated 12/20/14 indicated: "Will press the blender button."</p> <p>An interview with the Area Director (AD) was conducted on 1/15/15 at 2:45 P.M.. The AD indicated staff should have had client #2 assist with her meal preparation by pressing the button on the blender.</p> <p>9-3-8(a)</p> <p>State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>460 IAC 9-3-3 Facility Staffing</p>	W009999	<p>clients.</p> <p>The facility is committed to operating and following all state guidelines per the regulation. The Home Manager and the Program director will be retrained to make sure that all staff are current in all annual job requirements and trainings. The AD will monitor for staff development bi weekly to ensure staff are current and if any</p>	02/15/2015

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	<p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This state rule is not met as evidenced by:</p> <p>Based on interview and record review for 2 of 3 staff personnel records reviewed (staff #2 and #13), the facility failed to ensure Direct Support Professional (DSP) #2 and #13 received an annual mantoux test/screening.</p> <p>Findings include:</p> <p>The facility's employee records were reviewed on 1/15/15 at 2:10 P.M.. Review of DSP #2's personnel file indicated a most current mantoux</p>		<p>staff are coming due the AD will follow up with PD and HM to make sure training is completed.</p>				

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	<p>test/screening conducted on 12/23/13. DSP #13's personnel file indicated a most current mantoux test/screening conducted on 12/11/13. A review of the group home schedule dated 1/4/15 to 1/17/15 indicated DSP #2 and #13 worked at the group home with clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>The Area Director (AD) was interviewed on 1/15/15 at 2:45 P.M.. The AD indicated there was no documentation to indicate DSP #2 and #13 had annual mantoux skin tests. When asked how often staff are to get mantoux test/screening, she indicated annually.</p> <p>9-3-3(e)</p>				