

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/20/2013
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 10606 HAVERSTICK CARMEL, IN 46032
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W000000	<p>This visit was for an extended recertification and state licensure survey.</p> <p>Dates of Survey: June 10, 11, 12, 13, 14, 18, 19 and 20, 2013.</p> <p>Facility number: 001173 Provider number: 15G618 AIM number: 100244220</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/21/13 by Ruth Shackelford, QIDP.</p>	W000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based upon record review and interview, the governing body failed to provide oversight and operating direction over the facility to ensure implementation of their policy and procedures to protect 2 of 4 sampled clients (clients #1 and #2) and 1 additional client (client #8) from the potential of injury from staff falling asleep while transporting the clients after a history of staff falling asleep had been established.</p> <p>Findings include:</p> <p>1. Please see W149. The governing body failed to exercise general policy and operating direction over the facility to ensure implementation of policy and procedures and neglected to implement policy and procedures to protect 2 of 4 sampled clients (clients #1 and #2) and one additional client (client #8), from the potential for harm, injury, and neglect by failing to develop and implement corrective action to address a history of staff falling asleep, neglected to report an incident of physical aggression involving 2 of 4 sampled clients (clients #2 and #3) and 1 additional client (client #7) and</p>	W000104	<p>Refer to W149</p> <p>1. As soon as the QDIP became aware of the possibility of a staff falling asleep and a Home Manager not reporting possible previous incidents of sleeping immediate protective measures were implemented to protect the clients from potential further neglect by suspending both staff. Once the evidence to support the allegation of the staff sleeping and the manager not reporting previous incidents of sleeping was identified both staff were terminated from Indiana Mentor's employment. Indiana Mentor management and administration will continue to implement immediate protective measures, investigations, and corrective action as designated when allegations of abuse, neglect, or exploitation are made.</p> <p>All direct care staff will be retrained on incident reporting including reporting to the supervisor immediately when incidents of potential abuse or neglect occur, reporting timelines, and DSP and Home Manager role in reporting incidents. All direct care staff will also retrained on the Indiana Mentor Code of Conduct which includes not</p>	07/20/2013	

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	<p>failed to obtain timely medical treatment for a human bite to 1 of 4 sampled clients (client #4).</p> <p>2. Please see W153. The governing body failed to exercise general policy and operating direction over the facility by failing for clients #1, #2, and 1 additional client (client #8) to ensure incidents of staff falling asleep while driving and on duty were reported timely, and failed to ensure an incident of physical aggression involving 2 of 4 sampled clients (clients #2 and #4) resulting in injury requiring medical treatment was reported timely.</p> <p>2. Please see W157. The governing body failed to exercise general policy and operating direction over the facility to ensure development and implementation of effective plans of action to ensure staff were awake and able to drive safely and address the needs of clients, and prevent patterns of physical aggression involving 2 of 4 sampled clients (clients #2 and #3), and one additional client (client #7).</p> <p>9-3-1(a)</p>		<p>sleeping while on the clock.</p> <p>2, 3, 4 The Program Director will be retrained on involving a client's IDT when an incident of aggression occurs to develop a plan of action to prevent further incidents of aggression. The Program Director will convene the IDT for clients #2, #3 and #7 to discuss the incidents of aggression and make recommendations as appropriate including changes to plans, as needed.</p> <p>The Area Director will maintain a database of incidents in order to monitor the need for IDTs to address incidents of aggression. The Area Director will review the database a minimum of monthly to determine if any patterns of aggression are occurring. If a pattern of aggression is determined, the Area Director will work with the Program Director and consumer's IDT to determine if any changes to the consumers BSP need to be put into place or if any additional protective measures need to be implemented to prevent further incidents of aggression. The database will include the outcome/results in resolving the issue as part of the database.</p> <p>Refer to W153 As soon as the QDIP became aware of the possibility of a staff</p>		

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			<p>falling asleep and a Home Manager not reporting possible previous incidents of sleeping immediate protective measures were implemented to protect the clients from potential further neglect by suspending both staff. Once the evidence to support the allegation of the staff sleeping and the manager not reporting previous incidents of sleeping was identified both staff were terminated from Indiana Mentor's employment. Indiana Mentor management and administration will continue to implement immediate protective measures, investigations, and corrective action as designated when allegations of abuse, neglect, or exploitation are made.</p> <p>All direct care staff will be retrained on incident reporting including reporting to the supervisor immediately when incidents of potential abuse or neglect occur, reporting timelines, and DSP and Home Manager role in reporting incidents.</p> <p>The PD will be retrained on the requirement for the completion of investigations and the development of recommendations based on the factual findings of the investigation to include but not be limited to corrective action for staff, retraining of staff, client plan changes, etc.</p>		

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			<p>The Area Director will maintain a database of incidents in order to monitor the need for IDTs to address incidents of aggression. The Area Director will review the database a minimum of monthly to determine if any patterns of aggression are occurring. If a pattern of aggression is determined, the Area Director will work with the Program Director and consumer's IDT to determine if any changes to the consumers BSP need to be put into place or if any additional protective measures need to be implemented to prevent further incidents of aggression. The database will include the outcome/results in resolving the issue as part of the database.</p> <p>Refer to W157</p> <p>1. As soon as the QDIP became aware of the possibility of a staff falling asleep and a Home Manager not reporting possible previous incidents of sleeping immediate protective measures were implemented to protect the clients from potential further neglect by suspending both staff. Once the evidence to support the allegation of the staff sleeping and the manager not reporting previous incidents of sleeping was identified both staff were terminated from Indiana Mentor's employment. Indiana Mentor management and administration will continue to implement</p>		

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			<p>immediate protective measures, investigations, and corrective action as designated when allegations of abuse, neglect, or exploitation are made.</p> <p>All direct care staff will be retrained on incident reporting including reporting to the supervisor immediately when incidents of potential abuse or neglect occur, reporting timelines, and DSP and Home Manager role in reporting incidents. All direct care staff will also retrained on the Indiana Mentor Code of Conduct which includes not sleeping while on the clock.</p> <p>2, 3, 4 The Program Director will be retrained on involving a client's IDT when an incident of aggression occurs to develop a plan of action to prevent further incidents of aggression. The Program Director will convene the IDT for clients #2, #3 and #7 to discuss the incidents of aggression and make recommendations as appropriate including changes to plans, as needed.</p> <p>The Area Director will maintain a database of incidents in order to monitor the need for IDTs to address incidents of aggression. The Area Director will review the database a minimum of monthly to determine if any patterns of aggression are occurring. If a</p>	

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			<p>pattern of aggression is determined, the Area Director will work with the Program Director and consumer's IDT to determine if any changes to the consumers BSP need to be put into place or if any additional protective measures need to be implemented to prevent further incidents of aggression. The database will include the outcome/results in resolving the issue as part of the database.</p> <p>Responsible Staff: Program Director, Area Director</p>		

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W000112	<p>483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</p> <p>Based on observation, record review, and interview, the facility failed to protect the confidentiality of 1 of 4 sampled clients (client #1) and 1 additional client (client #7) by posting signs which contained personal information.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 6/10/13 from 5:10 PM until 6:35 PM. There were two handwritten signs on the medication closet located in the common area living room used by clients #1, #2, #3, #4, #5, #6, #7, and #8 and within view of visitors to the home. A sign dated 8/14/12 indicated, "Everyone. Please have [client #7] remove her glasses at bedtime and when she becomes upset to avoid destroying them. Lock the glasses up every night in the med cabinet every night, then return them to her in the morning." Another sign indicated "PLEASE weigh [client #1] every morning before breakfast starting 10/1/12."</p> <p>The Program Director (PD) was interviewed on</p>	W000112	<p>The Home Manager and/or Program Director will remove and secure all confidential information posted in this home.</p> <p>The Home Manager and staff working in this home will be retrained on confidentiality requirements.</p> <p>Program Director will be retrained on the requirement to be in the home at least once weekly to monitor the implementation of policy/procedures including those for confidentiality.</p> <p>Ongoing the Home Manager and Program Director will ensure all confidential information remains secured and confidential.</p> <p>Ongoing the Area Director, Quality Assurance Specialist and Regional Director will monitor the home to ensure confidentiality requirements are met whenever they happen to be on site.</p> <p>The Area Director will determine appropriate corrective action for any breach of confidentiality if necessary.</p> <p>Responsible Staff: Home Manager, Program Director, Area</p>	07/20/2013	

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	6/10/13 at 6:15 PM and indicated she was unsure why the signs were posted on the door and indicated staff do not lock client #7's glasses. She indicated the signs should not have been posted and she would take them down. 9-3-1(a)		Director, Quality Assurance Specialist		

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to protect clients from harm/injury by failing to implement policy and procedures to protect 2 of 4 sampled clients (clients #1 and #2) and one additional client (client #8), from the potential for harm, injury, and neglect by failing to report, develop and implement corrective action to address incidents of staff falling asleep while driving and on duty, neglected to report an incident of physical aggression involving 2 of 4 sampled clients (clients #2 and #4) resulting in injury requiring medical treatment, failed to obtain timely medical treatment for a human bite for 1 of 4 sampled clients (client #4), failed to develop effective corrective action to protect 1 of 4 sampled clients (client #1) and 3 additional clients (clients #6, #7 and #8) from a pattern of physically aggressive behavior by client #2, failed to develop and implement effective corrective action to protect 1 of 4 sampled clients (client #3) and one additional client (client #7) from a pattern of client #3's self injurious and aggressive behavior, failed to protect 1 additional</p>	W000122	<p>Refer to W149</p> <p>1 As soon as the QDIP became aware of the possibility of a staff falling asleep and a Home Manager not reporting possible previous incidents of sleeping immediate protective measures were implemented to protect the clients from potential further neglect by suspending both staff. Once the evidence to support the allegation of the staff sleeping and the manager not reporting previous incidents of sleeping was identified both staff were terminated from Indiana Mentor's employment. Indiana Mentor management and administration will continue to implement immediate protective measures, investigations, and corrective action as designated when allegations of abuse, neglect, or exploitation are made.</p> <p>All direct care staff will be retrained on incident reporting including reporting to the supervisor immediately when incidents of potential abuse or neglect occur, reporting timelines, and DSP and Home Manager role in reporting incidents. All direct care staff will also retrained on the Indiana Mentor Code of Conduct which includes not sleeping while on the clock.</p>	07/20/2013			

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	<p>client (client #7) from being aggressed upon, and failed to thoroughly investigate bruises of unknown source for 2 of 4 sampled clients (clients #3, #4).</p> <p>Findings include:</p> <p>1. Please see W149. The facility neglected to implement policy and procedures to protect 2 of 4 sampled clients (clients #1 and #2) and one additional client (client #8), from the potential for harm, injury, and neglect by failing to report, develop and implement corrective action to address incidents of staff falling asleep while driving and on duty, neglected to report an incident of physical aggression involving 2 of 4 sampled clients (clients #2 and #4) resulting in injury requiring medical treatment, failed to obtain timely medical treatment for a human bite for 1 of 4 sampled clients (client #4), failed to develop effective corrective action to protect 1 of 4 sampled clients (client #1) and 3 additional clients (clients #6, #7 and #8) from a pattern of physically aggressive behavior by client #2, failed to develop and implement effective corrective action to protect 1 of 4 sampled clients (client #3) and one additional client (client #7) from a pattern of client #3's self injurious and aggressive</p>		<p>2, 3, 4 The Program Director will be retrained on involving a client's IDT when an incident of aggression occurs to develop a plan of action to prevent further incidents of aggression. The Program Director will convene the IDT for clients #2, #3 and #7 to discuss the incidents of aggression and make recommendations as appropriate including changes to plans, as needed.</p> <p>The Area Director will maintain a database of incidents in order to monitor the need for IDTs to address incidents of aggression. The Area Director will review the database a minimum of monthly to determine if any patterns of aggression are occurring. If a pattern of aggression is determined, the Area Director will work with the Program Director and consumer's IDT to determine if any changes to the consumers BSP need to be put into place or if any additional protective measures need to be implemented to prevent further incidents of aggression. The database will include the outcome/results in resolving the issue as part of the database.</p> <p>Refer to W153 As soon as the QDIP became aware of the possibility of a staff falling asleep and a Home</p>		

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	<p>behavior, failed to protect 1 additional client (client #7) from being aggressed upon.</p> <p>2. Please see W153. The facility failed to report incidents of staff falling asleep and failed to report an incident of a bite resulting in injury requiring medical treatment involving 2 of 4 sampled clients (clients #2 and #4).</p> <p>2. Please see W157. The facility failed to implement corrective action to address a history of staff falling asleep, and failed to develop and implement effective corrective action to address a pattern of physical aggression involving 2 of 4 sampled clients (clients #2, #3) and 1 additional clients (client #7).</p> <p>9-3-2(a)</p>		<p>Manager not reporting possible previous incidents of sleeping immediate protective measures were implemented to protect the clients from potential further neglect by suspending both staff. Once the evidence to support the allegation of the staff sleeping and the manager not reporting previous incidents of sleeping was identified both staff were terminated form Indiana Mentor's employment. Indiana Mentor management and administration will continue to implement immediate protective measures, investigations, and corrective action as designated when allegations of abuse, neglect, or exploitation are made.</p> <p>All direct care staff will be retrained on incident reporting including reporting to the supervisor immediately when incidents of potential abuse or neglect occur, reporting timelines, and DSP and Home Manager role in reporting incidents.</p> <p>The PD will be retrained on the requirement for the completion of investigations and the development of recommendations based on the factual findings of the investigation to include but not be limited to corrective action for staff, retraining of staff, client plan changes, etc.</p> <p>The Area Director will maintain a</p>		

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			<p>database of incidents in order to monitor the need for IDTs to address incidents of aggression. The Area Director will review the database a minimum of monthly to determine if any patterns of aggression are occurring. If a pattern of aggression is determined, the Area Director will work with the Program Director and consumer's IDT to determine if any changes to the consumers BSP need to be put into place or if any additional protective measures need to be implemented to prevent further incidents of aggression. The database will include the outcome/results in resolving the issue as part of the database.</p> <p>Refer to W157</p> <p>1. As soon as the QDIP became aware of the possibility of a staff falling asleep and a Home Manager not reporting possible previous incidents of sleeping immediate protective measures were implemented to protect the clients from potential further neglect by suspending both staff. Once the evidence to support the allegation of the staff sleeping and the manager not reporting previous incidents of sleeping was identified both staff were terminated from Indiana Mentor's employment. Indiana Mentor management and administration will continue to implement immediate protective measures,</p>		

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			<p>investigations, and corrective action as designated when allegations of abuse, neglect, or exploitation are made.</p> <p>All direct care staff will be retrained on incident reporting including reporting to the supervisor immediately when incidents of potential abuse or neglect occur, reporting timelines, and DSP and Home Manager role in reporting incidents. All direct care staff will also retrained on the Indiana Mentor Code of Conduct which includes not sleeping while on the clock.</p> <p>2, 3, 4 The Program Director will be retrained on involving a client's IDT when an incident of aggression occurs to develop a plan of action to prevent further incidents of aggression. The Program Director will convene the IDT for clients #2, #3 and #7 to discuss the incidents of aggression and make recommendations as appropriate including changes to plans, as needed.</p> <p>The Area Director will maintain a database of incidents in order to monitor the need for IDTs to address incidents of aggression. The Area Director will review the database a minimum of monthly to determine if any patterns of aggression are occurring. If a pattern of aggression is</p>		

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			<p>determined, the Area Director will work with the Program Director and consumer's IDT to determine if any changes to the consumers BSP need to be put into place or if any additional protective measures need to be implemented to prevent further incidents of aggression. The database will include the outcome/results in resolving the issue as part of the database.</p> <p>Responsible Staff: Program Director, Area Director</p>		

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based upon record review and interview, the facility failed to implement policy and procedures to protect 2 of 4 sampled clients (clients #1 and #2) and one additional client (client #8), from the potential for harm, injury, and neglect by failing to report, develop and implement corrective action to address incidents of staff falling asleep while driving and on duty, neglected to report an incident of physical aggression involving 2 of 4 sampled clients (clients #2 and #4) resulting in injury requiring medical treatment, failed to obtain timely medical treatment for a human bite for 1 of 4 sampled clients (client #4), failed to develop effective corrective action to protect 1 of 4 sampled clients (client #1) and 3 additional clients (clients #6, #7 and #8) from a pattern of physically aggressive behavior by client #2, failed to develop and implement effective corrective action to protect 1 of 4 sampled clients (client #3) and one additional client (client #7) from a pattern of client #3's self injurious and aggressive behavior, and failed to protect 1 additional client (client #7) from being aggressed upon.</p>	W000149	<p>1 As soon as the QDIP became aware of the possibility of a staff falling asleep and a Home Manager not reporting possible previous incidents of sleeping immediate protective measures were implemented to protect the clients from potential further neglect by suspending both staff. Once the evidence to support the allegation of the staff sleeping and the manager not reporting previous incidents of sleeping was identified both staff were terminated from Indiana Mentor's employment. Indiana Mentor management and administration will continue to implement immediate protective measures, investigations, and corrective action as designated when allegations of abuse, neglect, or exploitation are made.</p> <p>All direct care staff will be retrained on incident reporting including reporting to the supervisor immediately when incidents of potential abuse or neglect occur, reporting timelines, and DSP and Home Manager role in reporting incidents. All direct care staff will also retrained on the Indiana Mentor Code of Conduct which includes not sleeping while on the clock.</p>	07/20/2013	

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	<p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 6/10/13 at 3:36 PM and included the following reports involving clients #1, #2, #3, #4, #7, and #8:</p> <p>1. A report dated 4/22/13 and reported 4/25/13 indicated on 4/22/13 during transportation of clients #1, #2 and #8 to day services in the morning, staff #11 possibly fell asleep causing him to swerve and almost hit the car in front of him. He missed the car and was able to come to a stop. The other staff took over the remainder of the driving for the trip. No clients were injured and had been wearing their seat belts. The report indicated staff #11 was suspended and an investigation had been started.</p> <p>An investigation dated 5/2/13 was attached to the 4/22/13 BDDS report and was reviewed on 6/10/13 at 4:00 PM. The investigation included the following interviews:</p> <p>Interview with the PD (Program Director) dated 4/30/13 indicated she had received a text message from the house manager on 4/25/13 that staff #11 "would likely</p>		<p>2, 3, 4 The Program Director will be retrained on involving a client's IDT when an incident of aggression occurs to develop a plan of action to prevent further incidents of aggression. The Program Director will convene the IDT for clients #2, #3 and #7 to discuss the incidents of aggression and make recommendations as appropriate including changes to plans, as needed.</p> <p>The Area Director will maintain a database of incidents in order to monitor the need for IDTs to address incidents of aggression. The Area Director will review the database a minimum of monthly to determine if any patterns of aggression are occurring. If a pattern of aggression is determined, the Area Director will work with the Program Director and consumer's IDT to determine if any changes to the consumers BSP need to be put into place or if any additional protective measures need to be implemented to prevent further incidents of aggression. The database will include the outcome/results in resolving the issue as part of the database.</p> <p>Responsible Staff: Program Director, Area Director</p> <p>Completion Date: 7-20-13</p>				

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	<p>need to be suspended for falling asleep on 4/22/13 during the van run." The PD indicated this was the first report she had received about staff sleeping from the house manager. The PD indicated she suspended staff #11 on 4/25/13 after receiving the report from the house manager.</p> <p>An interview with the house manager dated 4/30/13 "said on more than one occasion [staff #4 and #8] have reported staff #11 arrives to work at 6:30 AM, falls asleep, awakens, and then the transport is completed. [Staff #8 and staff #4] last reported this on 4/19/13 and staff #8 last reported on 4/23 or 24-13 (sic) that [staff #11] fell asleep while driving the van." She indicated she had attempted to contact the house via the house phone on 4/19/13, and was unable to get an answer. She then contacted staff #8 via staff #8's cell phone and was told staff #11 was sleeping. When the house manager then arrived at the home, she sent staff #11 home for the day. "On 4/23 or 24-13 (sic), [staff #4] informed her [staff #11] tried to kill her. He fell asleep at the wheel and started accelerating toward a car stopped at a light. He awakened in time to prevent them from rear ending the car stopped at the light. She drove the van back to the group home and believes [staff #11] slept on the return trip." The house manager</p>			

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	<p>indicated she had reported the 4/22/13 incident on 4/25/13 to the PD on 4/25/13 via text and had reported staff #11 sleeping on the job to the PD on multiple occasions, but had no proof of doing so until the 4/25/13 text to the QIDP.</p> <p>Interview with staff #4 dated 4/30/13 indicated she was riding in the van with staff #11 driving to day services on 4/22/13 when staff #11 failed to respond to a green light after the light had changed and staff #4 noticed his eyes were closed. A few minutes later, she was turned to talk to the clients in the back when she noted the van started accelerating toward a car, and staff #11's eyes were closed and his head was dropped slightly. She yelled at staff #11 that he was about to hit a car and he stopped the car at which time staff #4 took over the driving. She indicated she had reported the incident to the house manager on 4/23/13 and the house manger had indicated she would report the incident to the QIDP. On 4/25/13 staff #4 indicated she asked the house manager what the PD said about staff #11 falling asleep at the wheel and the house manager indicated the PD did not say anything about it. Staff #4 then indicated she would would speak to the QIDP, and staff #4 then saw the house manager text someone. Staff #4 indicated "about a month ago" the house manager had</p>						

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	<p>informed her staff #7 had reported staff #11 falling asleep while driving and almost hitting a pole. "A few Fridays ago (dates not specified) she witnessed [staff #7] informing the house manager that staff #11 fell asleep and she could not awaken him so she had to complete transport by herself."</p> <p>Interview with staff #4 dated 4/30/13 indicated on 4/19/13 she was unable to awaken staff #11 to get on the van to transport clients to day services, despite calling his name in a loud voice, then "screamed at [staff #11] the fourth time in an attempt to awaken him, but he continued not to respond." Staff #4 indicated she had informed the house manager she was completing the transportation route alone since she could not awaken staff #11. "Said she heard comments about staff #11's poor driving skills from [staff #7 and the house manager]."</p> <p>Interview with staff #7 dated 4/30/13 indicated "approximately one month ago" she was in the van and staff #11 was driving with the clients to day services when he "almost rear ended a car stopped at a light and swerved into the lane with an oncoming car." She indicated staff #11 slept in the back of the van for the trip back to the group home while staff #7</p>						

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	<p>drove. She indicated she had reported the incident to the house manager on the same day it occurred and the house manager had indicated she would talk to him about it. Staff #7 indicated she had witnessed the house manager having to awaken staff #11 and it had taken 3 attempts to awaken him.</p> <p>The conclusion of the investigation dated 5/2/13 indicated "evidence supports the allegation that [staff #11] has slept on the job endangering lives. Evidence supports that the house manager did not report this incident to her supervisor as required." No additional action was included in the investigation.</p> <p>The Area Director (AD) was interviewed on 6/12/13 at 4:10 PM. She indicated the staff falling asleep while driving and in the group home and the house manager's failure to report the incidents involving staff #11's sleeping while on duty were in violation of the facility's abuse and neglect prevention policy and procedures. She indicated staff #11 and the house manager had been terminated as a result of the incidents of staff #11 sleeping and the house manager's failure to report the incidents as per policy and procedures. The AD indicated corrective action would have been taken to address client #11's sleeping on the job had the incidents been</p>						

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	<p>reported when they occurred.</p> <p>2. BDDS reports dated 6/30/12 and reported 7/2/12 indicated client #2 bit client #4 on the head on 6/30/12 causing the skin to break. The report did not indicate where the bite occurred or additional information regarding the incident. Staff (unidentified) contacted the nurse who reported client #4 would need to be taken to the ER for medical treatment. After "several" attempts to call the on call Home Manager, the staff "did not have any luck." Upon returning to work on 7/2/12 unidentified staff reported the bite to the Home Manager and the Home Manager took client #4 to the ER for evaluation and treatment. "An investigation is underway as to why the on call supervisor was unavailable and why the staff did not follow up anymore after the failed returned calls." The plan to resolve in the report indicated the staff who did not follow up will receive corrective action and a "retraining on how to correctly report to the on call supervisor and what to do in case the on call supervisor is not responding." The plan indicated the agency would "continue to monitor [clients #4 and #2] for any other health and safety concerns." The report did not indicate a plan of action to prevent further incidents of physical aggression between the clients. A</p>				

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	<p>follow up report indicated "it is unclear as to why [client #2] became agitated and started becoming physically aggressive toward peers. During transport, one staff sits in the back with consumers while the other is driving to prevent further incidents." The Home Manager indicated she had not received any pages over the weekend and stated, "the pager must not be working." The Home Manager received a record of discussion to ensure the pager is always in good working order.</p> <p>An incident dated 6/30/12 indicated "During the investigation for a previous incident on 6/30/12 (listed above), it was reported that [client #2's] behavior involved more than what the original report stated. The report indicated while out in the group home van client #2 "became agitated" for an unknown reason. He then began to "aggressively his (sic) housemate [client #1] in the head and back." The staff pulled over and separated them by placing client #1 in the front of the van leaving client #2 in the rear. "A few minutes later, [client #2] continued with his aggressive physical behavior by hitting and punching on another housemate, [client #8]." Client #2 was then placed in the rear of the van with no other clients around him. The report did not indicate if there were</p>						

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	<p>injuries to clients #1 and #8. The plan to resolve in the report indicated the facility "will continue to monitor [client #2] and his behaviors. The team will convene to discuss [client #2's] BSP (behavior support plan), and to seek any medical attention to rule out medical concerns." There was no additional corrective action indicated.</p> <p>An incident dated 7/24/12 indicated client #2 had become "upset" because he couldn't get off the van at day programming. He was asked to sit down and sat behind client #7 and hit client #7 on the back. Staff immediately moved client #2 away from client #7. Plan to resolve indicated client #7 was found with a small bruise on his back and client #2 was moved to another seat away from client #7. The plan indicated the facility would monitor clients #2 and #7 for their safety, and "the BSPs will continue to be followed for both residents." There was no additional corrective action indicated.</p> <p>A report dated 1/31/13 indicated client #2 hit client #6 when he was redirected from getting off the van at day services. Client #6 "got agitated" and hit client #2, scratching him several times. Staff separated the clients and completed the van trip. Plan to resolve indicated the clients were separated and first aid was</p>						

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	<p>given to client #2's scratches. Clients #2 and #6 will be monitored for their health and safety. Nurse and guardian were notified. There was no additional corrective action indicated.</p> <p>Client #2's record was reviewed on 6/13/13 at 11:23 AM. Client #2's Behavior Development Program (BDP) dated 11/28/10 addressed resistance, rectal digging, stereotypical behavior physical assault, stealing, and medical/dental anxiety. There was no evidence of a revised plan in the record.</p> <p>The AD and the PD were interviewed on 6/14/13 at 1:40 PM and indicated staff should have taken client #4 to the ER for treatment as recommended by the nurse and reported the incident as per facility procedures. The AD indicated failing to obtain medical treatment for client #4 and failing to report the incident timely was in violation of the facility's policy and procedures to protect clients from abuse and neglect. She indicated client #2 had experienced increased physical aggression when a new client had moved into the home and the facility was unable to prevent him from injuring others during episodes of physical aggression as he adjusted to his housemate. The PD indicated she would check on an updated plan for client #2.</p>				

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	<p>An updated plan for client #2 dated 3/13 was reviewed on 6/19/13 at 2:30 PM and indicated target behaviors of rectal digging, fecal smearing, resistance, anger control, physical assault, self injurious behaviors, rocking/string twirling, food stealing, medical/dental appointment anxiety. There was no evidence client #2's plan was revised to address his physical aggression before 3/13.</p> <p>3. A report dated 6/28/12 indicated while at day services, client #3 attempted to bite another unidentified client, leaving teeth marks, and during "the behavior" bit her own arm, pulled some of her own hair out and attempted to flip a table over. The "trigger" for this behavior was unknown. Plan to resolve indicated staff spoke with client #3's house manager and informed her of the behavior. Staff tried to calm client #3 down, gave her a drink and took her for a short walk around the inside of the building. There was no additional corrective action indicated.</p> <p>A report dated 7/12/12 indicated client #3 became engaged in self injurious behavior of biting herself at day services. Plan to resolve indicated the house manager would discuss ways to address client #3's behaviors.</p>						

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	<p>A report dated 9/20/12 indicated client #3 bit herself at day services. Plan to resolve included monitoring client #3.</p> <p>A report dated 10/15/12 indicated while at day services at 2:45 PM, client #3 bit herself on the arm and hit an unidentified client repeatedly while yelling. Client #3 was guided to a sensory room where she remained with staff until calm. After completing some calming activities, she was taken home. Plan to resolve included "staff will continue to monitor [client #3's] interactions with peers and follow the proactive and reactive strategies per her ISP (Individual Support Plan)." No additional corrective action was available to review regarding the incident. A follow up report dated 3/15/13 indicated systemic actions being taken "Continue to follow [client #3's] behavior plan." There was no additional corrective action indicated.</p> <p>A report dated 10/29/12 indicated while at day services at 2:40 PM client #3 hit and pulled another unidentified client's hair. Client #3 was removed from the room and redirected to the sensory room where she calmed down minutes later. Before client #3 calmed down, client #3 ripped out several strands of hair from her head and bit her hand and foot. There was no indication of injuries to client #3 or the</p>				

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	<p>unidentified client from the physical aggression. Plan to resolve included "Staff will continue to follow standard BSP practices and procedures and separate [client #3] from others until she is calm. When unforeseen behaviors occur, staff will interfere immediately and redirect [client #3] away from others when she is calm." There was no additional corrective action indicated.</p> <p>A report dated 1/29/13 indicated while in the day services van, client #3 began to display signs of agitation by crying, screaming, and hitting the side of the van. "Staff attempted to redirect her by telling her it's OK and we are almost back to the day program...[Client #3] then began to bite her right arm and her left hand." Staff attempted to stop client #3 from biting herself and then client #3 bit an unidentified peer. Upon return to the day services, client #3 was engaged in sensory activities and staff took client #3 on a walk to calm down. Client #3 was reintegrated into her group and 30 minutes later again became agitated and bit another client on the shoulder. Client #3 was taken for a walk, but afterwards continued crying and attempted to knock tables and chairs over. The report indicated there were no injuries as a result of client #3's aggressive behavior. The plan to resolve indicated staff would sit</p>				

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	<p>between client #3 and other clients on the van, and "Staff will continue to follow proactive and reactive strategies in [client #3's] behavior support plan to assist her during these behaviors and prevent injuries." There was no additional corrective action indicated.</p> <p>A report dated 5/2/13 indicated during lunch time client #3 tried to leave the lunch area and enter an area that would leave her unsupervised. When staff redirected her by giving her several activities, client #3 "became aggressive and started yelling and pushing tables." Client #3 slapped day services client #9 and bit staff #12 and spit in her face. Staff #13 removed client #3 from the area, but client #3 began to push over tables and tried to attack other clients. Staff contacted client #3's residential manager to pick her up. Day services client #9 was not injured. Plan to resolve indicated "An IDT (interdisciplinary team) meeting will be scheduled to formulate a solution on how to handle [client 3#'s] behaviors going forward." There was no information to indicate the results of the meeting or additional corrective action taken.</p> <p>Client #3's record was reviewed on 6/13/13 at 11:23 AM. Her BDP dated reviewed 8/26/12 indicated target</p>						

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	<p>behaviors of extreme irritability, temper outburst, manipulative behavior, inappropriate nudity, physical assault, SIB (self injurious behavior), inappropriate sexual behavior, PD (property destruction), appointment anxiety, sleep disturbance, invading personal space, taking non-menu items, planned ignoring, area restriction. There was no evidence of a revised plan since 8/26/12.</p> <p>The AD and PD were interviewed on 6/14/13 at 1:40 PM. The PD indicated there had been IDT meetings regarding client #3's behaviors and she had been moved to a different day service location in Jan, February or March of 2013 because it had been determined staff at the day services had not been following client #3's behavior support plan. She indicated an IDT had been held regarding client #3's behaviors at day service as indicated in the incident report for 5/2/13 and staff were being retrained on her behavior plan. The AD indicated the facility was not able to prevent client #3 from injuring herself during the behaviors at day services.</p> <p>4. A report dated 10/15/12 indicated while at day services at 2:45 PM client #7 was hit repeatedly by another unidentified client after client #7 yelled at her for hitting her with a ball. The two were</p>				

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	<p>separated, and there were no injuries noted. Plan to resolve indicated "Staff will continue to monitor client interactions and continue to follow standard BSP protocols for safety during behaviors." There was no additional corrective action indicated.</p> <p>A report dated 10/29/12 indicated while at day services at 2:40 PM client #7 was hit in the back by another client (unidentified). She also had her hair pulled, and staff separated the clients. Client #7 was not injured in the incident. Plan to resolved indicated "Staff will continue to follow standard BSP policies and procedures and separate consumers from larger groups during behavior outbursts to ensure the safety of all." There was no additional corrective action indicated.</p> <p>A report dated 3/18/13 at 2:47 PM indicated client #7 was the "victim of peer on peer aggression. She was hit on her back, had her hair pulled and bean bags thrown at her by another peer. All incidents over a period of time in the afternoon on March 18, 2013." The report indicated client #7 did not have injuries as a result of the incident and the site manager notified the residential manager of the incident. Plan to resolve indicated client #7 will be kept separated from the</p>						

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	<p>peer that was aggressive with her and that peer was suspended from Day Program for March 19, 2013. There was no additional corrective action indicated.</p> <p>A report dated 4/21/13 indicated client #7 told her roommate client #3 to lay down and "yelled at her." Client #3 got mad at client #7 and bit her on the back. Staff separated the clients. There was no injury noted. Plan to resolve indicated clients #3 and #7 would be monitored for safety and their behavior plans followed.</p> <p>A report dated 5/29/13 indicated while at day services at 12:45 PM, client #7 was pushed by day services client #10 causing her to fall after client #7 pointed at her. Client #7 had a "small" scratch noted on the left side of her back. Plan to resolve indicated client #7 and day services client #10 are separated during their time at day program. There was no additional corrective action indicated.</p> <p>The AD and PD were interviewed on 6/14/13 at 1:40 PM. The AD indicated the facility was unable to prevent client #7 from being the victim of physical aggression while at day services and the clients had been moved to a different day service provider in January, February or March, 2013 because the original provider was not meeting client #7's</p>						

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	<p>supervision needs.</p> <p>The facility's policy and procedures to prevent abuse and neglect revised April, 2011 were reviewed on 6/10/13 at 4:00 PM. The policy indicated the facility followed the BDDS incident reporting policy and would report to BDDS, "alleged, suspected, or actual abuse, neglect or exploitation of an individual...Injury to an individual when the origin or cause of the injury is unknown and could be indicative of abuse, neglect or exploitation..., a significant injury to an individual, including: ...any injury requiring more than first aid, ...Inadequate staff support for an individual, including inadequate supervision, with the potential for 1) significant harm or injury to an individual...Inadequate medical support for an individual, including failure to obtain: (1) Necessary medical services;...The Area Director will review each incident and Quality Assurance recommendations monthly. This review will be completed with Program Director and other appropriate staff to assess the effectiveness of each recommendation made per incident...The Area Director will complete an Incident Summary Report detailing the progress made towards meeting the recommendations previously set forth. The report may</p>						

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	<p>include further recommendations that may have been provided by the Interdisciplinary Team or outside agency involved in the resolution of the incident. The procedure will provide Indiana MENTOR with the information needed to ensure the effectiveness of the recommendations and an opportunity to make additional recommendations as needed. The Quality Assurance staff will review the information received during the past quarter in order to analyze trends and or systemic problems within the company and to develop recommendations to prevent future incident. The Quality Assurance Staff will present this to the administrative team on a quarterly basis."</p> <p>9-3-2(a)</p>				

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W000153	<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 upon record review and interview, the facility failed for clients #1, #2, and 1 additional client (client #8) to timely report allegations of neglect (staff falling asleep while driving and on duty), and failed to report an incident of physical aggression involving 2 of 4 sampled clients (clients #2 and #4) resulting in injury requiring medical treatment in accordance with state law.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 6/10/13 at 3:36 PM and included the following reports involving clients #1, #2, #4, and #8:</p> <p>1. A report dated 4/22/13 and reported 4/25/13 indicated on 4/22/13 during transportation of clients #1, #2 and #8 to day services in the morning, staff #11 possibly fell asleep causing him to swerve and almost hit the car in front of him. He</p>	W000153	<p>As soon as the QDIP became aware of the possibility of a staff falling asleep and a Home Manager not reporting possible previous incidents of sleeping immediate protective measures were implemented to protect the clients from potential further neglect by suspending both staff. Once the evidence to support the allegation of the staff sleeping and the manager not reporting previous incidents of sleeping was identified both staff were terminated from Indiana Mentor's employment. Indiana Mentor management and administration will continue to implement immediate protective measures, investigations, and corrective action as designated when allegations of abuse, neglect, or exploitation are made.</p> <p>All direct care staff will be retrained on incident reporting including reporting to the supervisor immediately when incidents of potential abuse or neglect occur, reporting timelines, and DSP and Home Manager role in reporting incidents.</p> <p>The PD will be retrained on the</p>	07/20/2013			

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	<p>missed the car and was able to come to a stop. The other staff took over the remainder of the driving for the trip. No clients were injured and had been wearing their seat belts. The report indicated staff #11 was suspended and an investigation had been started.</p> <p>An investigation dated 5/2/13 was attached to the 4/22/13 BDDS report and was reviewed on 6/10/13 at 4:00 PM. The investigation included the following interviews:</p> <p>Interview with the PD (Program Director) dated 4/30/13 indicated she had received a text message from the house manager on 4/25/13 that staff #11 "would likely need to be suspended for falling asleep on 4/22/13 during the van run." The PD indicated this was the first report she had received about staff sleeping from the house manager. The PD indicated she suspended staff #11 on 4/25/13 after receiving the report from the house manager.</p> <p>An interview with the house manager dated 4/30/13 "said on more than one occasion [staff #4 and #8] have reported staff #11 arrives to work at 6:30 AM, falls asleep, awakens, and then the transport is completed. [Staff #8 and staff #4] last reported this on 4/19/13 and staff #8 last</p>		<p>requirement for the completion of investigations and the development of recommendations based on the factual findings of the investigation to include but not be limited to corrective action for staff, retraining of staff, client plan changes, etc.</p> <p>The Area Director will maintain a database of incidents in order to monitor the need for IDTs to address incidents of aggression. The Area Director will review the database a minimum of monthly to determine if any patterns of aggression are occurring. If a pattern of aggression is determined, the Area Director will work with the Program Director and consumer's IDT to determine if any changes to the consumers BSP need to be put into place or if any additional protective measures need to be implemented to prevent further incidents of aggression. The database will include the outcome/results in resolving the issue as part of the database.</p> <p>Responsible Staff: Program Director, Area Director</p>				

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	<p>reported on 4/23 or 24-13 (sic) that [staff #11] fell asleep while driving the van." She indicated she had attempted to contact the house via the house phone on 4/19/13, and was unable to get an answer. She then contacted staff #8 via staff #8's cell phone and was told staff #11 was sleeping. When the house manager then arrived at the home, she sent staff #11 home for the day. "On 4/23 or 24-13 (sic), [staff #4] informed her [staff #11] tried to kill her. He fell asleep at the wheel and started accelerating toward a car stopped at a light. He awakened in time to prevent them from rear ending the car stopped at the light. She drove the van back to the group home and believes [staff #11] slept on the return trip." The house manager indicated she had reported the 4/22/13 incident on 4/25/13 to the PD on 4/25/13 via text and had reported staff #11 sleeping on the job to the PD on multiple occasions, but had no proof of doing so until the 4/25/13 text to the QIDP.</p> <p>Interview with staff #4 dated 4/30/13 indicated she was riding in the van with staff #11 driving to day services on 4/22/13 when staff #11 failed to respond to a green light after the light had changed and staff #4 noticed his eyes were closed. A few minutes later, she was turned to talk to the clients in the back when she noted the van started accelerating toward</p>				

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	<p>a car, and staff #11's eyes were closed and his head was dropped slightly. She yelled at staff #11 that he was about to hit a car and he stopped the car at which time staff #4 took over the driving. She indicated she had reported the incident to the house manager on 4/23/13 and the house manger had indicated she would report the incident to the QIDP. On 4/25/13 staff #4 indicated she asked the house manager what the PD said about staff #11 falling asleep at the wheel and the house manager indicated the PD did not say anything about it. Staff #4 then indicated she would would speak to the QIDP, and staff #4 then saw the house manager text someone. Staff #4 indicated "about a month ago" the house manager had informed her staff #7 had reported staff #11 falling asleep while driving and almost hitting a pole. "A few Fridays ago (dates not specified) she witnessed [staff #7] informing the house manager that staff #11 fell asleep and she could not awaken him so she had to complete transport by herself."</p> <p>Interview with staff #4 dated 4/30/13 indicated on 4/19/13 she was unable to awaken staff #11 to get on the van to transport clients to day services, despite calling his name in a loud voice, then "screamed at [staff #11] the fourth time in an attempt to awaken him, but he</p>						

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	<p>continued not to respond." Staff #4 indicated she had informed the house manager she was completing the transportation route alone since she could not awaken staff #11. "Said she heard comments about staff #11's poor driving skills from [staff #7] and the house manager]."</p> <p>Interview with staff #7 dated 4/30/13 indicated "approximately one month ago" she was in the van and staff #11 was driving with the clients to day services when he "almost rear ended a car stopped at a light and swerved into the lane with an oncoming car." She indicated staff #11 slept in the back of the van for the trip back to the group home while staff #7 drove. She indicated she had reported the incident to the house manager on the same day it occurred and the house manager had indicated she would talk to him about it. Staff #7 indicated she had witnessed the house manager having to awaken staff #11 and it had taken 3 attempts to awaken him.</p> <p>The conclusion of the investigation dated 5/2/13 indicated "evidence supports the allegation that [staff #11] has slept on the job endangering lives. Evidence supports that the house manager did not report this incident to her supervisor as required." No additional action was included in the</p>						

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	<p>investigation.</p> <p>The Area Director (AD) was interviewed on 6/12/13 at 4:10 PM. She indicated the staff falling asleep while driving and in the group home and the house manager's failure to report the incidents involving staff #11's sleeping incidents were in violation of the facility's abuse and neglect prevention policy and procedures. She indicated staff #11 and the house manger had been terminated as a result of the incidents of staff #11 sleeping and the house manager's failure to report the incidents as per policy and procedures.</p> <p>2. BDDS reports dated 6/30/12 and reported 7/2/12 indicated client #2 bit client #4 on the head on 6/30/12 causing the skin to break. The report did not indicate where the bite occurred or additional information regarding the incident. Staff (unidentified) contacted the nurse who reported client #4 would need to be taken to the ER for medical treatment. After "several" attempts to call the on call Home Manager, the staff "did not have any luck." Upon returning to work on 7/2/12 unidentified staff reported the bite to the Home Manager and the Home Manager took client #4 to the ER for evaluation and treatment. "An investigation is underway as to why the on call supervisor was unavailable and</p>						

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	<p>why the staff did not follow up anymore after the failed returned calls." The plan to resolve in the report indicated the staff who did not follow up will receive corrective action and a "retraining on how to correctly report to the on call supervisor and what to do in case the on call supervisor is not responding." The plan indicated the agency would "continue to monitor [clients #4 and #2] for any other health and safety concerns."</p> <p>An incident dated 6/30/12 and reported 7/3/12 indicated "During the investigation for a previous incident on 6/30/12 (listed above), it was reported that [client #2's] behavior involved more than what the original report stated. The report indicated while out in the group home van client #2 "became agitated" for an unknown reason. He then began to "aggressively his (sic) housemate [client #1] in the head and back." The staff pulled over and separated them by placing client #1 in the front of the van leaving client #2 in the rear. "A few minutes later, [client #2] continued with his aggressive physical behavior by hitting and punching on another housemate, [client #8]." Client #2 was then placed in the rear of the van with no other clients around him. The report did not indicate if there were injuries to clients #1 and #8.</p>			

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	<p>The AD and the PD were interviewed on 6/14/13 at 1:40 PM and indicated staff should have taken client #4 to the ER for treatment as recommended by the nurse and reported the incident as per facility procedures. The AD indicated failing to obtain medical treatment for client #4 and failing to report the incident timely was in violation of the facility's policy and procedures to protect clients from abuse and neglect.</p> <p>9-3-2(a)</p>			
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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based upon record review and interview, the facility failed for 2 of 4 sampled clients (clients #1 and #2) and one additional client (client #8), to develop and implement corrective action to address incidents of staff falling asleep while driving and on duty, failed to develop effective corrective action to protect 1 of 4 sampled clients (client #1) and 3 additional clients (clients #6, #7 and #8) from a pattern of physically aggressive behavior by client #2, failed to develop and implement effective corrective action to protect 1 of 4 sampled clients (client #3) and one additional client (client #7) from a pattern of client #3's self injurious and aggressive behavior, and failed to protect 1 additional client (client #7) from being aggressed upon.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 6/10/13 at 3:36 PM and included the following reports involving clients #1, #2, #3, #4, #7, and #8:</p>	W000157	<p>1 As soon as the QDIP became aware of the possibility of a staff falling asleep and a Home Manager not reporting possible previous incidents of sleeping immediate protective measures were implemented to protect the clients from potential further neglect by suspending both staff. Once the evidence to support the allegation of the staff sleeping and the manager not reporting previous incidents of sleeping was identified both staff were terminated from Indiana Mentor's employment. Indiana Mentor management and administration will continue to implement immediate protective measures, investigations, and corrective action as designated when allegations of abuse, neglect, or exploitation are made.</p> <p>All direct care staff will be retrained on incident reporting including reporting to the supervisor immediately when incidents of potential abuse or neglect occur, reporting timelines, and DSP and Home Manager role in reporting incidents. All direct care staff will also retrained on the Indiana Mentor Code of Conduct which includes not sleeping while on the clock.</p>	07/20/2013			

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	<p>1. A report dated 4/22/13 and reported 4/25/13 indicated on 4/22/13 during transportation of clients #1, #2 and #8 to day services in the morning, staff #11 possibly fell asleep causing him to swerve and almost hit the car in front of him. He missed the car and was able to come to a stop. The other staff took over the remainder of the driving for the trip. No clients were injured and had been wearing their seat belts. The report indicated staff #11 was suspended and an investigation had been started.</p> <p>An investigation dated 5/2/13 was attached to the 4/22/13 BDDS report and was reviewed on 6/10/13 at 4:00 PM. The investigation included the following interviews:</p> <p>Interview with the PD (Program Director) dated 4/30/13 indicated she had received a text message from the house manager on 4/25/13 that staff #11 "would likely need to be suspended for falling asleep on 4/22/13 during the van run." The PD indicated this was the first report she had received about staff sleeping from the house manager. The PD indicated she suspended staff #11 on 4/25/13 after receiving the report from the house manager.</p> <p>An interview with the house manager</p>		<p>2, 3, 4 The Program Director will be retrained on involving a client's IDT when an incident of aggression occurs to develop a plan of action to prevent further incidents of aggression. The Program Director will convene the IDT for clients #2, #3 and #7 to discuss the incidents of aggression and make recommendations as appropriate including changes to plans, as needed.</p> <p>The Area Director will maintain a database of incidents in order to monitor the need for IDTs to address incidents of aggression. The Area Director will review the database a minimum of monthly to determine if any patterns of aggression are occurring. If a pattern of aggression is determined, the Area Director will work with the Program Director and consumer's IDT to determine if any changes to the consumers BSP need to be put into place or if any additional protective measures need to be implemented to prevent further incidents of aggression. The database will include the outcome/results in resolving the issue as part of the database.</p> <p>Responsible Staff: Program Director, Area Director</p>		

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	<p>dated 4/30/13 "said on more than one occasion [staff #4 and #8] have reported staff #11 arrives to work at 6:30 AM, falls asleep, awakens, and then the transport is completed. [Staff #8 and staff #4] last reported this on 4/19/13 and staff #8 last reported on 4/23 or 24-13 (sic) that [staff #11] fell asleep while driving the van." She indicated she had attempted to contact the house via the house phone on 4/19/13, and was unable to get an answer. She then contacted staff #8 via staff #8's cell phone and was told staff #11 was sleeping. When the house manager then arrived at the home, she sent staff #11 home for the day. "On 4/23 or 24-13 (sic), [staff #4] informed her [staff #11] tried to kill her. He fell asleep at the wheel and started accelerating toward a car stopped at a light. He awakened in time to prevent them from rear ending the car stopped at the light. She drove the van back to the group home and believes [staff #11] slept on the return trip." The house manager indicated she had reported the 4/22/13 incident on 4/25/13 to the PD on 4/25/13 via text and had reported staff #11 sleeping on the job to the PD on multiple occasions, but had no proof of doing so until the 4/25/13 text to the QIDP.</p> <p>Interview with staff #4 dated 4/30/13 indicated she was riding in the van with staff #11 driving to day services on</p>						

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	<p>4/22/13 when staff #11 failed to respond to a green light after the light had changed and staff #4 noticed his eyes were closed. A few minutes later, she was turned to talk to the clients in the back when she noted the van started accelerating toward a car, and staff #11's eyes were closed and his head was dropped slightly. She yelled at staff #11 that he was about to hit a car and he stopped the car at which time staff #4 took over the driving. She indicated she had reported the incident to the house manager on 4/23/13 and the house manger had indicated she would report the incident to the QIDP. On 4/25/13 staff #4 indicated she asked the house manager what the PD said about staff #11 falling asleep at the wheel and the house manager indicated the PD did not say anything about it. Staff #4 then indicated she would would speak to the QIDP, and staff #4 then saw the house manager text someone. Staff #4 indicated "about a month ago" the house manager had informed her staff #7 had reported staff #11 falling asleep while driving and almost hitting a pole. "A few Fridays ago (dates not specified) she witnessed [staff #7] informing the house manager that staff #11 fell asleep and she could not awaken him so she had to complete transport by herself."</p> <p>Interview with staff #4 dated 4/30/13</p>						

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	<p>indicated on 4/19/13 she was unable to awaken staff #11 to get on the van to transport clients to day services, despite calling his name in a loud voice, then "screamed at [staff #11] the fourth time in an attempt to awaken him, but he continued not to respond." Staff #4 indicated she had informed the house manager she was completing the transportation route alone since she could not awaken staff #11. "Said she heard comments about staff #11's poor driving skills from [staff #7] and the house manager]."</p> <p>Interview with staff #7 dated 4/30/13 indicated "approximately one month ago" she was in the van and staff #11 was driving with the clients to day services when he "almost rear ended a car stopped at a light and swerved into the lane with an oncoming car." She indicated staff #11 slept in the back of the van for the trip back to the group home while staff #7 drove. She indicated she had reported the incident to the house manager on the same day it occurred and the house manager had indicated she would talk to him about it. Staff #7 indicated she had witnessed the house manager having to awaken staff #11 and it had taken 3 attempts to awaken him.</p> <p>The conclusion of the investigation dated</p>			

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	<p>5/2/13 indicated "evidence supports the allegation that [staff #11] has slept on the job endangering lives. Evidence supports that the house manager did not report this incident to her supervisor as required." No additional action was included in the investigation.</p> <p>The Area Director (AD) was interviewed on 6/12/13 at 4:10 PM. She indicated staff #11 and the house manager had been terminated as a result of the incidents of staff #11 sleeping on duty and the house manager's failure to report the incidents as per policy and procedures. The AD indicated corrective action would have been taken to address client #11's sleeping on the job had the incidents been reported when they occurred.</p> <p>2. BDDS reports dated 6/30/12 and reported 7/2/12 indicated client #2 bit client #4 on the head on 6/30/12 causing the skin to break. The report did not indicate where the bite occurred or additional information regarding the incident. Staff (unidentified) contacted the nurse who reported client #4 would need to be taken to the ER for medical treatment. After "several" attempts to call the on call Home Manager, the staff "did not have any luck." Upon returning to work on 7/2/12 unidentified staff reported the bite to the Home Manager and the</p>						

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	<p>Home Manager took client #4 to the ER for evaluation and treatment. "An investigation is underway as to why the on call supervisor was unavailable and why the staff did not follow up anymore after the failed returned calls." The plan to resolve in the report indicated the staff who did not follow up will receive corrective action and a "retraining on how to correctly report to the on call supervisor and what to do in case the on call supervisor is not responding." The plan indicated the agency would "continue to monitor [clients #4 and #2] for any other health and safety concerns." The report did not indicate a plan of action to prevent further incidents of physical aggression between the clients. A follow up report generated 3/15/13 indicated "it is unclear as to why [client #2] became agitated and started becoming physically aggressive toward peers. During transport, one staff sits in the back with consumers while the other is driving to prevent further incidents." No additional corrective action was indicated.</p> <p>An incident dated 6/30/12 indicated "During the investigation for a previous incident on 6/30/12 (listed above), it was reported that [client #2's] behavior involved more than what the original report stated. The report indicated while out in the group home van client #2</p>				

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	<p>"became agitated" for an unknown reason. He then began to "aggressively his (sic) housemate [client #1] in the head and back." The staff pulled over and and separated them by placing client #1 in the front of the van leaving client #2 in the rear. "A few minutes later, [client #2] continued with his aggressive physical behavior by hitting and punching on another housemate, [client #8]." Client #2 was then placed in the rear of the van with no other clients around him. The report did not indicate if there were injuries to clients #1 and #8. The plan to resolve in the report indicated the facility "will continue to monitor [client #2] and his behaviors. The team will convene to discuss [client #2's] BSP (behavior support plan), and to seek any medical attention to rule out medical concerns." There was no additional corrective action indicated.</p> <p>An incident dated 7/24/12 indicated client #2 had become "upset" because he couldn't get off the van at day programming. He was asked to sit down and sat behind client #7 and hit client #7 on the back. Staff immediately moved client #2 away from client #7. Plan to resolve indicated client #7 was found with a small bruise on his back and client #2 was moved to another seat away from client #7. The plan indicated the facility</p>						

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	<p>would monitor clients #2 and #7 for their safety, and "the BSPs will continue to be followed for both residents." There was no additional corrective action indicated.</p> <p>A report dated 1/31/13 indicated client #2 hit client #6 when he was redirected from getting off the van at day services. Client #6 "got agitated" and hit client #2, scratching him several times. Staff separated the clients and completed the van trip. Plan to resolve indicated the clients were separated and first aid was given to client #2's scratches. Clients #2 and #6 will be monitored for their health and safety. Nurse and guardian were notified. There was no additional corrective action indicated.</p> <p>Client #2's record was reviewed on 6/13/13 at 11:23 AM. Client #2's Behavior Development Program (BDP) dated 11/28/10 addressed resistance, rectal digging, stereotypical behavior physical assault, stealing, and medical/dental anxiety. There was no evidence of a revised plan in the record.</p> <p>The AD and the PD were interviewed on 6/14/13 at 1:40 PM and indicated staff should have taken client #4 to the ER for treatment as recommended by the nurse and reported the incident as per facility procedures. The AD indicated failing to</p>						

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	<p>obtain medical treatment for client #4 and failing to report the incident timely was in violation of the facility's policy and procedures to protect clients from abuse and neglect. She indicated client #2 had experienced increased physical aggression when a new client had moved into the home and the facility was unable to prevent him from injuring others during episodes of physical aggression as he adjusted to his housemate. The PD indicated she would check on an updated plan for client #2.</p> <p>An updated plan for client #2 dated 3/13 was reviewed on 6/19/13 at 2:30 PM and indicated target behaviors of rectal digging, fecal smearing, resistance, anger control, physical assault, self injurious behaviors, rocking/string twirling, food stealing, medical/dental appointment anxiety. There was no evidence client #2's plan was revised to address his physical aggression before 3/13.</p> <p>3. A report dated 6/28/12 indicated while at day services, client #3 attempted to bite another unidentified client, leaving teeth marks, and during "the behavior" bit her own arm, pulled some of her own hair out and attempted to flip a table over. The "trigger" for this behavior was unknown. Plan to resolve indicated staff spoke with client #3's house manager and informed</p>			

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	<p>her of the behavior. Staff tried to calm client #3 down, gave her a drink and took her for a short walk around the inside of the building. There was no additional corrective action indicated.</p> <p>A report dated 7/12/12 indicated client #3 became engaged in self injurious behavior of biting herself at day services. Plan to resolve indicated the house manager would discuss ways to address client #3's behaviors.</p> <p>A report dated 9/20/12 indicated client #3 bit herself at day services. Plan to resolve included monitoring client #3</p> <p>A report dated 10/15/12 indicated while at day services at 2:45 PM, client #3 bit herself on the arm and hit an unidentified client repeatedly while yelling. Client #3 was guided to a sensory room where she remained with staff until calm. After completing some calming activities, she was taken home. Plan to resolve included "staff will continue to monitor [client #3's] interactions with peers and follow the proactive and reactive strategies per her ISP (Individual Support Plan)." No additional corrective action was available to review regarding the incident. A follow up report dated 3/15/13 indicated systemic actions being taken "Continue to follow [client #3's] behavior plan." There</p>				

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	<p>was no additional corrective action indicated.</p> <p>A report dated 10/29/12 indicated while at day services at 2:40 PM client #3 hit and pulled another unidentified client's hair. Client #3 was removed from the room and redirected to the sensory room where she calmed down minutes later. Before client #3 calmed down, client #3 ripped out several strands of hair from her head and bit her hand and foot. There was no indication of injuries to client #3 or the unidentified client from the physical aggression. Plan to resolve included "Staff will continue to follow standard BSP practices and procedures and separate [client #3] from others until she is calm. When unforeseen behaviors occur, staff will interfere immediately and redirect [client #3] away from others when she is calm." There was no additional corrective action indicated.</p> <p>A report dated 1/29/13 indicated while in the day services van, client #3 began to display signs of agitation by crying, screaming, and hitting the side of the van. "Staff attempted to redirect her by telling her it's OK and we are almost back to the day program...[Client #3] then began to bite her right arm and her left hand." Staff attempted to stop client #3 from biting herself and then client #3 bit an</p>			

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	<p>unidentified peer. Upon return to the day services, client #3 was engaged in sensory activities and staff took client #3 on a walk to calm down. Client #3 was reintegrated into her group and 30 minutes later again became agitated and bit another client on the shoulder. Client #3 was taken for a walk, but afterwards continued crying and attempted to knock tables and chairs over. The report indicated there were no injuries as a result of client #3's aggressive behavior. The plan to resolve indicated staff would sit between client #3 and other clients on the van, and "Staff will continue to follow proactive and reactive strategies in [client #3's] behavior support plan to assist her during these behaviors and prevent injuries." There was no additional corrective action indicated.</p> <p>A report dated 5/2/13 indicated during lunch time client #3 tried to leave the lunch area and enter an area that would leave her unsupervised. When staff redirected her by giving her several activities, client #3 "became aggressive and started yelling and pushing tables." Client #3 slapped day services client #9 and bit staff #12 and spit in her face. Staff #13 removed client #3 from the area, but client #3 began to push over tables and tried to attack other clients. Staff contacted client #3's residential</p>				

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	<p>manager to pick her up. Day services client #9 was not injured. Plan to resolve indicated "An IDT (interdisciplinary team) meeting will be scheduled to formulate a solution on how to handle [client 3#'s] behaviors going forward."There was no information to indicate the results of the meeting or additional corrective action taken.</p> <p>Client #3's record was reviewed on 6/13/13 at 11:23 AM. Her BDP dated reviewed 8/26/12 indicated target behaviors of extreme irritability, temper outburst, manipulative behavior, inappropriate nudity, physical assault, SIB (self injurious behavior), inappropriate sexual behavior, PD (property destruction), appointment anxiety, sleep disturbance, invading personal space, taking non-menu items, planned ignoring, area restriction. There was no evidence of a revised plan since 8/26/12.</p> <p>The AD and PD were interviewed on 6/14/13 at 1:40 PM. The PD indicated there had been IDT meetings regarding client #3's behaviors and she had been moved to a different day service location in Jan, February or March of 2013 because it had been determined staff at the day services had not been following client #3's behavior support plan. She indicated an IDT had been held regarding</p>			

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	<p>client #3's behaviors at day service as indicated in the incident report for 5/2/13 and staff were being retrained on her behavior plan. The AD indicated the facility was not able to prevent client #3 from injuring herself during the behaviors at day services.</p> <p>4. A report dated 10/15/12 indicated while at day services at 2:45 PM client #7 was hit repeatedly by another unidentified client after client #7 yelled at her for hitting her with a ball. The two were separated, and there were no injuries noted. Plan to resolve indicated "Staff will continue to monitor client interactions and continue to follow standard BSP protocols for safety during behaviors." There was no additional corrective action indicated.</p> <p>A report dated 10/29/12 indicated while at day services at 2:40 PM client #7 was hit in the back by another client (unidentified). She also had her hair pulled, and staff separated the clients. Client #7 was not injured in the incident. Plan to resolved indicated "Staff will continue to follow standard BSP policies and procedures and separate consumers from larger groups during behavior outbursts to ensure the safety of all." There was no additional corrective action indicated.</p>						

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	<p>A report dated 3/18/13 at 2:47 PM indicated client #7 was the "victim of peer on peer aggression. She was hit on her back, had her hair pulled and bean bags thrown at her by another peer. All incidents over a period of time in the afternoon on March 18, 2013." The report indicated client #7 did not have injuries as a result of the incident and the site manager notified the residential manager of the incident. Plan to resolve indicated client #7 will be kept separated from the peer that was aggressive with her and that peer was suspended from Day Program for March 19, 2013. There was no additional corrective action indicated.</p> <p>A report dated 4/21/13 indicated client #7 told her roommate client #3 to lay down and "yelled at her." Client #3 got mad at client #7 and bit her on the back. Staff separated the clients. There was no injury noted. Plan to resolve indicated clients #3 and #7 would be monitored for safety and their behavior plans followed.</p> <p>A report dated 5/29/13 indicated while at day services at 12:45 PM, client #7 was pushed by day services client #10 causing her to fall after client #7 pointed at her. Client #7 had a "small" scratch noted on the left side of her back. Plan to resolve indicated clients #7 and day services</p>				

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	<p>client #10 are separated during their time at day program. There was no additional corrective action indicated.</p> <p>The AD and PD were interviewed on 6/14/13 at 1:40 PM. The AD indicated the facility was unable to prevent client #7 from being the victim of physical aggression while at day services and the clients had been moved to a different day service provider in January, February or March, 2013 because the original provider was not meeting client #7's supervision needs.</p> <p>9-3-2(a)</p>				

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (client #3), the Individual Support Plan (ISP) failed to address her specific needs in the area of dining skills.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 6/10/13 from 5:10 PM until 6:35 PM. During the evening meal, client #3 ate with her right hand in her plate and food spilled from her mouth and on her shirt leaving her shirt soiled and wet with her food and her hands wet after she finished eating.</p> <p>Client #3's record was reviewed on 6/13/13 at 11:10 AM. Client #3's 10/15/12 Individual Support Plan (ISP) did not include an objective to increase her dining skills. Her 5/4/13 Camelot Behavioral Checklist indicated client #3 did not have skills for eating proper amounts of food, cuts with knife, or appropriate table etiquette.</p>	W000227	<p>The Program Director will consult with client #3's IDT in order to develop an appropriate goal and objective to address her dining skills. The Program Director will also ensure the IDT reviews the Comprehensive Functional Assessment to determine if any other specific objectives need to be included in the ISP.</p> <p>The Program Director will be retrained on the development of specific objectives needed in the ISP to meet a client's needs as identified in the Comprehensive Functional Assessment.</p> <p>The Area Director will review the next 3 ISPs completed by this Program Director to ensure this requirements is met. The Area Director will provide further guidance as needed after the 3 reviews.</p> <p>Responsible Staff: Program Director, Area Director</p>	07/20/2013	

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	The Area Director (AD) and Program Director (PD) were interviewed on 6/14/13 at 1:50 PM. The AD indicated client #3 should have an objective to increase her dining skills. 9-3-4(a)				

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W000268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (client #4), to promote dignity by ensuring he had a hair cut that was professionally styled.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 6/10/13 from 5:10 PM until 6:35 PM. Client #4's hair was cut into uneven ridges.</p> <p>Observations were completed at the day services on 6/11/13 from 1:35 PM to 1:55 PM. Client #4's hair remained unevenly cut. Day services staff #1 stated, "I'm not sure where you got that haircut."</p> <p>Day services staff #1 was interviewed on 6/11/13 at 1:45 PM. She indicated client #4's hair was usually long, and he had come to day services with the haircut on Monday.</p> <p>The Home Manager was interviewed on 6/11/13 at 6:19 AM and indicated client #4's hair was cut by staff. He indicated he was looking for a way to get client #4's hair cut professionally as he will not stay seated in the chair to receive a haircut.</p> <p>The Program Director (PD) was interviewed on 6/14/13 at 1:40 PM and when asked about client #4's hair cut, stated, "It did look funny."</p>	W000268	<p>The PD will convene the IDT for client #4 to address his inability to remain seated long enough to have his hair cut in a stylish manner along with a plan for managing his hair until he will allow his hair to be cut stylishly.</p> <p>The Direct Support Staff, Home Manager and Program Director will receive retraining on client dignity including ensuring that consumers' appearance looks appropriate including ensuring that hair is cut in a stylish fashion, nails are trimmed and clothing is clean and fits appropriately.</p> <p>Ongoing, the Home Manager will complete observations in the home a minimum of twice weekly to ensure all consumers' appearances are appropriate.</p> <p>Responsible Staff: Home Manager, Program Director</p>	07/20/2013			

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W000312	<p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on record review and interview, for 2 of 4 sampled clients (clients #2 and #4), the facility failed to develop a plan to reduce the need for medications to address maladaptive behaviors and medical appointment anxiety.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 6/12/13 at 2:20 PM. Client #2's psychiatric medication review dated 6/4/13 indicated he was prescribed clonidine .5 mg (milligram) 2 tabs daily and Zyprexa 10 mg daily. Client #2's Behavior Development Plan dated 11/28/10 did not include the use of olanzapine (anti-psychotic), or clonidine (anxiety).</p> <p>The Area Director (AD) and Program Director (PD) were interviewed on 6/14/13 at 1:40 PM. The PD indicated she</p>	W000312	<p>The QIDP will convene the IDT for client #2 and #4. The IDT will assess the behaviors for which clients #2 and #4 are prescribed medication and develop appropriate titration plans.</p> <p>The Behavior Consultant will be retrained on the requirement to include an appropriate plan to address medication withdrawal based on behaviors.</p> <p>The Behavior Consultant will revise the Behavior Plans to include the titration plan developed by the IDT.</p> <p>The QIDP will obtain required approvals as soon as the plans are available. The QIDP will also ensure the staff is trained on the implementation of the plans.</p> <p>The QIDP will review each client's files to ensure each client that receives medication to manage behavior has an appropriate titration plan.</p> <p>Responsible Staff: Program Director, Area Director, Behavior Consultant</p>	07/20/2013	

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	<p>would look for an updated plan.</p> <p>A Behavior Supports Services dated March, 2013 was provided on 6/18/13 at 4:23 PM. The plan did not include the use of olanzapine or clonidine.</p> <p>Client #4's record was reviewed on 6/13/13 at 11:40 AM. Client #4's physician orders dated 6/30/12 indicated client #4 was prescribed diazepam 20 mg (milligrams) prior to blood draw. Client #4's notes for a dental appointment on 4/15/13 indicated "special needs high anxiety/combatative pt. (patient) was pre-sedated by home with Halcion .25 mg 3 tabs." Client #4's behavior plan in the group home's program book indicated a 10/31/11 plan that included target behaviors of invading space, hands in mouth, non-compliance, anger control, self injurious behaviors, inappropriate touching, and choice making. The behavior plan did not include the use of medications to address behaviors or include a target behavior of medical procedures anxiety.</p> <p>The Area Director (AD) and Program</p>		Completion Date: 7-20-13		

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	<p>Director (PD) were interviewed on 6/14/13 at 1:50 PM and indicated they thought client #4's plan had been updated and would look for an updated behavior plan.</p> <p>An updated plan was provided on 6/18/13 at 4:23 PM. Client #4's Behavior Development Plan (BDP) dated 11/5/12 included target behaviors of invading space, hands in mouth, non-compliance, anger control, self injurious behaviors, inappropriate touching, incontinence, medical and/or dental appointment anxiety. The plan did not include the use of medications to address his behaviors.</p> <p>The AD was interviewed on 6/19/13 at 3:53 PM and indicated she had checked with client #4's behavior clinician and the medication client #4 used to address his anxiety before appointments was on an as needed basis and was not included in his behavior plan.</p> <p>The AD indicated on 6/20/13 at 2:06 PM, client #2's plan does not include the use of client #2's olanzapine or clonidine and she would notify the behavioral clinician.</p> <p>9-3-5(a)</p>			

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W000331	<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, the facility's nursing services failed for 1 of 4 sampled clients, (client #1) and 1 additional client (client #8) to ensure the MAR matched the medication labels and physician's orders.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 6/12/13 from 6:13 AM until 7:36 AM. Staff #4 gave client #8 Kavinace (sleep aid/anti-anxiety) at 6:40 AM. The medication label indicated client #8 was to receive the medication before breakfast.</p> <p>The medication administration (MAR) for 6/13 was reviewed on 6/12/13 at 7:15 AM. The instructions to give Kavinace to client #8 before breakfast had been crossed out.</p> <p>Staff #4 was interviewed on 6/12/13 at 6:45 AM. She indicated the medication label didn't match the MAR.</p> <p>The Area Director (AD) was interviewed on 6/14/13 at 1:40 PM and indicated she would check on the instructions for when</p>	W000331	<p>The Nurse responsible for crossing out before breakfast on client #8's MAR is no longer employed by Indiana Mentor.</p> <p>The Area Director has ensured the correct order for client #8's Kavinace is available and the MAR has been fixed to reflect the correct order for the medication. The correction in the order has been communicated to staff to ensure it is administered as prescribed.</p> <p>Ongoing the Program Nurse and/or Home Manager will review the MAR with the Physician's Order Sheets to ensure accuracy on the MAR.</p> <p>The new Program Nurse will be trained by the Nursing Supervisor to ensure that correct orders for all medications are reflected on the current month's MAR.</p> <p>Responsible Staff: Program Director, Home Manager, Program Nurse, Nursing Supervisor.</p>	07/20/2013			

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	<p>client #4 to be given his medication in regard to breakfast.</p> <p>The AD indicated in an e-mail dated 6/18/13 at 4:23 PM that "Before Breakfast and before on (MAR) should not have been crossed out." She indicated she was unsure why the information had been crossed out.</p> <p>Observations were completed at the group home on 6/12/13 from 6:14 AM until 7:36 AM. Staff #4 gave client #1 his medications at 6:45 AM. Client #1 did not receive Risperidone.</p> <p>Client #1's 6/13 medication administration record (MAR) was reviewed on 6/12/13 at 7:15 AM and indicated client #1 was to receive Risperidone 1 mg (milligrams) at 7:00 AM, 5:00 PM and 8:00 PM and 2 mg at 8:00 AM. The 7:00 AM and 5 PM time was handwritten in the MAR. The MAR did not include documentation client #1 received his Risperidone 1 mg at 7:00 AM on 6/11/12 or 6/12/12.</p> <p>Client #1's record was reviewed on 6/13/13 at 10:56 AM. Client #1's physician's orders dated 6/30/13 indicated he was to receive Risperidone 2 mg at 8:00 AM and Risperidone 1 mg at 6:00 PM and 8 PM.</p>						

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	<p>Staff #4 was interviewed on 6/12/13 at 7:30 AM and indicated the nurse had changed client #1's MAR and the Risperidone was not in client #1's 7:00 AM medications.</p> <p>The Area Coordinator (AC) was interviewed on 6/14/13 at 1:40 PM and indicated she would check to see why client #1 was not given his Risperidone at 7:00 AM.</p> <p>An e-mail was received from the AC on 6/18/13 at 4:23 PM and indicated "Staff for some reason wrote in 7 AM time and were initialing, but not giving him a 1 mg dose at 7:00 AM, they were in fact just giving him the 2 mg dose at 8:00 AM.</p> <p>9-3-6(a)</p>			
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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #3) and 1 additional client (client #8) to administer medications per physician's orders.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 6/10/13 at 3:36 PM and included the following medication errors:</p> <ol style="list-style-type: none"> 1. For client #3: Reports dated 10/22/12, 11/29/12 and 1/11/13 indicated she did not receive her Haldol (psychosis) at 1:00 PM as ordered while at day services. 2. For client #8: A report dated 12/1/12 indicated he didn't receive his Ensure for 2 weeks as there was none available in the house. The report indicated staff were retrained on procedures to ensure medications were available to give to clients. A report dated 1/1/13 indicated client #8 did not receive his Calm-PRT (anxiety) caps, Digestive enzyme caps (digestive aid), Excitaplus caps (energy 	W000368	<p>Indiana Mentor recently switched Pharmacy providers in order to address ongoing issues of medications not being delivered timely creating medication errors beyond Indiana Mentor's control</p> <p>The Home Manager will continue to ensure medications are inventoried upon arrival and requests for any medications not delivered are made immediately.</p> <p>The Home Manager will be responsible for ensuring the medication is ordered and delivered. The QIDP will determine how frequently the Home Manager will contact the pharmacy.</p> <p>The staff working in this home will be retrained on medication administration policy and procedures.</p> <p>The Home Manager and/or the QIDP will complete a weekly medication administration observation to ensure the staff administers medications as prescribed. The Home Manager and/or Program Director will be responsible for ensuring any necessary follow-up is completed for any errors made in the administration of medications.</p>	07/20/2013			

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	<p>supplement), Kavince caps (sleep aid/anti-anxiety), Probiotic Eleven cap (digestive aid), TMG caps (supplement), or zinc 20 mg (supplement) as the pharmacy had not delivered his medication. A report dated 6/2/13 indicated client #8 did not receive TMG 175 mg caps at 7:00 AM and 5 PM as they had not been sent from the pharmacy.</p> <p>The Area Director was interviewed on 6/14/13 at 1:40 PM and indicated the pharmacy had recently been changed and there had been some errors that resulted from the change. She indicated client #3 had been moved from the day services in part because of the pattern of missed medication for her.</p> <p>9-3-6(a)</p>		Responsible Staff: Program Director, Area Director		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G618		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/20/2013	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 10606 HAVERSTICK CARMEL, IN 46032			
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W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based on interview and record review for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7 and #8) living in the group home, the facility failed to ensure evacuation drills were conducted every ninety (90) days for each shift of personnel. Findings include:</p> <p>The facility evacuation drills for clients #1, #2, #3, #4, #5, #6, #7 and #8 were reviewed on 6/13/13 at 4:45 PM and indicated evacuation drills for the overnight shift personnel were completed on 3/9/13 at 5:54 AM and on 6/8/12. There were no evacuation drills recorded for July, August, September, October, November, and December, 2012 on the overnight shift.</p> <p>The Area Director (AD) and the Program Director (PD) were interviewed on 6/14/13 at 1:40 PM and indicated they would try to locate the missing drills.</p> <p>The AD sent an e-mail on 6/18/13 at 4:23 PM which included an attachment of a</p>	W000440	<p>The Home Manager will be retrained on the policy and procedures for the completion of evacuation drills.</p> <p>The Home Manager will be responsible for submitting a copy of the fire drill to the Program Director and Quality Assurance Specialist before the last day of each month.</p> <p>The Quality Assurance Specialist will review the report and request any necessary follow-up. The Program Director will be responsible for ensuring the needed follow-up is completed.</p> <p>Responsible Staff: Program Director, Home Manager, Quality Assurance Specialist</p>	07/20/2013			

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	<p>drill dated 12/8/12 at 4:00 AM.</p> <p>The Area Director was interviewed on 6/19/13 at 3:53 PM and indicated they were unable to find additional drills for the overnight shift.</p> <p>9-3-7(a)</p>				