STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G466	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	1926 W 75TH PL INDIANAPOLIS, IN 46260

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W000000	This visit was for a fundamental annual recertification and state licensure survey. Dates of Survey: 11/18/13, 11/19/13, 11/20/13 and 11/21/13. Facility Number: 000980 Provider Number: 15G466 AIMS Number: 100244620 Surveyor: Keith Briner, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed November 26, 2013 by Dotty Walton, QIDP.	W000000		
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 1 of 3 sampled clients (#2), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure client #2's finances were not in excess of a predetermined maximum amount allowed by Medicaid. Findings include:	W000104	The Home Manager and Program Director will complete an audit of all consumers finances, to determine if anyone's account balance is in excess of the allowable amount. If any consumers account balances are in excess of the allowable amount the Home Manager and Program Director will work with the Social Worker and Client Finance Specialist to spend the money in an appropriate manner to get the	12/21/2013

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

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

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	Client #2's financial record was reviewed on 11/19/13 at 11:47 AM. Client #2's facility based cluster account ledger dated 8/2/13 through 11/19/13 indicated the following: -9/4/13, Deposit, $9,005.81 with an ending balance of $11,121.51. -10/3/13, Deposit, $1,260.00 with an ending balance of $10,077.51. -11/19/13 ending balance in the amount of $8,094.42. AS (Administrative Staff) #1 was interviewed on 11/19/13 at 12:07 PM. AS #1 indicated the predetermined maximum amount allowed by Medicaid for clients receiving services was $1,500.00. AS #1 indicated client #2's account was in excess of the $1,500.00 Medicaid limit. 9-3-1(a)		balance below the allowable amount. The Home Manager and Program Director will receive retraining on consumers' finances including ensuring that all consumers' accounts are below the allowable amount. Ongoing the Client Finance Specialist will provide a record monthly to the Area Director of all consumers that have an account balance in excess of the allowable amount. The Area Director will ensure that the Program Director and Home Manager are notified so they can work with the Social Worker and Client Finance Specialist to spend the money in an appropriate manner to get the balance below the allowable amount. Responsible Party: Home Manager, Program Director, Area Director, Client Finance Specialist	
W000120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility failed to ensure the day	W000120	A meeting will be scheduled with Client #1 day services staff to address the lack of supervision present during the observation.	12/21/2013

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	services met the needs of client #1. Findings include: Observations were conducted at the day service provider on 11/19/13 from 1:40 PM through 2:40 PM. At 1:40 PM client #1 was seated at a table in their work station area. Client #1's work station had 25 other, male and female non-survey, participants assigned to the area. Client #1's work area did not have day service staff from 1:40 PM until 2:05 PM. At 1:45 PM client #1 stated, "We have two staff but [DSS (Day Service Staff) #1] is in the office and [DSS #2] is in the bathroom." At 2:05 PM DSS #2 returned to the work area while DSS #1 was not present in the area. At 2:10 PM DSS #2 walked away from client #1's work area towards the back of the facility and out of line of eyesight. At 2:15 PM, DSS #2 returned to client #1's work area with a plate of food and cup of coffee. At 2:15 PM DSS #1 returned to the work area. Client #1 was observed in the work area throughout the observation period. Client #1 sat at a work station table while talking with male peers. Client #1 did not have work or other activity throughout the observation period. Client #1's record was reviewed on 11/19/13 at 9:25 AM. Client #1's ISP		The discussion will also include ensuring that alternate activities are provided to consumers when formal work is not available. Day Services staff will receive retraining to include ensuring that Client #1 receives constant supervision during the duration of time she is present at her day services program. The HM, PD, Quality Assurance Specialist and/or AD will complete active treatment observations a minimum of weekly to ensure Client #1 is provided with constant supervision throughout the day. After the initial 4 weeks, observations will be completed at least twice per month for the next 8 weeks to ensure that Client #1 is receiving constant supervision throughout the day. Ongoing the HM, PD and/or AD will complete active treatment observations a minimum of monthly to ensure Client #1 is receiving constant supervision. Responsible Party: Home Manager, Program Director, Area Director, Day Services staff	

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	(Individual Support Plan) dated 3/1/13 indicated client #1 required 24 hour supervision. Client #1's ISP dated 3/1/13 indicated, "Describe past activities that have caused a negative or positive result: [client #1] has had some issues at day placement on a couple of different occasions with male clients touching her inappropriately. [Client #1] reports she does not like it but she continues to allow it even after she had been told what to do if this situation occurs." Client #1's ISP dated 3/1/13 indicated staff should: -"Provide informal training for recreation and leisure skills." -"Informally assist with making decisions throughout the day." -"Engage [client #1] in casual conversation (non-directive and non-correcting) daily." -"Informally assist with building new relationships." -"Informally encourage exercise." Client #1 was interviewed on 11/19/13 at 2:10 PM. Client #1 stated, "They ran out of work this morning. I haven't had anything to do since I got here. I got here late because I had an appointment but the work was already done by then." AS #1 (Administrative Staff) was			

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	interviewed on 11/20/13 at 3:15 PM. AS #1 indicated client #1 should be provided with 24 hour supervision while at the day services. AS #1 indicated day service staff should offer formal and informal training at each opportunity. AS #1 stated, "She, [client #1], should be monitored especially with her history of sexual issues." 9-3-1(a)			
W000125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to ensure client rights by failing to allow clients to have the right to access kitchen knives, as the knives were locked in the group home's medication storage cabinet. The facility failed to secure a surrogate to assist client #3 with making informed choices and decisions. Findings include: Observations were conducted at the group home on 11/18/13 from 4:30 PM	W000125	1, 2, 3, The Program Director will review the need for all consumers regarding restricted access to the knives in the home. If it is determined that any consumers need restricted access, the Program Director will ensure that the restriction is put into the consumers Behavior Support Plan and guardian and Human Rights Committee Approval is obtained. For other consumers that do not require restricted access to the knives in the home, the Home Manager and Program Director will develop a way for them to have access to the knives as needed such as having	12/21/2013

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	through 5:30 PM. At 4:40 PM DSP (Direct Support Professional) #3 began passing the evening medications. At 4:45 PM, DSP #2 entered the medication administration area and placed a kitchen knife in the medication cabinet with three additional knives already present in the cabinet. DSP #3 indicated the kitchen knives were kept locked in the cabinet. DSP #3 was interviewed on 11/18/13 at 4:50 PM. DSP #3 indicated the group home kept the kitchen knives locked in the medication storage cabinet. 1. Client #1's record was reviewed on 11/19/13 at 9:25 AM. Client #1's ISP (Individual Support Plan) dated 3/1/13 did not indicate the need for locked knives. Client #1's BSP (Behavior Support Plan) dated 9/26/12 did not identify the need for locked knives. The client's ISP and/or ISP did not indicate the knives should be locked and/or indicate the facility's HRC (Human Rights Committee) had reviewed or approved the blanket restriction. 2. Client #2's record was reviewed on 11/19/13 at 10:22 AM. Client #2's ISP dated 4/30/13 did not indicate the need for locked knives. Client #2's BSP dated 7/30/12 did not identify the need for		a key to where the knives are locked up. The Home Manager and Program Director will receive retraining on not violating consumers' rights by restricting access to the knives in the home without due process through assessment of individual need. Ongoing, the Home Manager and Program Director will ensure that all consumers rights are not violated by restricting access to anything unless determined by the IDT and approval obtained from guardian (if needed) and Human Rights Committee. 3. The Program Director will work with the Home Manager and Quality Assurance Specialist to obtain guardians or Health Care Representatives for Clients #3 to assist her in making informed decisions regarding her healthcare needs. The Program Director will receive retraining to include ensuring all consumers that are not able to fully make informed decisions on their own regarding healthcare needs and finances have a legal representative that can assist with making decisions on their behalf. Ongoing, the Program Director will ensure that upon admission and ongoing as circumstances change, all consumers that are not able to fully make informed decisions on their own have a legal representative that can assist in making decisions on their behalf. When reviewing consumers Individual Support	

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	locked knives. The client's ISP and/or BSP did not indicate the knives should be locked and/or indicated the facility's HRC had reviewed or approved the blanket restriction. 3. Client #3's record was reviewed on 11/19/13 at 11:30 AM. Client #3's ISP dated 6/3/13 did not indicate the need for locked knives. Client #3's 6/3/13 BSP did not identify the need for locked knives. The client's ISP and/or ISP did not indicate the knives should be locked and/or indicate the facility's HRC (Human Rights Committee) had reviewed or approved the blanket restriction. Client #3's ISP dated 6/3/13 indicated client #3 was an emancipated adult. Client #3's ISP dated 6/3/13 indicated client #3 was not able to give informed consent. Client #3's POF (Physicians Order Form) dated 10/29/13 indicated client #3's diagnoses included, but were not limited to, moderate intellectual disability and depression. Client #3's CFA (Comprehensive Functional Assessment) dated 6/4/13 indicated client #3 was not independent in decision making regarding her personal finances, medical care, or social relationships. Client #3's Informed Consent- Skills List (ICSL) dated 6/4/13		Plans, the Area Director will review if all consumers that are not able to fully make decisions on their own regarding healthcare or finances have legal representation and if not will follow up with the Program Director to ensure the process is started to obtain legal representation. Responsible Parties: Program Director, Area Director	

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	indicated client #3 was not independent with the following; (a) Photograph consent; (b) Financial Affairs; (c) Release of Information; (d) Endangered Adult; (e) Resident rights; (f) Dietary Needs; (g) Psychotropic medication; (h) IDT (Interdisciplinary Team) membership; (i) Behavior assessment; (k) Medical treatment needs and/or; (l)Supervision level." Client #3's ICSL dated 6/4/13 indicated client #3 needed an advocate/HCR (Health Care Representative) or guardian to assist her in giving informed consent. Client #3's record did not indicate documentation of an advocate/HCR or guardian for client #3. AS (Administrative Staff) #1 was interviewed on 11/19/13 at 12:07 PM. AS #1 indicated the group home should not lock or restrict the clients' access to knives. AS #1 indicated client #3 was assessed as needing a HCR to assist her in making informed choices and decisions. 9-3-2(a)			
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.			

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	Based on record review and interview for 2 of 3 allegations of abuse, neglect and mistreatment reviewed, the facility failed to implement its policy and procedures to ensure the facility immediately notified the BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an allegation of abuse/mistreatment of client #3, to ensure the facility conducted an investigation of an allegation of sexual abuse for client #3 and to ensure the facility completed an investigation of an allegation of staff abuse regarding client #3 within 5 business days. Findings include: The facility's BDDS reports and investigations were reviewed on 11/18/13 at 1:04 PM. The review indicated the following: 1. BDDS report dated 11/13/13 indicated on 11/11/13 "[Client #3] reported that two staff, [DSP (Direct Support Professional) #4] and [DSP #5], held her down by her arms and legs during a disagreement and that she was forced to sleep on the floor in the hallway." The review indicated the BDDS was not notified within 24 hours of the facility's knowledge of the	W000149	All Direct care staff will be receive retraining on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents. Addendum: The Program Director that was supervising the home at the time of the survey is no longer with the company. The new Program Director will receive formal training from the Regional Quality Assurance Specialist and the Area Director on BDDS reporting requirements, including ensuring that BDDS reportable incidents are filed within 24 hours of knowledge of the incident. Training will also include that the Program Director will notify the Area Director if a BDDS reportable incident is not able to be reported by the Program Director within the 24 hour timeframe so that the Area Director can make arrangements to complete the BDDS report within the 24 hour timeframe or designate another QIDP to complete the report. For the first 30 days after the new Program Director starts, they will notify the Area Director of every on call report received immediately so that the PD and AD can consult to determine which situations require BDDS reports to be filed. The Area Director and new Program Director will work	12/21/2013

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	allegation. -Investigation dated 11/20/13 regarding the 11/11/13 allegation of staff abuse by client #3 did not indicate the administrator had been notified of the conclusion of the investigation within 5 business days of the alleged incident. 2. BDDS report dated 10/23/13 indicated, "[Client #3] reported to [HM #1 (Home Manager)] that at [day services] some guy touched her butt and breast and that he asked her to have sex in the bathroom. [Client #3] reported that she told staff at [day services] and they said, 'okay'." The 10/23/13 BDDS report indicated, "Will follow up with [day services] and an investigation will be completed." The review did not indicate documentation of an investigation regarding client #3's 10/23/13 allegation of sexual misconduct of a peer. AS (Administrative Staff #1) was interviewed on 11/19/13 at 12:07 PM. AS #1 indicated allegations of abuse, neglect and mistreatment should be reported to BDDS within 24 hours of knowledge of the allegation. AS #1 indicated allegations of abuse, neglect		together to determine who will complete the BDDS report. If the PD is not able to complete the report within the 24 hour guideline, they will notify the AD as soon as they are aware the delay will occur so that the AD can complete the report or designate another QIDP to complete the report within the designated guidelines. For the first 30 days after the PD has been trained on BDDS reports, the Area Director will discuss with the new Program Director daily the progress of any BDDS reports that need to be completed to ensure they are completed within the designated guidelines. Ongoing, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of twice weekly for 30 days to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines. The Home Manager will receive retraining on documentation review including reviewing all consumer Daily support records, behavior tracking and narrative notes to ensure all incidents that have been documented have been reported to the Program Director so reports can be made to the Bureau of Developmental Disability Services and	

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	and mistreatment should be thoroughly investigated. AS #1 indicated the results of investigations of allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be reported to the administrator within 5 business days. AS #1 indicated the facility's abuse and neglect policy should be implemented. The facility's policy and procedures were reviewed on 11/21/13 at 12:30 PM. The facility's April 2011 policy and procedure entitled Quality Risk Management indicated "Indiana Mentor (parent company) follows the BDDS Incident Reporting policy as outlined in the Providers Standards. An incident described as follows shall be reported to the BDDS on the incident report from prescribed by BDDS: 1. Alleged, suspected, or actual abuse, neglect, or exploitation of an individual." The April 2011 policy and procedure indicated, "An initial report regarding an incident shall be submitted within 24 hours of (a) the occurrence of the incident; or (b) the reporter becoming aware of or receiving information about an incident." The April 2011 policy and procedure indicated "Indiana Mentor is committed		investigations can be completed as needed. Ongoing, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of twice weekly for 30 days to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines. After the 30 days, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of once per week to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelinesThe Program Director will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed. Addendum: The Program Director that was supervising the home at the time of the survey is no longer with the company. The new Program Director will receive formal training from the Regional Quality Assurance Specialist and the Area Director on investigation requirements including what	

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	to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. (1.) Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident." 9-3-2(a)		situations need to be investigated and the timeframes that investigations need to be completed in and reported to the Administrator. For the first 30 days after the new Program Director has been trained on investigations, they will notify the Area Director of every on call report received immediately so that the PD and AD can consult to determine which situations require an investigation to be completed. The Area Director and new Program Director will work together to determine who will complete the investigation. If the PD is not able to complete the investigation within the 5 day guideline, they will notify the AD as soon as they are aware the delay will occur so that the AD can complete the report or designate another QIDP or Quality Assurance staff to complete the report within the designated guidelines. For the first 30 days after the new Program Director has been trained on investigations, the Area Director will discuss with the new Program Director daily the progress of any investigations that need to be completed to ensure they are completed within the designated guidelines. Ongoing, the Regional Quality Assurance Specialist will track the status of all investigations and report to the Area Director a minimum of weekly any outstanding investigations so that	

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			the Area Director can follow up with the Program Director on the status of getting the investigation completed. All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made. Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.	
W000153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 3 allegations of abuse, neglect and mistreatment reviewed, the facility failed to immediately notify the BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an allegation of abuse of client #3.	W000153	All Direct care staff will be receive retraining on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents. The Home Manager will receive retraining on documentation review including	12/21/2013

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	Findings include: The facility's BDDS reports and investigations were reviewed on 11/18/13 at 1:04 PM. The review indicated the following: -BDDS report dated 11/13/13 indicated on 11/11/13 "[Client #3] reported that two staff, [DSP (Direct Support Professional) #4] and [DSP #5], held her down by her arms and legs during a disagreement and that she was forced to sleep on the floor in the hallway." The review indicated the BDDS was not notified within 24 hours of the facility's knowledge of the allegation. AS (Administrative Staff #1) was interviewed on 11/19/13 at 12:07 PM. AS #1 indicated allegations of abuse, neglect and mistreatment should be reported to the BDDS within 24 hours of knowledge. 9-3-1(b)(5) 9-3-2(a)		reviewing all consumer Daily support records, behavior tracking and narrative notes to ensure all incidents that have been documented have been reported to the Program Director so reports can be made to the Bureau of Developmental Disability Services and investigations can be completed as needed. Ongoing, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of twice weekly for 30 days to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines. After the 30 days, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of once per week to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelinesAddendum: The Program Director that was supervising the home at the time of the survey is no longer with the company. The new Program Director will receive formal training from the Regional Quality Assurance Specialist and the Area Director on BDDS reporting	

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			requirements, including ensuring that BDDS reportable incidents are filed within 24 hours of knowledge of the incident. Training will also include that the Program Director will notify the Area Director if a BDDS reportable incident is not able to be reported by the Program Director within the 24 hour timeframe so that the Area Director can make arrangements to complete the BDDS report within the 24 hour timeframe or designate another QIDP to complete the report. For the first 30 days after the new Program Director starts, they will notify the Area Director of every on call report received immediately so that the PD and AD can consult to determine which situations require BDDS reports to be filed. The Area Director and new Program Director will work together to determine who will complete the BDDS report. If the PD is not able to complete the report within the 24 hour guideline, they will notify the AD as soon as they are aware the delay will occur so that the AD can complete the report or designate another QIDP to complete the report within the designated guidelines. For the first 30 days after the PD has been trained on BDDS reports, the Area Director will discuss with the new Program Director daily the progress of any BDDS reports that need to be completed to	

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			ensure they are completed within the designated guidelines. Ongoing, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of twice weekly for 30 days to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines.Responsible Party: Home Manager, Program Director, Area Director, Quality Assurance Specialist	
W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 3 allegations of abuse, neglect and mistreatment reviewed, the facility failed to conduct an investigation of an allegation of sexual abuse for client #3. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/18/13 at 1:04 PM. The review indicated the following: -BDDS report dated 10/23/13 indicated, "[Client #3] reported to [HM #1 (Home	W000154	The Program Director will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed. All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough	12/21/2013

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	Manager)] that at [day services] some guy touched her butt and breast and that he asked her to have sex in the bathroom. [Client #3] reported that she told staff at [day services] and they said, 'okay'." The 10/23/13 BDDS report indicated, "Will follow up with [day services] and an investigation will be completed." The review did not indicate documentation of an investigation regarding client #3's 10/23/13 allegation of sexual misconduct. AS (Administrative Staff #1) was interviewed on 11/19/13 at 12:07 PM. AS #1 indicated allegations of abuse, neglect and mistreatment should be thoroughly investigated. 9-3-2(a)		enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made. Addendum: The Program Director that was supervising the home at the time of the survey is no longer with the company. The new Program Director will receive formal training from the Regional Quality Assurance Specialist and the Area Director on investigation requirements including what situations need to be investigated and the timeframes that investigations need to be completed in and reported to the Administrator. For the first 30 days after the new Program Director has been trained on investigations, they will notify the Area Director of every on call report received immediately so that the PD and AD can consult to determine which situations require an investigation to be completed. The Area Director and new Program Director will work together to determine who will complete the investigation. If the PD is not able to complete the investigation within the 5 day guideline, they will notify the AD as soon as they are aware the delay will occur so that the AD can complete the report or designate another QIDP or Quality Assurance staff to complete the report within the designated guidelines. For the first 30 days after the new	

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			Program Director has been trained on investigations, the Area Director will discuss with the new Program Director daily the progress of any investigations that need to be completed to ensure they are completed within the designated guidelines. Ongoing, the Regional Quality Assurance Specialist will track the status of all investigations and report to the Area Director a minimum of weekly any outstanding investigations so that the Area Director can follow up with the Program Director on the status of getting the investigation completed. Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director..	
W000156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 3 allegations of abuse, neglect and mistreatment reviewed, the facility failed to complete an investigation of an allegation of staff abuse regarding client #3 within 5 business days. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services)	W000156	The Program Director will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed. All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an	12/21/2013

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	reports and investigations were reviewed on 11/18/13 at 1:04 PM. The review indicated the following: -BDDS report dated 11/13/13 indicated on 11/11/13 "[Client #3] reported that two staff, [DSP (Direct Support Professional) #4] and [DSP #5], held her down by her arms and legs during a disagreement and that she was forced to sleep on the floor in the hallway." The review indicated the BDDS was not notified within 24 hours of the facility's knowledge of the allegation. -Investigation dated 11/20/13 regarding the 11/11/13 allegation of staff abuse by client #3 did not indicate the administrator had been notified of the conclusion of the investigation within 5 business days of the alleged incident. AS (Administrative Staff #1) was interviewed on 11/19/13 at 12:07 PM. AS #1 indicated the results of investigations of allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be reported to the administrator within 5 business days. 9-3-2(a)		investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made. Addendum: The Program Director that was supervising the home at the time of the survey is no longer with the company. The new Program Director will receive formal training from the Regional Quality Assurance Specialist and the Area Director on investigation requirements including what situations need to be investigated and the timeframes that investigations need to be completed in and reported to the Administrator. For the first 30 days after the new Program Director has been trained on investigations, they will notify the Area Director of every on call report received immediately so that the PD and AD can consult to determine which situations require an investigation to be completed. The Area Director and new Program Director will work together to determine who will complete the investigation. If the PD is not able to complete the investigation within the 5 day guideline, they will notify the AD as soon as they are aware the	

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			delay will occur so that the AD can complete the report or designate another QIDP or Quality Assurance staff to complete the report within the designated guidelines. For the first 30 days after the new Program Director has been trained on investigations, the Area Director will discuss with the new Program Director daily the progress of any investigations that need to be completed to ensure they are completed within the designated guidelines. Ongoing, the Regional Quality Assurance Specialist will track the status of all investigations and report to the Area Director a minimum of weekly any outstanding investigations so that the Area Director can follow up with the Program Director on the status of getting the investigation completed.Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.	
W000159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3) plus 3 additional clients (#4, #5 and #6), the QIDP (Qualified Intellectual Disabilities Professional) failed to monitor, coordinate and	W000159	1.A meeting will be scheduled with Client #1 day services staff to address the lack of supervision present during the observation. The discussion will also include ensuring that alternate activities are provided to consumers when	12/21/2013

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	integrate each clients active treatment program by failing to ensure the day services met the needs of client #1, ensure clients #1, #3, #4, #5 and #6 had the opportunity to choose alternate food during meal time, to ensure staff implemented client #1's training objectives' during formal/informal training opportunities, to revise clients #1, #2 and #3's goals when the clients' met the objectives criteria for completion, to revise client #2's goals when she failed to make progress towards her adaptive equipment objective, to ensure the facility's HRC (Human Rights Committee) reviewed, monitored and approved the use of psychotropic medications for the management of clients #2 and #3's behavior and to ensure the facility's HRC obtained the client or the client's guardian's written informed consent before implementation of the use of psychotropic medications for behavior management. Findings include: 1. The QIDP failed to ensure the day services met the needs of client #1. Please see W120. 2. The QIDP failed to ensure clients #1, #3, #4, #5 and #6 had the opportunity to		formal work is not available. Day Services staff will receive retraining to include ensuring that Client #1 receives constant supervision during the duration of time she is present at her day services program. The HM, PD, Quality Assurance Specialist and/or AD will complete active treatment observations a minimum of weekly to ensure Client #1 is provided with constant supervision throughout the day. After the initial 4 weeks, observations will be completed at least twice per month for the next 8 weeks to ensure that Client #1 is receiving constant supervision throughout the day. Ongoing the HM, PD and/or AD will complete active treatment observations a minimum of monthly to ensure Client #1 is receiving constant supervision. 2.All Program Staff will receive retraining to include ensuring that all clients are given a choice of alternative food items during mealtime. For the next four weeks the HM and/or PD will complete mealtime observations at least 2 times per week to ensure that consumers are being offered choices at mealtime as needed. Ongoing, after the four weeks the HM and/or PD will complete mealtime observations at least 2 times per week to ensure that consumers are being offered choices at mealtime as needed. 3.All Direct Care staff will receive retraining on all consumers Medication	

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	choose food during meal time. Please see W247. 3. The QIDP failed to ensure staff implemented client #1's training objectives during formal/informal training opportunities. Please see W249. 4. The QIDP failed to revise clients #1, #2 and #3's goals when the clients met the objectives' criteria for completion. Please see W255. 5. The QIDP failed to revise client #2's goals when she failed to make progress towards her adaptive equipment objective. Please see W257. 6. The QIDP failed to ensure the facility's HRC reviewed, monitored and approved the use of psychotropic medications for the management of clients #2 and #3's behavior. Please see W262. 7. The QIDP failed to ensure the facility's HRC obtained the client or the client's guardian's written informed consent before implementation of the use of psychotropic medications for behavior management. Please see W263. 9-3-3(a)		Administration goals and the need to complete formal training goals as indicated, especially at Medication administration times. Addendum: For the next four weeks, the Home Manager and/or Program Director will complete Medication Administration observations a minimum of three times weekly to ensure that all staff are completing all consumers Medication Administration goals as written.For the next four weeks, the Home Manager and/or Program Director will complete Medication Administration observations a minimum of two times weekly to ensure that all staff are completing all consumers Medication Administration goals as written.Ongoing, the Home Manager and/or Program Director will complete Medication Administration observations a minimum of once weekly to ensure that all staff are completing all consumers Medication Administration goals as written.There is a new Program Director that is completing training that will supervise this program site. Part of the training will include reviewing all consumers' goals and objectives, including medication administration objectives to evaluate for goal progress. The new Program Director will be working closely with the Area Director to ensure	

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			consumers goals and objectives are appropriate based on the consumers' needs and abilities. The Program Director will be completing active treatment observations as well as mealtime and medication administration observations a minimum of twice weekly to ensure they are being implemented correctly and accurately based on the consumers' needs and abilities. 4. An audit will be completed on all consumers' goals and objectives to assess level of completion. All goals and objectives that the consumer has successfully completed will be revised as needed to allow for further progress. The Program Director will receive retraining to include ensuring that all consumers goals and objectives are reviewed a minimum of monthly and assessed a minimum of quarterly to review level of completion. If consumers are successfully completing objectives, they will be revised as needed to allow for further progress. The Area Director will review the next 3 ISPs completed by this Program Director to review if consumers goals and objectives are being reviewed and revised as needed when consumers are achieving objectives as identified in the individual program plans. Addendum: The Program Director will complete a formal monthly review of each consumers goals and objectives to document goal	

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			progress. The Program Director will assess the consumers goal progress a minimum of quarterly to review the level of completion and make any changes to goals and objectives as necessary based on the consumers needs and abilities. The Area Director will review the Program Directors monthly reviews each month to ensure completion. The Area Director will review the quarterly assessments for each consumer a minimum of quarterly to ensure that the Program Director is making changes to goals and objectives as needed based on the consumers level of goal completion as well as the consumers' needs and abilities. The Area Director will provide a list of monthly and quarterly dates of review to the Program Director for each consumer so that the Program Director is aware of what reports are needed each month. 5. Client #2 goal/objective for adaptive equipment use has been revised to assist with making further progress toward completion. An audit will be completed on all consumers' goals and objectives to assess level of completion. All goals and objectives that the consumer has failed to complete will be revised as needed to allow for further progress. The Program Director will receive retraining to include ensuring that all consumers goals and objectives are reviewed a minimum of monthly and	

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			assessed a minimum of quarterly to review level of completion. If consumers are failing to complete objectives, they will be revised as needed to allow for further progress. The Area Director will review the next 3 ISPs completed by this Program Director to review if consumers goals and objectives are being reviewed and revised as needed when consumers are failing to complete objectives as identified in the individual program plans. Addendum: The Program Director will complete a formal monthly review of each consumers goals and objectives to document goal progress. The Program Director will assess the consumers goal progress a minimum of quarterly to review the level of completion and make any changes to goals and objectives as necessary based on the consumers needs and abilities. The Area Director will review the Program Directors monthly reviews each month to ensure completion. The Area Director will review the quarterly assessments for each consumer a minimum of quarterly to ensure that the Program Director is making changes to goals and objectives as needed based on the consumers level of goal completion as well as the consumers' needs and abilities. The Area Director will provide a list of monthly and quarterly dates of review to the Program Director for each consumer so that the	

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			Program Director is aware of what reports are needed each month.6. Human Rights Committee Approval will be obtained for Client #2 and #3 psychotropic medications. The Home Manager and Program Director will receive retraining to include ensuring that all psychotropic medications have Human Rights Committee approval before use of any psychotropic medications is implemented. Training will include ensuring that documentation is available for review of Human Rights Committee approvals of any additions or increases to psychotropic medications. For the next 3 months, the Program Director will provide documentation to the Area Director that Human Rights Committee approval has been obtained for any additions or increases to consumers' psychotropic medications prior to their implementation. After the 3 month period, the Area Director will review the documentation that Human Rights Committee has approved any additions or increases to consumers' psychotropic medications a minimum of quarterly to ensure that these requirements continue to be met. 7. The Program Director will receive retraining on ensuring that consumers' guardians or Health Care Representatives are notified of any additions or changes to	

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			consumers' psychotropic medications. The Program Director will also receive retraining on ensuring that consumers' guardians and/or Health Care Representatives review and approve any changes or updates to psychotropic medications prior to their implementation. For the next 3 months, the Program Director will provide documentation to the Area Director that consumers' guardians or Health Care Representatives have received notification of any changes to psychotropic medications and have approved any changes. After the 3 month period, the Area Director will review the documentation that guardians or Health Care Representatives are receiving updates and changes to consumers' psychotropic medications a minimum of quarterly to ensure that these requirements continue to be met. Responsible Party: Home manager, Program Director, Area Director	
W000186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, record review and	W000186	All direct care staff will receive	12/21/2013

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	interview for 2 of 3 sampled clients (#1 and 2), the facility failed to ensure there were adequate staff levels in the group home to implement clients #1 and #2's meal time risk plans. Findings include: Observations were conducted at the group home on 11/19/13 from 6:55 AM through 8:15 AM. At 6:55 AM, overnight staff, DSP (Direct Support Professional) #1, morning staff, DSP #2 and HM (Home Manager) #1 were present in the house. At 7:15 AM, DSP #1 indicated she was finished with her shift and DSP #2 would be finishing the morning medication administration. At 7:25 AM, DSP #1 exited the group home. At 7:30 AM, DSP #2 entered the medication administration area to resume the morning medication administration. HM #1 was seated at the group home office desk. Clients #1 and #2 were seated at the dining room table with peers eating cereal and toast with milk for breakfast. Clients #1 and #2 were unsupervised while eating breakfast at the group home dining room table from 7:30 AM through 7:45 AM. 1. Client #1's record was reviewed on 11/19/13 at 9:25 AM. Client #1's Choking Protocol form dated 7/12/10		retraining on consumers' mealtime risk plans to review need for adequate supervision during mealtimes.Home Manager and Program Director will revise schedule to ensure that adequate staffing is present during mealtimes to ensure supervision of clients to implement mealtime risk plans. The Home Manager will ensure that staffing is arranged so that adequate staffing is present daily to implement client risk plans. For four weeks the Home Manager and/or Program Director will complete mealtime observations a minimum of 3 times per week to ensure that adequate staffing is present to ensure consumers mealtime risk plans are being implemented.After the 4 weeks the Home Manager and/or Program Director will complete mealtime observations a minimum of 2 times per week to ensure that adequate staffing is present to ensure consumers mealtime risk plans are being implemented.Addendum: The observations will be completed randomly throughout the week. The majority of the observations will occur during the work week at either the breakfast or dinner mealtimes since all of the consumers are at day placement almost every day. For the first 2 months, once every two weeks a weekend observation will be completed at a random meal. Responsible Party: Home	

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	with reviews on 7/5/11 and 8/30/13 indicated, "Staff remind to eat at a slower rate and to swallow before next bite. Staff to remind, [client #1], not to overfill mouth. Staff to encourage sips of liquid often to clear mouth of food." Client #1's Choking Protocol dated 7/12/10 indicated client #1 should be monitored during meals. 2. Client #2's record was reviewed on 11/19/13 at 10:22 AM. Client #2's Choking Protocol form dated 3/8/13 indicated, "Staff remind to eat at a slower rate and to swallow before next bite. Staff to remind, [client #2], not to overfill mouth. Staff to encourage sips of liquid often to clear mouth of food." Client #2's Choking Protocol dated 3/8/13 indicated client #2 should be monitored during meals. Interview with HM #1 on 11/18/13 at 12:40 PM indicated clients #1 and #2 should be monitored by staff during meals. HM #1 stated, "The overnight staff, [DSP #1], should have finished passing the morning medications before leaving. The morning staff, [DSP #2], shouldn't have to finish the morning medications and monitor the meal." Interview with AS #1 (Administrative Staff) on 11/18/13 at 12:40 PM		Manager, Program Director	

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	indicated clients #1 and #2 had risk plans for choking. AS #1 indicated clients #1 and #2's risk plans for choking should be implemented. AS #1 indicated clients #1 and #2's choking risk plans included staff supervision of meals. AS #1 indicated there should be adequate staffing in the home to implement clients #1 and #2's choking risk plans. 9-3-3(a)			
W000247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. Based on observation and interview for 2 of 3 sampled clients (#1 and #3) plus 3 additional clients (#4, #5 and #6), the facility failed to ensure clients #1, #3, #4, #5 and #6 had a choice of alternative food during meal time. Findings include: Observations were conducted at the group home on 11/18/13 from 4:30 PM through 5:30 PM. At 5:05 PM clients #1, #3, #4, #5 and #6 were prompted to sit at the dining room table to participate in the family style evening meal. DSP (Direct Support Professional) #3 and client #3 placed a dish of cooked	W000247	All Program Staff will receive retraining to include ensuring that all clients are given a choice of alternative food items during mealtime. For the next four weeks the HM and/or PD will complete mealtime observations at least 2 times per week to ensure that consumers are being offered choices at mealtime as needed. Ongoing, after the four weeks the HM and/or PD will complete mealtime observations at least 2 times per week to ensure that consumers are being offered choices at mealtime as needed. Responsible staff: Program Director, Home Manager	12/21/2013

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	squash, dish of pasta, dish of meatballs, tossed salad and fruit on the dining room table. At 5:05 PM client #1 stated, "I don't like squash. I don't want any." Clients #4 and #6 also stated, "Me either, I don't want any." At 5:08 PM clients #1, #3, #4, #5 and #6, served themselves portions of salad and pasta with meatballs. Clients #1, #3, #4, #5 and #6 did not served themselves a portion of cooked squash. At 5:15 PM DSP #3 stated, "Can you guys pass the squash around to [client #2], she wants some. Isn't anybody else going to eat the squash, don't you want some?" Clients #1, #3, #4, #5 and #6 each indicated they did not like squash and did not want any for their meal. DSP #3 did not offer clients #1, #3, #4, #5 and #6 an alternative food choice. Client #3 was interviewed on 11/19/13 at 2:10 PM. Client #3 indicated she did not squash. AS (Administrative Staff) #1 was interviewed on 11/19/13 at 12:07 PM. AS #1 indicated staff should offer clients choices of alternative foods during meal times. 9-3-4(a)			

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W000249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility failed to implement client #1's training objectives during formal/informal training opportunities. Findings include: Observations were conducted at the group home on 11/19/13 from 6:55 AM through 8:15 AM. At 7:12 AM, client #1 was prompted by DSP (Direct Support Professional) #2 to come to the medication administration area. Client #1 received Loratadine 10 milligram tablet (allergies), Metamucil Powder (constipation) and Omeprazole 20 milligram tablet (reflux). DSP #2 did not prompt client #1 to explain the reasons why she was taking her medications. Client #1's record was reviewed on 11/19/13 at 9:25 AM. Client #1's ISP (Individual Support Plan) dated 3/1/13 indicated, "Increase, [client #1's], medication administration skills through	W000249	All Direct Care staff will receive retraining on all consumers Medication Administration goals and the need to complete formal training goals as indicated, especially at Medication administration times. Addendum: For the next four weeks, the Home Manager and/or Program Director will complete Medication Administration observations a minimum of three times weekly to ensure that all staff are completing all consumers Medication Administration goals as written.For the next four weeks, the Home Manager and/or Program Director will complete Medication Administration observations a minimum of two times weekly to ensure that all staff are completing all consumers Medication Administration goals as written.Ongoing, the Home Manager and/or Program Director will complete Medication Administration observations a minimum of once weekly to ensure that all staff are completing all consumers Medication Administration goals	12/21/2013

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	a formal goal." Client #1's Monthly Summary of Goals dated October 2013 indicated client #1 had a formal training objective to "Twice daily, [client #1] will state why she is taking her medication." AS (Administrative Staff) #1 was interviewed on 11/19/13 at 12:07 PM. AS #1 indicated formal and informal training should occur at each opportunity. 9-3-4(a)		as written.There is a new Program Director that is completing training that will supervise this program site. Part of the training will include reviewing all consumers' goals and objectives, including medication administration objectives to evaluate for goal progress. The new Program Director will be working closely with the Area Director to ensure consumers goals and objectives are appropriate based on the consumers' needs and abilities. The Program Director will be completing active treatment observations as well as mealtime and medication administration observations a minimum of twice weekly to ensure they are being implemented correctly and accurately based on the consumers' needs and abilities. Responsible Staff: Home Manager, Program Director	
W000255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the QIDP (Qualified Intellectual Disabilities Professional) failed to revise clients #1, #2 and #3's goals when the	W000255	An audit will be completed on all consumers' goals and objectives to assess level of completion. All goals and objectives that the consumer has successfully completed will be revised as	12/21/2013

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	clients met the objectives' criteria for completion. Findings include: 1. Client #1's record was reviewed on 11/19/13 at 9:25 AM. Client #1's MSFs (Monthly Summary Forms) for the months of May 2013 through the month of October 2013 indicated the following level of performance regarding client #1's 3/1/13 ISP (Individual Support Plan) goals and objectives: -"Goal/Objective #2: Three times per week, [client #1] will prepare a dish at a mealtime with no more than 2 VP (Verbal Prompts) at 75% for 3 CMs (Consecutive Months)." -May 2013 Performance: 50% -June 2013 Performance: 100% -July 2013 Performance: 100% -August 2013 Performance: 100% -September 2013 Performance: 90% -October 2013 Performance: 90% The review indicated client #1 had met or exceeded objective #2's criteria for 5 consecutive months between June 2013 and October 2013. The review did not indicate client #1's training objective had been revised to increase client #1's mealtime/domestic skills.		needed to allow for further progress. The Program Director will receive retraining to include ensuring that all consumers goals and objectives are reviewed a minimum of monthly and assessed a minimum of quarterly to review level of completion. If consumers are successfully completing objectives, they will be revised as needed to allow for further progress. The Area Director will review the next 3 ISPs completed by this Program Director to review if consumers goals and objectives are being reviewed and revised as needed when consumers are achieving objectives as identified in the individual program plans. Addendum: The Program Director will complete a formal monthly review of each consumers goals and objectives to document goal progress. The Program Director will assess the consumers goal progress a minimum of quarterly to review the level of completion and make any changes to goals and objectives as necessary based on the consumers needs and abilities. The Area Director will review the Program Directors monthly reviews each month to ensure completion. The Area Director will review the quarterly assessments for each consumer a minimum of quarterly to ensure that the Program Director is making changes to goals and objectives as needed based on the consumers level of goal	

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	-"Goal/Objective #3: Daily, [client #1] will complete her assigned task on the chore chart with no more than 2 VP at 75% for 3 CMs." -May 2013 Performance: 86% -June 2013 Performance: 75% -July 2013 Performance: 88% -August 2013 Performance: 91% -September 2013 Performance: 81% -October 2013 Performance: 81% The review indicated client #1 had met or exceeded objective #3's criteria for 6 consecutive months between May 2013 and October 2013. The review did not indicate client #1's training objective had been revised to increase client #1's chore/cleaning skills. -"Goal/Objective #4: Three times per week, [client #1] will exercise for at least 15 minutes with no more than 2 VP at 70% for 3 CMs." -June 2013 Performance: 100% -July 2013 Performance: 80% -August 2013 Performance: 100% -September 2013 Performance: 100% -October 2013 Performance: 85% The review indicated client #1 had met		completion as well as the consumers' needs and abilities. The Area Director will provide a list of monthly and quarterly dates of review to the Program Director for each consumer so that the Program Director is aware of what reports are needed each month. Responsible Party: Program Director, Area Director	

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	or exceeded objective #4's criteria for 5 consecutive months between June 2013 and October 2013. The review did not indicate client #1's training objective had been revised to increase client #1's exercise skills. -"Goal/Objective #5: Twice daily, [client #1] will state why she is taking her medication with no more than 2 VP at 50% for 3 CMs." -May 2013 Performance: 100% -June 2013 Performance: 100% -July 2013 Performance: 100% -August 2013 Performance: 100% -September 2013 Performance: 100% -October 2013 Performance: 100% The review indicated client #1 had met or exceeded objective #5's criteria for 6 consecutive months between May 2013 and October 2013. The review did not indicate client #1's training objective had been revised to increase client #1's medication administration skills. 2. Client #2's record was reviewed on 11/19/13 at 10:22 AM. Client #2's MSFs for the months of May 2013 through the month of October 2013 indicated the following level of performance regarding client #2's 4/30/13 ISP goals			

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	and objectives: -"Goal/Objective #4: Three times per week, [client #2] will join in on an activity and participate with no more than 1 VP at 75% for 3 CMs." -May 2013 Performance: 79% -June 2013 Performance: 94% -July 2013 Performance: 100% -August 2013 Performance: 86% -September 2013 Performance: 80% -October 2013 Performance: 100% The review indicated client #2 had met or exceeded objective #4's criteria for 6 consecutive months between May 2013 and October 2013. The review did not indicate client #2's training objective had been revised to increase client #2's leisure skills. 3. Client #3's record was reviewed on 11/19/13 at 11:30 AM. Client #3's MSFs for the months of May 2013 through the month of October 2013 indicated the following level of performance regarding client #3's 6/3/13 ISP goals and objectives: -"Goal/Objective #1: At least once a week, [client #3] will recognize the need to shave and shave her underarms and her legs with no more than 1 VP at 70%			

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	for 3 CMs." -June 2013 Performance: 80% -July 2013 Performance: 100% -August 2013 Performance: 71% -September 2013 Performance: 100% -October 2013 Performance: 100% The review indicated client #3 had met or exceeded objective #1's criteria for 5 consecutive months between June 2013 and October 2013. The review did not indicate client #3's training objective had been revised to increase client #3's personal care skills. -"Goal/Objective #2: Once a week, [client #3] will plan an activity to participate in with her peers independently at 80% for 3 CMs." -June 2013 Performance: 100% -July 2013 Performance: 100% -August 2013 Performance: 100% -September 2013 Performance: 100% -October 2013 Performance: 100% The review indicated client #3 had met or exceeded objective #2's criteria for 5 consecutive months between June 2013 and October 2013. The review did not indicate client #3's training objective			

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	had been revised to increase client #3's social skills. -"Goal/Objective #4: Three times a week, [client #3] will help prepare a healthy side dish for evening meal, with no more than 1 VP at 80% for 3 CMs." -June 2013 Performance: 100% -July 2013 Performance: 100% -August 2013 Performance: 88% -September 2013 Performance: 100% -October 2013 Performance: 100% The review indicated client #3 had met or exceeded objective #4's criteria for 5 consecutive months between June 2013 and October 2013. The review did not indicate client #3's training objective had been revised to increase client #3's cooking skills. -"Goal/Objective #5: Weekly, [client #3] will separate her clothes, wash and dry her clothes and fold them independently at 75% for 3 CMs." -June 2013 Performance: 100% -July 2013 Performance: 83% -August 2013 Performance: 83% -September 2013 Performance: 80% -October 2013 Performance: 100%			

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	The review indicated client #3 had met or exceeded objective #5's criteria for 5 consecutive months between June 2013 and October 2013. The review did not indicate client #3's training objective had been revised to increase client #3's laundry skills. Interview with AS #1 (Administrative Staff) on 11/18/13 at 12:40 PM indicated clients' objectives should be revised when criteria is met. AS #1 indicated the PD (Program Director)/QIDP, who was unavailable for interview at the time, should revise programming goals when clients achieved criteria/skills. 9-3-4(a)			
W000257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. Based on record review and interview for 1 of 3 sampled clients (#2), the QIDP (Qualified Intellectual Disabilities Professional) failed to revise client #2's goals when she failed to make progress towards her adaptive equipment objective.	W000257	Client #2 goal/objective for adaptive equipment use has been revised to assist with making further progress toward completion. An audit will be completed on all consumers' goals and objectives to assess level of completion. All goals and	12/21/2013

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	Findings include: Client #2's record was reviewed on 11/19/13 at 10:22 AM. Client #2's MSFs (Monthly Summary Forms) for the months of May 2013 through the month of October 2013 indicated the following level of performance regarding client #2's 4/30/13 ISP (Individual Support Plan) goals and objectives: -"Goal/Objective #2: Daily, [client #2] will use her walker to help her walk with no more than 2 VP (Verbal Prompts) at 60% for 3 CMs (Consecutive Months)." -May 2013 Performance: 0% -June 2013 Performance: 0% -July 2013 Performance: 0% -August 2013 Performance: 0% -September 2013 Performance: 0% -October 2013 Performance: 0% The review indicated client #2 had not made progress toward meeting objective #2's criteria for 6 consecutive months between May 2013 and October 2013. The review did not indicate client #2's training objective had been revised to increase client #2's adaptive equipment compliance. Interview with AS #1 (Administrative		objectives that the consumer has failed to complete will be revised as needed to allow for further progress. The Program Director will receive retraining to include ensuring that all consumers goals and objectives are reviewed a minimum of monthly and assessed a minimum of quarterly to review level of completion. If consumers are failing to complete objectives, they will be revised as needed to allow for further progress. The Area Director will review the next 3 ISPs completed by this Program Director to review if consumers goals and objectives are being reviewed and revised as needed when consumers are failing to complete objectives as identified in the individual program plans. Addendum: The Program Director will complete a formal monthly review of each consumers goals and objectives to document goal progress. The Program Director will assess the consumers goal progress a minimum of quarterly to review the level of completion and make any changes to goals and objectives as necessary based on the consumers needs and abilities. The Area Director will review the Program Directors monthly reviews each month to ensure completion. The Area Director will review the quarterly assessments for each consumer a minimum of quarterly to ensure that the Program Director is making changes to goals and	

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1926 W 75TH PL INDIANAPOLIS, IN 46260	

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	Staff) on 11/18/13 at 12:40 PM indicated client objectives should be revised when a client is unable to make progress. AS #1 indicated the PD (Program Director)/QIDP who was unavailable for interview at the time, should revise programming goals when clients are failing to progress. 9-3-4(a)		objectives as needed based on the consumers level of goal completion as well as the consumers' needs and abilities. The Area Director will provide a list of monthly and quarterly dates of review to the Program Director for each consumer so that the Program Director is aware of what reports are needed each month. Responsible Party: Program Director, Area Director	
W000262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview for 2 of 3 sampled clients (#2 and #3) with restrictive programs, the facility's HRC (Human Rights Committee) failed to review, monitor and approve the use of psychotropic medications for the management of clients #2 and #3's behavior. Findings include: 1. Client #2's record was reviewed on 11/19/13 at 10:22 AM. Client #2's POF (Physicians Order Form) dated 11/1/13 indicated the use of Risperidone 1	W000262	Human Rights Committee Approval will be obtained for Client #2 and #3 psychotropic medications. The Home Manager and Program Director will receive retraining to include ensuring that all psychotropic medications have Human Rights Committee approval before use of any psychotropic medications is implemented. Training will include ensuring that documentation is available for review of Human Rights Committee approvals of any additions or increases to psychotropic medications. For the next 3 months, the Program Director will provide documentation to the Area	12/21/2013

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	milligram tablet (impulse control disorder), Fluoxetine 40 milligram capsule (impulse control disorder) and Lithium Carbonate 300 milligram capsule (impulse control disorder). Client #2's BSP (Behavior Support Plan) dated 7/30/12 indicated, "[Client #2] currently receives total daily dosages of risperidone 1 milligram, fluoxetine 40 milligrams and lithium 600 milligrams for behavior control." Client #2's record did not indicate documentation of review/approval by the facility's HRC for the use of psychotropic medications. 2. Client #3's record was reviewed on 11/19/13 at 11:30 AM. Client #3's POF dated 11/1/13 indicated the use of Bupropion 75 milligram (depression) one tablet by mouth once a day (5/1/13). Client #3's BSP dated June 2013 indicated "Wellbutrin (Bupropion) 150 milligrams, anti-depressant." Client #3's record indicated the facility's HRC approved the use of Wellbutrin/Bupropion 150 milligrams on 10/10/13. Client #3's record did not indicate documentation of HRC approval for the use of Wellbutrin/Bupropion 150 milligrams from June 2013 through 10/10/13. AS #1 (Administrative Staff) was interviewed on 11/19/13 at 12:07 PM.		Director that Human Rights Committee approval has been obtained for any additions or increases to consumers' psychotropic medications prior to their implementation. After the 3 month period, the Area Director will review the documentation that Human Rights Committee has approved any additions or increases to consumers' psychotropic medications a minimum of quarterly to ensure that these requirements continue to be met. Responsible Party: Home Manager, Program Director, Area Director	

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	AS #1 indicated there was no documentation available regarding client #2's psychotropic medications. AS #1 indicated client #3's psychotropic medications were HRC approved on 10/10/13. AS #1 indicated the use of psychotropic medications should be HRC reviewed and approved before implementation of the drugs. 9-3-4(a)			
W000263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 2 of 3 sampled clients (#2 and #3) with restrictive programs, the facilities HRC (Human Rights Committee) failed to obtain the client's or the client's guardian's written informed consent before implementation of the use of psychotropic medications for behavior management. Findings include: 1. Client #2's record was reviewed on 11/19/13 at 10:22 AM. Client #2's POF (Physicians Order Form) dated 11/1/13 indicated the use of risperidone 1	W000263	The Program Director will receive retraining on ensuring that consumers' guardians or Health Care Representatives are notified of any additions or changes to consumers' psychotropic medications. The Program Director will also receive retraining on ensuring that consumers' guardians and/or Health Care Representatives review and approve any changes or updates to psychotropic medications prior to their implementation. For the next 3 months, the Program Director will provide documentation to the Area Director that consumers' guardians or Health Care Representatives have received	12/21/2013

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	milligram tablet (impulse control disorder), fluoxetine 40 milligram capsule (impulse control disorder) and lithium carbonate 300 milligram capsule (impulse control disorder). Client #2's BSP (Behavior Support Plan) dated 7/30/12 indicated, "[Client #2] currently receives total daily dosages of risperidone 1 milligram, fluoxetine 40 milligrams and lithium 600 milligrams for behavior control." Client #2's ISP (Individual Support Plan) dated 4/30/13 indicated client #2 had a legal guardian. Client #2's record did not indicate documentation of client #2's guardian's written informed consent for the use of psychotropic medication for behavior management. 2. Client #3's record was reviewed on 11/19/13 at 11:30 AM. Client #3's POF dated 11/1/13 indicated the use of Bupropion 75 milligram (depression) one tablet by mouth once a day (5/1/13). Client #3's BSP dated June 2013 indicated "Wellbutrin (Bupropion) 150 milligrams, anti-depressant." Client #3's record indicated the facility's HRC approved the use of Wellbutrin/Bupropion 150 milligrams on 10/10/13. Client #3's ISP dated 6/3/13 indicated client #3 was an emancipated adult. Client #3's record did not indicate documentation of client #3's		notification of any changes to psychotropic medications and have approved any changes. After the 3 month period, the Area Director will review the documentation that guardians or Health Care Representatives are receiving updates and changes to consumers' psychotropic medications a minimum of quarterly to ensure that these requirements continue to be met. Responsible Party: Program Director, Area Director	

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	written informed consent for the use of psychotropic medication for behavior management. AS #1 (Administrative Staff) was interviewed on 11/19/13 at 12:07 PM. AS #1 indicated client #2's BSP and use of psychotropic medications should have her guardian's written informed consent. AS #1 indicated there was no available documentation of client #2's guardian's approval for the use of client #2's psychotropic medication. AS #1 indicated client #3 was emancipated and did not have a guardian or HCR (Health Care Representative). AS #1 indicated client #3's written informed consent was needed for the use of psychotropic medications prior to implementation. 9-3-4(a)			
W000369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 1 of 20 medications observed, the facility failed to ensure staff administered client #1's medication as ordered. Findings include:	W000369	All staff will receive retraining on all consumers medication orders including Client #1 Docusate Sodium needing to be given as directed by the physician. Training will include staff notifying the Home Manager and Program Nurse immediately if a medication is not present in the home to give	12/21/2013

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	Observations were conducted at the group home on 11/19/13 from 6:55 AM through 8:15 AM. At 7:17 AM, client #1 received her morning medications. DSP #2 indicated client #1 was out of docusate sodium 100 milligram capsule (constipation). Client #1's pharmacy bubble pack of docusate sodium 100 milligram capsule was empty. Client #1 did not receive her 8:00 AM scheduled dose of docusate sodium 100 milligram capsule. The facility's MAR (Medication Administration Record) book was reviewed on 11/19/13 at 7:45 AM. Client #1's POs (Physician Orders) form dated 11/1/13 indicated client #1 had an order to receive "Docusate Sodium 100 milligram Capsule: take one capsule by mouth twice a day for constipation." Client #1's 11/19/13 8:00 AM dose was circled by DSP #2 with a note on the back of the POs form indicating the dose was not administered. AS #1 (Administrative Staff) was interviewed on 11/19/13 at 1:30 PM. AS #1 indicated medication should be administered as ordered. LPN #1 (Licensed Practical Nurse) was interviewed via telephone on 11/19/13 at		so arrangements can be made to obtain the medication. Home Manager and/or Program Director will complete medication administration observations at least twice per week for four weeks to ensure that all staff are following all consumers medication orders as written. Ongoing, the Home Manager and/or Program Director will complete medication administration observations at least once per week to ensure that all staff are following all consumers medication orders as written. Responsible staff: Home Manager, Program Director	

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	1:35 PM. LPN #1 indicated she was the nurse for the group home. LPN #1 indicated medication should be administered as ordered by the physician. LPN #1 indicated she had not been notified of client #1's missed dose of docusate sodium. LPN #1 stated, "If they had called, we could have possibly pulled a dose of her docusate from her 8:00 PM package." 9-3-6(a)			
W000371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. Based on record review and interview for 1 of 3 sampled clients (#3), the facility failed to ensure client #3 had medication administration training. Findings include: Client #3's record was reviewed on 11/19/13 at 11:30 AM. Client #3's ISP (Individual Support Plan) dated 6/3/13 indicated, "Assessment of ability to schedule and keep medical appointments: Indiana Mentor is	W000371	A Medication Administration goal has been developed for Client #3. All Direct Support staff will receive retraining on Client #1 Medication Administration goal and how to implement and document it. The Program Director will receive retraining to include the need to ensure that all consumers have Medication Administration goals developed and implemented based on their individual abilities. Ongoing, the Program Director will ensure that all consumers have Medication Administration goals developed and implemented based on their	12/21/2013

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	responsible for scheduling and transporting [client #3] to appointments. Assessment of ability to self-medicate: Indiana Mentor is responsible for providing [client #3] with her medication and supervising." Client #3's ISP dated 6/3/13 indicated the "Proposed Strategy/Activity" to assist client #3's medication administration skills was to "Increase medication administration skills through a formal goal." Client #3's POs (Physicians Orders) dated 10/29/13 indicated client #3 received the following medications: Fluticasone 50 MCG (Micrograms) (dry nose), Multivitamin tablet (supplement), Oyster Shell Calcium 500 milligram tablet (supplement) and Bupropion 75 milligram tablet (depression). Client #3's record did not indicate medication training was contraindicated. Client #3's MSFs (Monthly Summary Forms) for the months of May 2013 through the month of October 2013 did not indicate documentation of a formal training objective/goal regarding medication administration for client #3. AS #1 (Administrative Staff) was interviewed on 11/21/13 at 1;30 PM. AS #1 indicated client #3 was not independent in medication administration. AS #1 indicated client		individual abilities. The Area Director will review the next 3 ISPs submitted by this Program Director to ensure that all consumers have Medication Administration goals developed and implemented based on their individual abilities. Responsible Staff: Program Director, Area Director	

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	#3 should have a medication administration objective. 9-3-6(a)			
W000382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 3 of 3 sampled clients (#1, #2 and #3) plus 3 additional clients (#4, #5 and #6), the facility failed to maintain the clients' medication in a secure location. Findings include: Observations were conducted at the group home on 11/19/13 from 6:55 AM through 8:15 AM. At 6:55 AM, overnight staff, DSP (Direct Support Professional) #1, administered client #6's morning medications. At 7:10 AM, DSP #1 indicated it was the end of her shift and exited the medication administration area. DSP #1 exited the medication administration room without locking the medication storage cabinet which contained clients #1, #2, #3, #4, #5 and #6's medications. At 7:12 AM, client #1 entered the medication administration room unsupervised while the medication storage cabinet was unlocked. At 7:17 AM, DSP #2 entered	W000382	All staff will receive retraining on ensuring that the medication cabinet is locked during medication administration when exiting the medication area for any reason. Home Manager and/or Program Director will complete medication administration observations at least twice per week for four weeks to ensure that all staff are locking the medication cabinet during medication administration when staff are out of the area for any reason. Ongoing, the Home Manager and/or Program Director will complete medication administration observations at least once per week to ensure that all staff are locking the medication cabinet during medication administration when staff are out of the area for any reason. Responsible Party: Home Manager, Program Director	12/21/2013

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	the medication administration area to resume the morning medication pass. DSP #2 indicated she did not know the location of the lock that should be used to secure the medication storage cabinet. DSP #2 asked DSP #1 where she left the lock. DSP #1 indicated the medication storage cabinet lock was lying on the arm rest of the couch next to the medication storage cabinet. DSP #2 was interviewed on 11/19/13 at 7:17 AM. When asked if the medication storage cabinet was locked when she entered the medication administration room, DSP #2 stated, "Oh, well she, [DSP #1], just left." DSP #2 indicated DSP #1 had not locked the medication storage cabinet when she exited the area at 7:10 AM. DSP #2 indicated the medication storage cabinet contained clients #1, #2, #3, #4, #5 and #6's medications. AS #1 (Administrative Staff) was interviewed on 11/21/13 at 1:30 PM. AS #1 indicated the group home medication storage cabinet should be locked when staff were not administering medications. 9-3-6(a)			