

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G318	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/20/2013
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2560 GERMAN CHURCH RD INDIANAPOLIS, IN 46229
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W000000	<p>This visit was for an annual recertification and state licensure survey.</p> <p>Dates of survey: December 2, 3, 19 and 20, 2013.</p> <p>Facility Number: 000836 AIM Number: 100243940 Provider Number: 15G318</p> <p>Surveyors: Christine Colon, QIDP-TC Keith Briner, QIDP-(12/19/13)</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed January 2, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, the facility failed for 1 of 4 sampled clients</p>	W000130	Program Director and Home Manager will retrain staff on ensuring privacy during bathroom	01/19/2014

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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W000149	<p>(client #2), to promote her dignity by not ensuring privacy during toileting.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 12/3/13 from 5:50 A.M. until 8:00 A.M. At 7:05 A.M., client #2 was observed using the toilet located directly across from the living room where clients #4 and #6 sat, with the door open. Direct Support Professional (DSP) #7 walked past the bathroom and did not prompt the client and did not close the bathroom door.</p> <p>An interview with the Area Director (AD) was conducted on 12/19/13 at 10:11 A.M. The AD indicated client #2 should be taught and provided privacy during toileting.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3, and #4), and 2 additional clients (#5 and #8), the facility neglected to implement</p>	W000149	<p>use and promoting client dignity. Program Director and Home Manager will retrain staff on prompting all clients to close the bathroom door in the instance that they do not close the door behind them. Home manager will complete active treatment observations 3 times weekly for 30 days to ensure client's dignity is maintained. Ongoing, Home Manager will complete active treatment observations per established frequency. Responsible Party: Home Manager, Program Director</p> <p>Area Director will retrain Program Director on completing investigations within 5 business days; including allegations of abuse and neglect. Program</p>	01/19/2014	

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	<p>written policy and procedures to prevent alleged abuse/neglect regarding medical issues, sexual misconduct and elopement and failed to provide evidence thorough investigations were conducted for 11 of 12 reportable incidents reviewed.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports was conducted on 12/2/13 at 2:45 P.M. Review of the records indicated:</p> <p>-BDDS report dated 1/3/13 involving client #5 indicated: "[Client #5] was riding to [Store name] in the group home van. When staff pulled the group home van into the parking spot at [Store name] they backed up to reposition the van and bumped into the vehicle in the next spot over. The client had no injuries as a result of the incident. [Client #5] was seated and wearing his seat belt at the time of the incident. [Client #5] was evaluated by the Residential RN (Registered Nurse] and there were no signs of injury as a result of the incident. [Client #5] was responding appropriately and showed no signs of emotional distress as a result of the incident. Staff will continue to</p>		<p>Director will complete Investigations for BDDS reportable incidents that require an investigation for every consumer in the home. Program Director will email draft investigations to Area Director, Quality Assurance Specialist and Regional Director for review. The investigation will be signed by administrator once all follow-up questions are answered and investigation is determined to be thorough. Area Director and Quality Assurance Specialist tracks all BDDS reportable incidents by date and all investigations needed for reports. Responsible Party: Area Director, Program Director, Quality Assurance Specialist.</p>		

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	<p>monitor the client's health and safety." Further review of the record failed to indicate an investigation was conducted in regards to this incident.</p> <p>-BDDS report dated 2/1/13 involving client #8 indicated: "Upon arrival to [Day Program], [client #8] was very agitated. He told day program staff that he did not want to be at [Day program] because he was sick. [Day program] staff tried to calm [client #8] down by redirecting his attention on other things. [Client #8] continued to become more agitated and began yelling at several staff. [Client #8] threatened to leave the building. Staff continued to offer [client #8] more choices to redirect his attention and try (sic) to calm him down. [Client #8] began yelling and ran our (sic) the classroom slamming the door behind him. He began kicking the door and banging his fist on the window. While kicking and hitting the window, [client #8] shouted obscenities at staff. Staff tried to give [client #8] some space in an attempt to allow [client #8] to calm down. [Client #8] grabbed his lunch box and began to eat his lunch in a designated break area. After eating his lunch, [client #8] returned to class and started yelling at staff again. He ran into the hallway and picked up a chair and proceeded to bang the chair against the</p>				

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	<p>window and the door. Staff asked [client #8] if he would like to go to a quiet area and sit and calm down. [Client #8] began to apologize to staff. He also told staff that his hand was hurting. Staff checked [client #8's] hand and noticed that it was bruised. Ice was applied to the afflicted area. During his first aggressive incident [Day program] staff contacted his group home to come pick him up. After 30 minutes, [client #8] hurt his hand banging on the door window to the classroom. [Day program] staff called his nurse and left a voice message. His house was called again to come pick him up and take him to the ER (Emergency Room) to have his hand checked by a doctor. Staff arrived at 10:30 A.M. [Client #8's] home staff then contacted their nurse and took him to the doctor." Further review of the record did not indicate an investigation was conducted in regard to this incident.</p> <p>-BDDS report dated 2/16/13 involving client #1 indicated: "[Client #1] was having difficulty with his feeding tube it was the tube itself was backing (sic) up as if it was clogged or had a blockage. He was taken to the local ER for evaluation of tube. Program director will investigate this incident with staff." Further review of the record did not</p>						

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	<p>indicate an investigation was conducted in regard to this incident.</p> <p>-BDDS report dated 3/4/13 involving client #1 indicated: "Staff was assisting [client #1] with his peg tube (percutaneous endoscopic gastrostomy) feeding and the tub (sic) appeared to be loose. Staff noted that it had come unattached. [Client #1] was taken to [Hospital]. Staff reported to the attending MD (doctor) that [client #1] had just had the tub (sic) replaced by his PCP (Primary Care Physician) earlier in the day, the MD felt that it may have not been inserted correctly at that time. [Client #1] had a temporary peg tub (sic) place (sic) by the ER staff and was released to the group home with no further concerns noted."</p> <p>-BDDS report dated 3/9/13 involving client #1 indicated: "Staff was assisting [client #1] with a g-tube (gastrostomy) feeding when they noted that there may be a blockage in the tube because the formula wouldn't drain into the stomach. Staff attempted to follow protocol to clear the blockage. When this did not work, staff notified residential RN and was instructed to take him to the ER. [Client #1] was evaluated in the ER and they replaced his g-tube with a new one. [Client #1] was released back to the</p>				

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	<p>group home." Further review of the record did not indicate an investigation was conducted in regard to this incident.</p> <p>-BDDS report dated 3/13/13 involving client #1 indicated: "Staff was assisting [client #1] with his peg tube feeding and there appeared to be a blockage half way through. Staff tried to clear it and notified the RN when it would not. RN instructed staff to take [client #1] to the ER for an evaluation. [Client #1] was seen by the ER physician. They cleared the blockage and tried to finish the morning feeding and it became blocked again while in the ER. They were able to clear the blockage a second time and found no further concerns. [Client #1] was released back to the group home." Further review of the record did not indicate an investigation was conducted in regard to this incident.</p> <p>-BDDS report dated 4/16/13 involving client #4 indicated: "It was reported that [client #4] became upset when being picked up for transport home from the day program because he didn't want to go home. [Client #4] went AWOL (Absent Without Leave) and staff called the police for assistance. Staff found [client #4] in the woods by the house and attempted to escort him back to the house. [Client #4] began kicking,</p>						

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	<p>screaming and cursing at the police and any of the staff present. [Client #4] was taken to [Hospital] for an evaluation. [Client #4] was calm when arriving to the hospital with no further incidents. [Client #4] was released back to the group home. There were no further incident (sic) the remainder of the evening. The PD (Program Director) is currently investigating the incident. Staff will continue to monitor the client's health and safety." Further review of the record did not indicate an investigation was conducted in regards to this incident.</p> <p>-BDDS report dated 4/20/13 involving client #1 indicated: "[Client #1] was taken to the ER because his G-tube became clogged. The hospital has unclogged his tube and [client #1] has been release (sic) with no further problems."</p> <p>-BDDS report dated 5/22/13 involving client #4 indicated: "During the period of mealtime and medication pass, [client #4] went to sit outside on the porch as he does daily. Staff went to check on him after approximately 5 minutes and [client #4] was unable to be located. Staff checked the entire home and went outside to check the wooded area behind the home. After approximately 10-15</p>						

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	<p>minutes, the police were called and assisted with the search. Approximately 1.5 hours of being unseen, [client #4] came out of the wooded area with no injuries. He was not combative and was redirectable after trying to walk away again when he sighted the police. Police took him to be evaluated by Psych (psychiatrist) at [Hospital name] as a precaution and he was released a few hours later." Further review of the record did not indicate an investigation was conducted in regards to this incident.</p> <p>-BDDS report dated 5/25/13 involving client #2 indicated: "On 5/25/13, [client #2] arrived to the group home from her sister's house and staff notice (sic) a bruise inside right knee about the size of a fifty cent piece. Staff notified the on-call nurse and reported the incident to her." Further review of the record did not indicate an investigation was conducted in regard to the injury of unknown origin.</p> <p>-BDDS report dated 9/30/13 involving client #3 indicated: "Staff walked into the restroom to check on a client that had gone to the bathroom to find [client #3] standing in front of the toilet with his pants around his ankles and the other client with his hand on [client #3's]</p>						

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	<p>private parts. Staff's presence startled both individuals as they both jumped. [Client #3] immediately pulled up his pants and the other client left the restroom." Further review of the record did not indicate an investigation was conducted in regard to this incident.</p> <p>A review of the facility's "Operating Practices-Supervised Group Living Services" policy, no date noted, was conducted on 12/2/13 at 7:30 P.M. Review of the policy indicated:</p> <p>"Indiana Mentor has a fundamental responsibility to protect and promote the rights of the persons served...The following actions are prohibited by employees of Indiana Mentor: abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds; or violation of an individual's rights....Practices prohibited include the following: ...hitting...A proactive intervention that denies an individual of any of the following without a physicians order: ...medical care or treatment....Quality and Risk Management: Indiana MENTOR promotes a high quality of service and seeks to protect individuals receiving Indiana MENTOR services through oversight of management procedures and company operations, close</p>						

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	<p>monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed....Alleged, suspected or actual abuse, neglect, or exploitation of an individual...All incidents that require a report to the Bureau of Developmental Disabilities Services, or internal incident reports will be entered into a database maintained by The Mentor Network."</p> <p>"Indiana Mentor believes that human rights are protected by creating an environment in which abuse of human rights is not tolerated....Any allegation of abuse or human rights violation is thoroughly investigated by the Director of Program Services in consultation with Human Resources Department and/or the Risk Management Department."</p> <p>An interview with the Area Director (AD) was conducted on 12/19/13 at 4:10 P.M.. The AD indicated staff should follow the facility's abuse/neglect policy. The AD indicated all incidents of abuse and neglect are to be immediately reported to the administrator and within 24 hours to BDDS. The AD indicated all incidents should be investigated and the results are to be reported to the administrator within 5 days and follow up reports should be submitted within 7</p>			

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W000154	<p>days.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 11 of 12 incidents, involving 4 of 4 sampled clients (clients #1, #2, #3 and #4), and 2 additional clients (clients #5 and #8), the facility failed to provide written evidence investigations were conducted of incidents of alleged abuse/neglect regarding medical issues, sexual misconduct and elopement.</p> <p>Findings include:</p>	W000154	<p>Area Director will retrain Program Director on completing investigations thoroughly and within 5 business days; including allegations of abuse and neglect. Program Director will complete Investigations for BDDS reportable incidents that require an investigation for every consumer in the home. Program Director will email draft investigations to Area Director, Quality Assurance Specialist and Regional Director for review. The</p>	01/19/2014	

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	<p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports was conducted on 12/2/13 at 2:45 P.M. Review of the records indicated:</p> <p>-BDDS report dated 1/3/13 involving client #5 indicated: "[Client #5] was riding to [Store name] in the group home van. When staff pulled the group home van into the parking spot at [Store name] they backed up to reposition the van and bumped into the vehicle in the next spot over. The client had no injuries as a result of the incident. [Client #5] was seated and wearing his seat belt at the time of the incident. [Client #5] was evaluated by the Residential RN (Registered Nurse) and there were no signs of injury as a result of the incident. [Client #5] was responding appropriately and showed no signs emotional distress as a result of the incident. Staff will continue to monitor the client's health and safety." Further review of the record failed to indicate an investigation was conducted in regards to this incident.</p> <p>-BDDS report dated 2/1/13 involving client #8 indicated: "Upon arrival to [Day Program], [client #8] was very agitated. He told day program staff that</p>		<p>investigation will be signed by administrator once all follow-up questions are answered and investigation is determined to be thorough. Area Director and Quality Assurance Specialist tracks all BDDS reportable incidents by date and all investigations needed for reports. Responsible Party: Area Director, Program Director, Quality Assurance Specialist.</p>		

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	<p>he did not want to be at [Day program] because he was sick. [Day program] staff tried to calm [client #8] down by redirecting his attention on other things. [Client #8] continued to become more agitated and began yelling at several staff. [Client #8] threatened to leave the building. Staff continued to offer [client #8] more choices to redirect his attention and try to calm him down. [Client #8] began yelling and ran our (sic) the classroom slamming the door behind him. He began kicking the door and banging his fist on the window. While kicking and hitting the window, [client #8] shouted obscenities at staff. Staff tried to give [client #8] some space in an attempt to allow [client #8] to calm down. [Client #8] grabbed his lunch box and began to eat his lunch in a designated break area. After eating his lunch, [client #8] returned to class and started yelling at staff again. He ran into the hallway and picked up a chair and proceeded to bang the chair against the window and the door. Staff asked [client #8] if he would like to go to a quiet area and sit and calm down. [Client #8] began to apologize to staff. He also told staff that his hand was hurting. Staff checked [client #8's] hand and noticed that it was bruised. Ice was applied to the afflicted area. During his first aggressive incident [Day program]</p>						

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	<p>staff contacted his group home to come pick him up. After 30 minutes, [client #8] hurt his hand banging on the door window to the classroom. [Day program] staff called his nurse and left a voice message. His house was called again to come pick him up and take him to the ER (Emergency Room) to have his hand checked by a doctor. Staff arrived at 10:30 A.M. [Client #8's] home staff then contacted their nurse and took him to the doctor." Further review of the record did not indicate an investigation was conducted in regard to this incident.</p> <p>-BDDS report dated 2/16/13 involving client #1 indicated: "[Client #1] was having difficulty with his feeding tube it was the tube itself was backing up (sic) as if it was clogged or had a blockage. He was taken to the local ER for evaluation of tube. Program director will investigate this incident with staff." Further review of the record did not indicate an investigation was conducted in regard to this incident.</p> <p>-BDDS report dated 3/4/13 involving client #1 indicated: "Staff was assisting [client #1] with his peg (percutaneous endoscopic gastrostomy) tube feeding and the tub (sic) appeared to be loose.</p>						

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	<p>Staff noted that it had come unattached. [Client #1] was taken to [Hospital]. Staff reported to the attending MD (doctor) that [client #1] had just had the tub (sic) replaced by his PCP (Primary Care Physician) earlier in the day, the MD felt that it may have not been inserted correctly at that time. [Client #1] had a temporary peg tub (sic) place (sic) by the ER staff and was released to the group home with no further concerns noted." Further review of the record did not indicate an investigation was conducted in regards to this incident.</p> <p>-BDDS report dated 3/9/13 involving client #1 indicated: "Staff was assisting [client #1] with a g-tube (gastrostomy) feeding when they noted that there may be a blockage in the tube because the formula wouldn't drain into the stomach. Staff attempted to follow protocol to clear the blockage. When this did not work, staff notified residential RN and was instructed to take him to the ER. [Client #1] was evaluated in the ER and they replaced his g-tube with a new one. [Client #1] was released back to the group home." Further review of the record did not indicate an investigation was conducted in regard to this incident.</p> <p>-BDDS report dated 3/13/13 involving</p>						

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	<p>client #1 indicated: "Staff was assisting [client #1] with his peg tube feeding and there appeared to be a blockage half way through. Staff tried to clear it and notified the RN when it would not. RN instructed staff to take [client #1] to the ER for an evaluation. [Client #1] was seen by the ER physician. They cleared the blockage and tried to finish the morning feeding and it became blocked again while in the ER. They were able to clear the blockage a second time and found no further concerns. [Client #1] was released back to the group home." Further review of the record did not indicate an investigation was conducted in regard to this incident.</p> <p>-BDDS report dated 4/16/13 involving client #4 indicated: "It was reported that [client #4] became upset when being picked up for transport home from the day program because he didn't want to go home. [Client #4] went AWOL (Absent Without Leave) and staff called the police for assistance. Staff found [client #4] in the woods by the house and attempted to escort him back to the house. [Client #4] began kicking, screaming and cursing at the police and any of the staff present. [Client #4] was taken to [Hospital] for an evaluation. [Client #4] was calm when arriving to the hospital with no further incidents.</p>						

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	<p>[Client #4] was released back to the group home. There were no further incident (sic) the remainder of the evening. The PD (Program Director) is currently investigating the incident. Staff will continue to monitor the client's health and safety." Further review of the record did not indicate an investigation was conducted in regards to this incident.</p> <p>-BDDS report dated 4/20/13 involving client #1 indicated: "[Client #1] was taken to the ER because his G-tube became clogged. The hospital has unclogged his tube and [client #1] has been release (sic) with no further problems." Further review of the record did not indicate an investigation was conducted in regards to this incident.</p> <p>-BDDS report dated 5/22/13 involving client #4 indicated: "During the period of mealtime and medication pass, [client #4] went to sit outside on the porch as he does daily. Staff went to check on him after approximately 5 minutes and [client #4] was unable to be located. Staff checked the entire home and went outside to check the wooded area behind the home. After approximately 10-15 minutes, the police were called and assisted with the search. Approximately 1.5 hours of being unseen, [client</p>						

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	<p>#4] came out of the wooded area with no injuries. He was not combative and was redirectable after trying to walk away again when he sighted the police. Police took him to be evaluated by Psych (psychiatrist) at [Hospital name] as a precaution and he was released a few hours later." Further review of the record did not indicate an investigation was conducted in regards to this incident."</p> <p>-BDDS report dated 5/25/13 involving client #2 indicated: "On 5/25/13, [client #2] arrived to the group home from her sister's house and staff notice (sic) a bruise inside right knee about the size of a fifty cent piece. Staff notified the on-call nurse and reported the incident to her." Further review of the record did not indicate an investigation was conducted in regard to the injury of unknown origin.</p> <p>-BDDS report dated 9/30/13 involving client #3 indicated: "Staff walked into the restroom to check on a client that had gone to the bathroom to find [client #3] standing in front of the toilet with his pants around his ankles and the other client with his hand on [client #3's] private parts. Staff's presence startled both individuals as they both jumped. [Client #3] immediately pulled up his</p>						

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	<p>pants and the other client left the restroom." Further review of the record did not indicate an investigation was conducted in regard to this incident.</p> <p>An interview with the Area Director (AD) was conducted on 12/2/13 at 3:50 P.M. The AD indicated staff should follow the facility's abuse/neglect policy. The AD indicated all incidents should be investigated. When asked if the above incidents were investigated, the AD indicated if the incidents were investigated, the investigations would have been attached to the BDDS reports. No investigations were submitted for review in regards to the mentioned incidents.</p> <p>9-3-2(a)</p>			

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, the facility failed to implement written objectives during times of opportunity for 4 of 4 sampled clients (clients #1, #2, #3 and #4).</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 12/2/13 from 5:00 P.M. until 6:35 P.M. During the entire observation period, clients #1 and #4 stayed in their rooms with no activity or interaction. Clients #2 and #3 sat in the dining room with no activity. Direct Support Professionals (DSP) #1, #2, #3 and #4 would walk through the facility and visually check on clients #1, #2, #3 and #4 but did not offer meaningful active treatment activities or implement client objectives.</p> <p>A morning observation was conducted at the group home on 12/3/13 from 6:20 A.M. until 8:10 A.M. During the entire observation period, clients #1 and #4</p>	W000249	<p>Program Director and Home Manager will retrain staff on engaging clients in active treatment at every available opportunity. Program Director and Home Manager will retrain staff on all clients' goals; including meal-time goals. Home Manager will complete active treatment observations 3 times weekly for 30 days. Home Manager will complete mealtime observations 3 times weekly for 30 days. Ongoing, Home Manager will complete active treatment and mealtime observations per established frequency.</p>	01/19/2014	

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	<p>stayed in their rooms with no activity or interaction. Clients #2 and #3 sat in the dining room with no activity. DSP #5, #6 and #7 would walk through the facility and visually check on clients #1, #2, #3 and #4 but did not offer meaningful active treatment activities or implement client objectives.</p> <p>A review of client #1's records was conducted on 12/3/13 at 2:00 P.M. A review of the client's 1/25/13 Individual Support Plan (ISP) indicated the following objectives which could have been implemented during the observation periods: "Will write his name...Will assist in meal preparation...Will increase money management skills."</p> <p>A review of client #2's records was conducted on 12/3/13 at 2:30 P.M. A review of the client's 10/9/13 ISP indicated the following objectives which could have been implemented during the observation periods: "Will increase communication skills by identifying pictures...Increase money management skills...Will clean off the table after her meals."</p> <p>A review of client #3's records was conducted on 12/3/13 at 3:10 P.M. A review of the client's 1/24/13 ISP</p>						

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	<p>indicated the following objectives which could have been implemented during the observation periods: "Will increase her money management skills...Will improve meal preparation skills...Will increase communication skills by engaging in conversation."</p> <p>A review of client #4's records was conducted on 12/3/13 at 3:40 P.M.. A review of the client's 10/3/13 ISP indicated the following objectives which could have been implemented during the observation periods: "Will increase money management skills...Will participate in household skills...Will participate in community integration."</p> <p>The Area Director (AD) was interviewed on 12/19/13 at 10:11 A.M. The AD stated client objectives should be implemented "at all times." The AD further indicated clients #1, #2, #3 and #4 should have been provided with meaningful active treatment activities during the observation periods.</p> <p>9-3-4(a)</p>				

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W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (clients #1 and #2) to provide an annual vision and hearing evaluation/assessment.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 12/3/13 at 2:00 P.M. Client #1's record indicated a most current annual physical dated 11/22/13 which did not indicate his hearing was evaluated/assessed Client #1's record did not contain evidence he had an annual hearing evaluation/assessment.</p> <p>A review of client #2's record was conducted on 12/3/13 at 2:44 P.M. Client #2's record indicated a most current annual physical dated 7/26/13 which did not indicate her hearing and vision was evaluated/assessed Client #2's record did not contain evidence she had an annual hearing and vision evaluation/assessment.</p> <p>An interview with the Program Director (PD) was conducted on 12/19/13 at 1:11</p>	W000323	Home Manager will obtain dictation notes from the physician of client's #1 and #2 to include vision and hearing assessments. Program Director will review physical examination forms for all the other consumers in the home to ensure vision and hearing assessments were noted as required. Any clients with missing required assessments and no physician dictation showing that an assessment was completed will be scheduled for an appointment to have the vision and hearing assessment completed. The Facility's Annual Physical Form includes a screening section for hearing and vision to be completed on an annual basis. Ongoing, a new Facility Nurse has been hired and will ensure that hearing and vision screening are completed by the primary physician at the annual physical appointment. Responsible Party: Facility Nurse, Home Manager, Program Director	01/19/2014			

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W000352	<p>P.M. The PD indicated there was no evidence of an annual evaluation/assessment of client #1's hearing and client #2's hearing and vision.</p> <p>9-3-6(a)</p> <p>483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. Based on record review and interview, the facility failed to assure 1 of 4 sampled clients (client #1) had an annual dental evaluation.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted at the facility's administrative office on 12/3/13 at 2:00 P.M. Review of client #1's record indicated client #1 did not have an annual dental evaluation in his file. There was no indication when client #1 had a dental evaluation in his file.</p> <p>An interview with the Area Director (AD) was conducted at the facility's administrative office on 12/19/13 at 1:11 P.M. The AD indicated client #1 did not</p>	W000352	Home Manager located the dental examination form for client #1 dated for 2/25/13 that was not included in the medical record. Program Director will review all clients' files to ensure that a current annual dental was completed and that it is filed in the medical record. The Facility Nurse was retrained on 12/10/13 on filing documentation and maintaining the client's records; to include all medical appointments and follow-up. Facility Nurse was also placed on a performance completion schedule created by Nursing Director to complete all outstanding nursing items; including German Church. On 12/20/13 Indiana Mentor accepted the resignation of Facility Nurse. Ongoing, a new facility nurse has been hired and will ensure the timely completion	01/19/2014

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W000369	<p>have an annual dental exam in his record.</p> <p>9-3-6(a)</p> <p>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, the facility failed for 1 of 4 sampled clients observed during the morning medication administration (client #1) to ensure staff administered 1 of 2 of the client's medications, as ordered without error.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 12/3/13 from 5:50 A.M. until 8:00 A.M. At 7:10 A.M., Direct Support Professional (DSP) # 7 began administering client #1's prescribed oral medications. DSP #7 sprayed 3 sprays of client #1's "Flonase Nasal Spray" into his left nostril and 3 sprays in his right nostril.</p> <p>Review of the Flonase bottle label and Medication Administration Record (MAR) dated 12/1/13 to 12/31/13</p>	W000369	<p>and filing for clients' dental examinations and other appointments. Responsible Party: Home Manager, Program Director, Facility Nurse</p> <p>Home Manager and Program Director will retrain staff on medication administration of client #1; including nasal spray.Home Manager and Program Director will retrain staff on administration orders for all medications administered for other clients that reside in the home.Home Manager will complete a medication observation for all individual staff working in the home.Ongoing, Home Manager will complete medication observations per established frequency for observations.Responsible Party: Home Manager and Program Director</p>	01/19/2014	

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W000388	<p>indicated: "Flonase nasal Spray...Use 2 sprays in each nostril 1 time daily."</p> <p>An interview with the Area Director (AD) was conducted on 12/19/13 at 10:11 A.M. The AD indicated client #1's medications should have been administered as directed on the label and MAR.</p> <p>9-3-6(a)</p> <p>483.460(m)(1)(i) DRUG LABELING Labeling for drugs and biologicals must be based on currently accepted professional principles and practices. Based on observation, record review, and interview, the facility failed for 1 of 4 sampled clients observed during morning medication administration (client #1), to have the medication labeled.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 12/3/13 from 5:50 A.M. until 8:00 A.M. Client #1's medications were administered by Direct Support Professional (DSP) #7 at 7:10 A.M. A bottle was taken from client #1's medication bin. The bottle did not</p>	W000388	<p>Program Director will retrain Home Manager on ensuring pharmacy labels are always on medication packaging; in particular, when liquid medications may be placed in zip bags for storage. Home Manager will place appropriate pharmacy label on client #1 eye drops. Home Manager will complete an inventory of all medications stored in the home to ensure that they all have the appropriate pharmacy label. Home Manager completes weekly medication inventories for ordering medications. Ensuring appropriate medication labels will be assessed during this time as well. Responsible Party: Program</p>	01/19/2014			

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W000484	<p>contain client #1's name or instructions for administration. The bottle did not contain a pharmacy label.</p> <p>A review of the Medication Administration Record dated December 1, 2013 to December 31, 2013 was conducted at 7:11 A.M. The MAR indicated: "Sodium Chloride...to flush g-tube (gastrostomy feeding tube)."</p> <p>An interview with the Area Director (AD) was conducted on 12/19/13 at 10:11 A.M. The AD indicated all medications should be labeled with each client's name and instructions for administration.</p> <p>9-3-6(a)</p> <p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview, the facility failed for 7 of 8 clients (clients #2, #3, #4, #5, #6, #7 and #8) residing in the group home to provide table knives and condiments at the dining table.</p>	W000484	<p>Director, Home Manager</p> <p>Home Manager and Program Director will retrain staff on mealtime preparation; including proving condiments of choice and needed utensils for the consumers at each meal.Home Manager will complete mealtime observations 3 times weekly for</p>	01/19/2014			

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	<p>Findings include:</p> <p>A morning observation was conducted at the group on 12/3/13 from 5:50 A.M. until 8:00 A.M. Upon entering the group home, the dining table was pre-set with prepared bowls of cold, unsweetened cereal and toasted bagels cut up into bite sized pieces. Beginning at 6:00 A.M., clients #4, #5, #6, #7 and #8 began eating their breakfast. At 6:47 A.M., clients #2 and #3 began eating their breakfast. No table knives, sugar/sugar substitute, jelly and butter/margarine were observed on the table for clients #2, #3, #4, #5, #6, #7 and #8's use.</p> <p>An interview with the Area Director (AD) was conducted on 12/19/13 at 10:11 A.M. The AD indicated table knives, sugar/sugar substitute, butter/margarine and jelly should be put on the table for the clients to use.</p> <p>9-3-8(a)</p>		30 days to ensure implementation. Ongoing, Home Manager will complete mealtime observations per established frequency for observations. Responsible Party: Home Manager and Program Director		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G318		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2013	
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W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview, the facility failed to assure 7 of 8 clients residing at the group home (clients #2, #3, #4, #5, #6, #7 and #8) were involved in meal preparation and served themselves while dining.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group on 12/3/13 from 5:50 A.M. until 8:00 A.M. Upon entering the group home, the dining table was pre-set with prepared bowls of cold, unsweetened cereal and toasted bagels cut up into bite sized pieces. Beginning at 6:00 A.M., clients #4, #5, #6, #7 and #8 began eating their breakfast. At 6:47 A.M., clients #2 and #3 began eating their breakfast. Clients #2, #3, #4, #5, #6, #7 and #8 did not assist in meal preparation and did not serve themselves. Clients #2, #3, #4, #5, #6, #7 and #8 ate their meal independently.</p> <p>An interview with the Area Director (AD) was conducted on 12/19/13 at 10:11 A.M. The AD indicated clients were capable of assisting in meal preparation and serving themselves and</p>	W000488	Home Manager and Program Director will retrain staff on incorporating active treatment into mealtime observations and encouraging client participation. Home Manager and Program Director will retrain staff on all clients dining needs and using least restrictive measures when assisting clients at mealtime. Home Manager and Program Director will retrain staff on all clients mealtime training objectives. Home Manager will complete mealtime observations 3 times a week for 30 days to ensure implementation. Ongoing, Home Manager will complete mealtime observations per established frequency for observations. Responsible Party: Home Manager, Program Director	01/19/2014			

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	further indicated they should be assisting in preparation and serving themselves at meal time. 9-3-8(a)				