

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/13/2016
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NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
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W 0000  Bldg. 00	<p>This visit was for a full annual recertification and state licensure survey.</p> <p>This visit was in conjunction with the Post Certification Revisit (PCR) to the investigation of complaint #IN00191789.</p> <p>Survey dates: May 9, 10, 11, 12 and 13, 2016</p> <p>Facility number: 000823 Provider number: 15G304 AIM number: 100249090</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/18/16.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility's governing body failed to exercise operating direction over the facility by failing to develop and implement a policy to address recurring</p>	W 0104	<p>A procedure to address recurring issues with bed bugs was developed and all staff will be trained to follow the procedures if there is an occurrence of bed bugs in the home.</p> <p>Quarterly pest control inspections will continue to be completed to</p>	06/12/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>issues with bed bugs at the group home.</p> <p>Findings include:</p> <p>On 5/9/16 at 12:17 PM, a review of the facility's policies and procedures indicated there was no documentation of a policy and procedure being developed and staff trained on the procedure. The Area Director (AD) indicated the procedure was the information the facility received from the pest control company. There was no documentation the facility developed and implemented the pest control information into a facility policy and procedure.</p> <p>On 5/11/16 at 12:56 PM, the Area Director (AD) indicated he could not locate the documentation for the procedure and training so he trained the staff on 5/10/16 on the pest control information. The AD indicated the information from the pest control company was not developed into a facility policy and procedure.</p> <p>On 5/11/16 at 12:56 PM, there was no documentation of a policy and procedure being developed to address recurring issues with bed bugs. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>9-3-1(a)</p>		<p>check the home.</p> <p>Persons responsible: Area Director, Program Director (QIDP), Program Coordinator</p>				

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W 0120  Bldg. 00	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client. Based on record review and interview for 4 of 4 clients in the sample (#2, #3, #4 and #6) and one additional client (#1), the facility failed to ensure the outside services (day program and workshops) met the needs of each client.</p> <p>Findings include:</p> <p>1) On 5/9/16 from 1:20 PM to 2:26 PM, an observation was conducted at day program #1. Clients #1 and #6 attended the day program and were present during the observation. From 1:20 PM to 2:15 PM, client #6 sat at a work table with his head down. Client #6 appeared to be asleep. At 1:28 PM when the supervisor was asked about client #6, the supervisor stated, "Do you want me to wake him up?" At 1:36 PM when client #6 raised his head, the supervisor attempted to get client #6 to do some work. At 2:00 PM when client #6 raised his head off the table, the supervisor asked him if he wanted to work to make some money. Client #6 indicated he was tired and put his head back down. At 2:15 PM, client</p>	W 0120	<p>The Program Director (QIDP) was retrained on Day Program Responsibilities. This includes communicating with day program staff to address issues or concerns as they arise. The PD will complete observations at least monthly for all day program sites. The PD will ensure that all clients' current ISPs, BSPs, and other requested documentation is in place at the day program sites to ensure outside services can meet the needs of the clients.</p> <p>The Area Director will review any completed observations by the PD at weekly meetings to ensure they are completed at least monthly for all day program sites.</p> <p>Persons responsible: Area Director, Program Director (QIDP)</p>	06/12/2016

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	<p>#6 went on break with the group. Client #1 was working during the observation until it was break time at 2:15 PM. Client #1 had a radio next to him however the radio was not on during the observation.</p> <p>On 5/9/16 at 1:34 PM, the Workshop Manager (WM) indicated client #6 sleeps most of the time. The WM stated client #6 would get "testy" when prompted to engage in work activities. The WM indicated client #6 had attended the workshop for approximately 6 weeks. The WM indicated client #1 brought his radio to the workshop on a daily basis. The WM indicated client #1 should not bring a radio without a headphone jack. The WM indicated the group home had been notified of this however client #1 continued to bring his radio with him. The WM indicated the radio was a distraction to the others working around client #1. The WM indicated client #1 could listen to music while he worked but needed to do so using headphones. The WM indicated client #1's radio did not have a headphone jack. The WM indicated she had not seen anyone conduct observations at the workshop for about 6 weeks. The WM indicated she did not know who the Program Director was at the group home and had not met her.</p>			

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	<p>On 5/9/16 at 1:50 PM, client #1 indicated he needed to buy headphones. Client #1 indicated he did not have headphones to use.</p> <p>On 5/9/16 at 2:21 PM, a review of client #6's record at the workshop was conducted. The record did not contain client #6's Individualized Support Plan (ISP). The record included a Behavior Support Plan (BSP) dated 3/1/16 (the current plan was dated 4/11/16).</p> <p>On 5/9/16 at 2:23 PM, a review of client #1's record at the workshop was conducted. The record contained an ISP dated 2/13/15 (his current plan was dated 3/16/16).</p> <p>On 5/11/16 at 11:15 AM, a focused review of client #1's record was conducted. There was no documentation observations were conducted at the outside services workshop during the past 12 months. Client #1's current ISP was dated 3/16/16.</p> <p>On 5/11/16 at 12:09 PM, a review of client #6's record was conducted. There was no documentation observations were conducted at the outside services workshop during the past 12 months. Client #6's current BSP was dated</p>			

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	<p>4/11/16.</p> <p>2) On 5/9/16 from 2:46 PM to 3:33 PM, an observation was conducted at the workshop clients #2 and #4 attended. Clients #2 and #4 were present during the observation. Client #2 left the workshop area at 3:00 PM. He was observed sitting outside the building at 3:33 PM. Client #2 stated when asked why he did not ride the bus to his group home, "I have enough sense to stay out of the rain." Client #2 indicated he would ride the group home van home since it was raining.</p> <p>On 5/9/16 at 2:50 PM, the Workshop Supervisor (WS) indicated there had been no on-going issues for client #4. The WS indicated there were on-going issues with client #2 including not staying in his program area and leaving the program area. The WS indicated she had met with the Behavior Consultant several times over the past few months to address the issues involving client #2. The WS indicated client #2 now leaves the workshop at 3:00 PM and rides the bus home. The WS indicated client #2 had Tuesdays off from the workshop. On 5/9/16 at 2:58 PM, the WS indicated she did not know and had not met the Program Director. On 5/9/16 at 3:09 PM, the WS indicated she requested client #2</p>			

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	<p>and #4's ISPs in February 2016 but had not received them from the group home.</p> <p>On 5/9/16 at 3:03 PM, a review of client #2's record at the workshop was conducted. The record did not contain an ISP or BSP for client #2. The workshop record indicated the following:</p> <p>-Client #2's record indicated there was a meeting to "review programs" on 12/11/15. The Case Conference Summary indicated, "[Client #2] has not been reporting to room on time... Not reporting back to [name of workshop] after he gets here from hotel job...." The Behavior Consultant for client #2's group home attended the meeting but not the QIDP.</p> <p>-A 1/13/16 Case Conference Summary indicated the purpose of the meeting was "Emergency Support Meeting." The notes indicated, in part, "On the week of December 28, 2015, some fabric pieces came up missing. [Client #2] was suspected of removing them. He was questioned and denied it. Home staff were (sic) then questioned about it and the fabric was located in [client #2's] room...." The notes indicated, "TSI-Mentor also agreed to pick [client #2] up (at) 3:15 PM daily as he is not following the rules to stay in his program</p>			

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	<p>room. [Name of behavior consultant for the group home] is involved in planning for his BSP (behavior support plan) and schedule rewards. She will be working with him to maintain his placement in the workshop...." The notes indicated, "Discussed the need for [client #2] to follow rules or be encouraged to seek another program. [Client #2] sets the example and people want to follow his lead. This includes leaving programs early, carrying many items that don't belong here and genuinely having a poor attitude." The QIDP did not attend the meeting.</p> <p>-A 3/25/16 Case Conference Summary indicated, in part, "Meeting held with [client #2] re: (last week) of allegation of touching breast with another client... Will look (at) changing his AM routine so he does not have to come to [name of workshop] prior to his community job... [Client #2] continues to be in situations that make others frustrated. He is teasing and in this current situation, he reportedly touched the female on the head. She stated on breast. Not substantiated. Currently working with [name of behavior consultant for the group home]... Will be allowing him to leave (at) 3:15 PM all days to go catch bus. Will also not be present on Tuesday...." The QIDP did not attend the meeting.</p>			

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	<p>-A 4/28/16 Case Conference Summary indicated, in part, "[Client #2] has been working to improve work habits. Have been scheduling 30 day meetings for review. Had also lost privileges to go upstairs. He has resumed...." The QIDP did not attend the meeting.</p> <p>On 5/9/16 at 3:04 PM, a review of client #4's record at the workshop was conducted. The record did not contain an ISP.</p> <p>On 5/11/16 at 10:50 AM, a review of client #2's record at the group home was conducted. There was no documentation the group home staff conducted observations at the workshop during the past 12 months.</p> <p>On 5/11/16 at 11:46 AM, a review of client #4's record at the group home was conducted. There was no documentation the group home staff conducted observations at the workshop during the past 12 months.</p> <p>3) On 5/11/16 from 9:07 AM to 9:59 AM, an observation of the day program client #3 attended was conducted. Client #3 was present during the observation. At 9:07 AM, client #3 was in the van in the parking lot ready to leave to go to the</p>			

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	<p>public library.</p> <p>On 5/11/16 at 9:09 AM, a Direct Support Professional (DSP) at client #3's day program indicated there were several on-going issues with the group home. The DSP stated, "Where do I start?" The DSP indicated on 5/11/16 client #3 was dropped off, unsupervised, at the day program office at 8:10 AM. The DSP indicated the day program hours were from 9:00 AM to 3:00 PM. The DSP indicated client #3 sat in the lobby until 9:00 AM. The DSP indicated this was not the first time client #3 was dropped off by the group home staff early. The DSP indicated there were on-going issues with client #3's hygiene. The group home did not bring in extra clothes (for incontinence issues) for months until 5/10/16. The DSP indicated she had to call the Program Coordinator on 5/10/16 in order for client #3 to have his prescribed medications while at the day program. The DSP indicated she had not observed anyone from the group home conducting observations at the day program. The DSP indicated she did not know who the Program Director was at the group home.</p> <p>On 5/11/16 at 9:15 AM, client #3 arrived to the public library. Client #3 went in, sat down at a computer and started</p>			

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	<p>watching a movie. Client #3 got up a few minutes later to get a drink and returned to the computer. Client #3 watched a movie for the remainder of the observation.</p> <p>On 5/11/16 at 9:21 AM, the DSP indicated there were times client #3 arrived at the day program without a drink or an appropriate amount of food in his lunch. The DSP indicated the communication with the group home needed to improve. The DSP indicated when he was dropped off on 5/11/16, client #3 indicated to her he told the group home staff the day program hours did not start until 9:00 AM. The staff dropped him off anyway.</p> <p>On 5/11/16 at 1:57 PM, the Employment Director (ED - oversees client #3's day program) indicated there were on-going issues with client #3's hygiene. The ED indicated client #3 arrived wearing the same clothes or dirty clothes and he had body odor issues. The ED indicated client #3 slept most of the time he attended the day program. The ED indicated there were no regular meetings with the group home staff. The ED indicated she had attempted to contact the Program Coordinator however the Program Coordinator was not responsive. The ED indicated if she needed an issue</p>			

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	<p>addressed, she usually had to call the Area Director. The ED indicated she was not aware of the group home conducting observations at the day program. The ED stated when asked if she knew the Program Director by name, "is she with TSI?" The ED indicated on 5/11/16 client #3 was dropped off at 8:10 AM by the group home. The ED indicated the day program did not start and supervision was not provided until 9:00 AM. The ED indicated this had happened before as well but not lately. The ED indicated there have been times when the group home arrived late to the day program office and client #3 missed the van. The ED indicated the group home had to take client #3 to the community location of the activity.</p> <p>On 5/11/16 at 11:19 AM, a review of client #3's group home record was conducted. There was no documentation the group home staff conducted observations at the day program to ensure the program met the needs of client #3.</p> <p>On 5/11/16 at 12:39 PM, the Program Director (PD) indicated she did not have documentation of observations being conducted at the outside services programs. The PD indicated the day program and workshops should have the clients' current plans. The PD indicated</p>			

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	<p>the group home needed to ensure the outside services met the needs of the clients. On 5/11/16 at 12:44 PM, the PD indicated she did not know the hours of client #3's day program.</p> <p>On 5/11/16 at 1:05 PM, the Area Director (AD) indicated client #3 being dropped off early had been addressed in the past. The AD indicated client #3 should not be dropped off prior to the day program starting time of 9:00 AM. On 5/13/16 at 11:00 AM, the Area Director (AD) indicated the PD missed the meetings due to trainings. The AD indicated the expectation was the PD would be present for the meetings either in person or by phone. The AD stated observations at the outside services were "required." The AD indicated the PD should be involved. The AD stated the PD should conduct observations "at least monthly" at the outside services programs or more frequently if there were issues. The AD indicated the PD should address issues with behaviors by visiting the outside services more frequently than once a month. The AD indicated if a client was having issues with returning to the program area or sleeping, the PD should be in the outside services addressing the issues once a week until the issues were resolved.</p>			

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W 0149 Bldg. 00	<p>9-3-1(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 3 of 3 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #6, #7 and #8, the facility neglected to implement its policies and procedures to prevent client to client abuse, submit an incident to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner and conduct an investigation of a fire at the group home.</p> <p>Findings include:</p> <p>On 5/9/16 at 12:04 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 3/22/16 at 7:00 PM, client #5 hit clients #2 and #8. The 3/23/16 BDDS report indicated, in part, "[Program Coordinator - PC] reported that [client #5] became upset at [client #2] because [client #5] gave [client #2] a dollar and then was upset because he said [client #2]</p>	W 0149	<p>An advanced Physical Intervention Alternatives class which includes the hierarchy of procedures in regards to least restrictive to most restrictive interventions to be used to help staff develop the skills they need to prevent incidents of client to client abuse.</p> <p>Observations will be completed in the home at least times per week for two weeks and then two times per week for two weeks and then at least weekly ongoing when clients are home to ensure staff are implementing plans to prevent incidents of client to client abuse.</p> <p>The Program Director (QIDP) was retrained on completing incidents in a timely manner in compliance with regulations and what incidents require investigations and completing timely investigations.</p> <p>The Area Director will review incidents and investigations with the Program Director weekly to ensure completion for any that occurred that week.</p> <p>Persons responsible: Area Director, Program Director (QIDP), Program Coordinator</p>	06/12/2016

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	<p>stole it, which [client #2] did not. [PC] attempted to verbally redirect [client #5] but [client #5] continued to escalate and then started attempting to hit [client #2] but [PC] had gotten in between the two clients. [Client #5] continued to escalate and grabbed [PC's] hood of her sweatshirt and [PC] was able to get out of his advances and [client #5] was swinging the whole time and made contact with [client #2] on his left cheek... During the time that [client #5's] behavior was escalating [client #8] became verbally upset and was yelling at [client #5]. [Client #5] turned his direction to [client #8] and [PC] got in between the two of them but they were both fighting back. [Client #5] was making contact with [client #8] through [PC's] body and as [client #5] was striking [PC] it was causing her arms and other parts of her body to run in to [client #8's] arm and stomach... [Client #2's] cheek was red but [client #2] stated it did not hurt and that he was fine. [Client #8] complained that he was hurt and laid himself on the ground but there was no visible injury to [client #8]...." The 3/28/16 Investigation Summary indicated in the Conclusion section, "Evidence supports staff did not intervene appropriately. Staff should have immediately evacuated everyone from the room when [client #5] first stated cursing</p>			

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	<p>and threatening the other client. Staff will be retrained on how to intervene appropriately for client to client aggression."</p> <p>On 5/9/16 at 12:07 PM, the Area Director (AD) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>2) On 4/14/16 at 7:00 PM (reported to BDDS on 4/18/16), client #6 hit client #4 in the face while on an outing at the park. The 4/21/16 Investigation Summary indicated in staff #3's statement, in part, "...[Client #6] had become upset because he wanted to leave. [Staff #3] stated that he directed the clients that it was time to leave, so they started walking back. [Client #6] started yelling at [client #4] that he was too slow and to walk faster. [Staff #3] redirected [client #6] and stepped in between the two of them. [Staff #3] stated that he was trying to separate the two but [client #6] was able to punch [client #4] in the face before he could get them separated. [Staff #3] stated that he then managed to separate the two and everything was fine. However, someone at the park witnessed [client #6] hit [client #4] and called the police. The police came and talked to</p>			

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	<p>both staff members, [client #6] and [client #4]...." The investigation indicated, "Evidence supports staff did not intervene appropriately. One staff should have separated [client #6] immediately from the others. The other staff member should have remained with the others until the situation was diffused. Staff will be retrained on how to intervene appropriately for client to client aggression."</p> <p>On 5/9/16 at 12:07 PM, the AD indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The AD indicated the facility had a policy and procedure prohibiting abuse of the clients. The AD indicated incidents should be reported to BDDS within 24 hours.</p> <p>3) On 4/29/16 at 8:15 PM, client #5 was making a bag of microwave popcorn and when he took it out of the microwave the bag was on fire. Client #5 threw the bag of popcorn in the trash which caused the trash can to catch on fire. Staff #3 got the fire extinguisher and put the fire out. Staff #3 instructed the clients in the home at the time (#1, #2, #3, #4, #5, #7 and #8) to evacuate the home as a precaution due to the fumes from the fire extinguisher. Staff #3 stayed outside with the clients for about 30-45 minutes to allow the</p>			

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	<p>fumes to die down and then everyone returned inside the home.</p> <p>There was no documentation the facility conducted an investigation of the incident.</p> <p>On 5/9/16 at 4:28 PM, client #5 indicated he microwaved popcorn and when he took it out of the microwave the bag caught on fire. Client #5 stated it "almost burned my hand off." Client #5 indicated he threw the bag into the trash. Client #5 indicated the alarm sounded. Client #5 indicated staff put out the fire with a fire extinguisher. Client #5 indicated staff took the trash can outside. Client #5 indicated the house did not get smoky.</p> <p>On 5/9/16 at 4:45 PM, the Program Director (PD) indicated she was not sure if the fire department responded to the fire or not. The PD indicated she did not conduct an investigation. The PD indicated she was not sure if an investigation was conducted.</p> <p>On 5/9/16 at 12:07 PM, the Program Coordinator (PC) indicated staff used a fire extinguisher to put out the fire. The PC indicated there was a spot on the wall from the heat. The PC indicated she was not sure if the fire alarm sounded. The PC indicated she was not sure if the fire</p>			

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	<p>department went to the home. The PC indicated staff #3 spoke to the fire department but was not sure if it was in person or on the phone. The PC indicated the fire marshal told the staff to clear out of the house for a certain amount of time. The PC indicated client #5 was able to cook on the stove independently and had used the microwave numerous times in the past without incident. The PC indicated she was not sure if an investigation was conducted. The PC indicated following the incident, she retrained the staff and clients.</p> <p>On 5/9/16 at 12:25 PM, the AD indicated there was no investigation of the incident. The AD stated, "it wasn't nothing big." The AD indicated client #5 burned popcorn in the microwave, threw the bag in the trash and the trash caught on fire. The AD indicated the fire was put out by staff #3 using a fire extinguisher. The AD indicated staff spoke to the fire department on the phone. The AD indicated the clients were evacuated. The AD indicated the fire alarm did not sound. On 5/11/16 at 12:57 PM, the AD indicated an investigation was not conducted. The AD stated he "didn't ask her (PD) to do one."</p> <p>On 5/9/16 at 10:02 PM, a review of the</p>			

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	<p>the facility's policy and procedures related to abuse and neglect was conducted. The facility's April 2011 Quality and Risk Management policy indicated, "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 monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The April 2011 Human Rights policy indicated, in part, "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." The policy indicated, in part, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e. Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment." The policy indicated, in part, "Indiana MENTOR follows the BDDS Incident Reporting policy as outlined in the Provider Standards. An incident described as follows shall be reported to</p>			

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W 0153 Bldg. 00	<p>the BDDS on the incident report form prescribed by the BDDS... An initial report regarding an incident shall be submitted within twenty-four (24) hours of: a) the occurrence of the incident; or b) the reporter becoming aware of or receiving information about an incident..." The policy indicated, in part, "Indiana MENTOR is committed 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...."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 3 incident reports reviewed affecting clients #4 and #6, the facility failed to submit an incident report of client to client abuse to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p>	W 0153	<p>The Program Director (QIDP) was retrained on completing incidents in a timely manner in compliance with regulations. The Area Director will review incidents with the Program Director weekly to ensure timely completion for any that occurred that week.</p> <p>Persons responsible: Area Director, Program Director (QIDP)</p>	06/12/2016

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W 0154 Bldg. 00	<p>On 5/9/16 at 12:04 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 4/14/16 at 7:00 PM (reported to BDDS on 4/18/16), client #6 hit client #4 in the face while on an outing at the park.</p> <p>On 5/9/16 at 12:07 PM, the Area Director indicated the incident should have been reported to BDDS within 24 hours.</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 1 of 3 investigative reports reviewed affecting clients #1, #2, #3, #4, #5, #7 and #8, the facility failed to conduct an investigation of a fire at the group home.</p> <p>Findings include:</p> <p>On 5/9/16 at 12:04 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 4/29/16 at 8:15 PM, client #5 was making a bag of microwave</p>	W 0154	<p>The Program Director (QIDP) was retrained on completing investigations. The Area Director will review incidents and investigations with the Program Director weekly to ensure completion for any that occurred that week.</p> <p>Persons responsible: Area Director, Program Director (QIDP), Program Coordinator</p>	06/12/2016

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	<p>popcorn and when he took it out of the microwave the bag was on fire. Client #5 threw the bag of popcorn in the trash which caused the trash can to catch on fire. Staff #3 got the fire extinguisher and put the fire out. Staff #3 instructed the clients in the home at the time (#1, #2, #3, #4, #5, #7 and #8) to evacuate the home as a precaution due to the fumes from the fire extinguisher. Staff #3 stayed outside with the clients for about 30-45 minutes to allow the fumes to die down and then everyone returned inside the home.</p> <p>There was no documentation the facility conducted an investigation of the incident.</p> <p>On 5/9/16 at 4:28 PM, client #5 indicated he microwaved popcorn and when he took it out of the microwave the bag caught on fire. Client #5 stated it "almost burned my hand off." Client #5 indicated he threw the bag into the trash. Client #5 indicated the alarm sounded. Client #5 indicated staff put out the fire with a fire extinguisher. Client #5 indicated staff took the trash can outside. Client #5 indicated the house did not get smoky.</p> <p>On 5/9/16 at 4:45 PM, the Program Director (PD) indicated she was not sure if the fire department responded to the</p>			

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	<p>fire or not. The PD indicated she did not conduct an investigation. The PD indicated she was not sure if an investigation was conducted.</p> <p>On 5/9/16 at 12:07 PM, the Program Coordinator (PC) indicated staff used a fire extinguisher to put out the fire. The PC indicated there was a spot on the wall from the heat. The PC indicated she was not sure if the fire alarm sounded. The PC indicated she was not sure if the fire department went to the home. The PC indicated staff #3 spoke to the fire department but was not sure if it was in person or on the phone. The PC indicated the fire marshal told the staff to clear out of the house for a certain amount of time. The PC indicated client #5 was able to cook on the stove independently and had used the microwave numerous times in the past without incident. The PC indicated she was not sure if an investigation was conducted. The PC indicated following the incident, she retrained the staff and clients.</p> <p>On 5/9/16 at 12:25 PM, the AD indicated there was no investigation of the incident. The AD stated, "it wasn't nothing big." The AD indicated client #5 burned popcorn in the microwave, threw the bag in the trash and the trash caught on fire.</p>			

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W 0159 Bldg. 00	<p>The AD indicated the fire was put out by staff #3 using a fire extinguisher. The AD indicated staff spoke to the fire department on the phone. The AD indicated the clients were evacuated. The AD indicated the fire alarm did not sound. On 5/11/16 at 12:57 PM, the AD indicated an investigation was not conducted. The AD stated he "didn't ask her (PD) to do one."</p> <p>9-3-2(a)</p> <p>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 4 of 4 clients in the sample (#2, #3, #4 and #6) and one additional client (#1), the facility's Qualified Intellectual Disabilities Professional (QIDP - called Program Director by the facility) failed to ensure the clients' program plans were integrated, coordinated and monitored.</p> <p>Findings include:</p> <p>1) On 5/9/16 from 2:46 PM to 3:33 PM, an observation was conducted at the</p>	W 0159	<p>The Program Director (QIDP) was retrained on Day Program Responsibilities. This includes communicating with day program staff to address issues or concerns as they arise. The PD will complete observations at least monthly for all day program sites. The PD will ensure that all clients' current ISPs, BSPs, and other requested documentation is in place at the day program sites to ensure outside services can meet the needs of the clients.</p> <p>The Area Director will review any completed observations by the PD at weekly meetings to ensure they are</p>	06/12/2016	

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	<p>workshop client #2 attended. Client #2 was present during the observation. Client #2 left the workshop area at 3:00 PM. He was observed sitting outside the building at 3:33 PM. Client #2 stated when asked why he did not ride the bus to his group home, "I have enough sense to stay out of the rain." Client #2 indicated he would ride the group home van home since it was raining.</p> <p>On 5/9/16 at 2:50 PM, the Workshop Supervisor (WS) indicated there were on-going issues with client #2 including not staying in his program area and leaving the program area. The WS indicated she had met with the Behavior Consultant several times over the past few months to address the issues involving client #2. The WS indicated client #2 now leaves the workshop at 3:00 PM and rides the bus home. The WS indicated client #2 had Tuesdays off from the workshop. On 5/9/16 at 2:58 PM, the WS indicated she did not know and had not met the Program Director. On 5/9/16 at 3:09 PM, the WS indicated she requested client #2's ISP in February 2016 but had not received it from the group home.</p> <p>On 5/9/16 at 3:03 PM, a review of client #2's record at the workshop was conducted. The record did not contain an</p>		<p>completed at least monthly for all day program sites.</p> <p>Persons responsible: Area Director, Program Director (QIDP)</p>	

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	<p>ISP or BSP for client #2. The workshop record indicated the following:</p> <p>-Client #2's record indicated there was a meeting to "review programs" on 12/11/15. The Case Conference Summary indicated, "[Client #2] has not been reporting to room on time... Not reporting back to [name of workshop] after he gets here from hotel job...." The Behavior Consultant for client #2's group home attended the meeting but not the QIDP.</p> <p>-A 1/13/16 Case Conference Summary indicated the purpose of the meeting was "Emergency Support Meeting." The notes indicated, in part, "On the week of December 28, 2015, some fabric pieces came up missing. [Client #2] was suspected of removing them. He was questioned and denied it. Home staff were (sic) then questioned about it and the fabric was located in [client #2's] room...." The notes indicated, "TSI-Mentor also agreed to pick [client #2] up (at) 3:15 PM daily as he is not following the rules to stay in his program room. [Name of behavior consultant for the group home] is involved in planning for his BSP (behavior support plan) and schedule rewards. She will be working with him to maintain his placement in the workshop...." The notes indicated,</p>			

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	<p>"Discussed the need for [client #2] to follow rules or be encouraged to seek another program. [Client #2] sets the example and people want to follow his lead. This includes leaving programs early, carrying many items that don't belong here and genuinely having a poor attitude." The QIDP did not attend the meeting.</p> <p>-A 3/25/16 Case Conference Summary indicated, in part, "Meeting held with [client #2] re: (last week) of allegation of touching breast with another client... Will look (at) changing his AM routine so he does not have to come to [name of workshop] prior to his community job... [Client #2] continues to be in situations that make others frustrated. He is teasing and in this current situation, he reportedly touched the female on the head. She stated on breast. Not substantiated. Currently working with [name of behavior consultant for the group home]... Will be allowing him to leave (at) 3:15 PM all days to go catch bus. Will also not be present on Tuesday...." The QIDP did not attend the meeting.</p> <p>-A 4/28/16 Case Conference Summary indicated, in part, "[Client #2] has been working to improve work habits. Have been scheduling 30 day meetings for review. Had also lost privileges to go</p>			

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	<p>upstairs. He has resumed...." The QIDP did not attend the meeting.</p> <p>On 5/11/16 at 10:50 AM, a review of client #2's record at the group home was conducted. There was no documentation the group home staff conducted observations at the workshop during the past 12 months.</p> <p>On 5/11/16 at 11:46 AM, a review of client #4's record at the group home was conducted. There was no documentation the group home staff conducted observations at the workshop during the past 12 months.</p> <p>On 5/11/16 at 12:39 PM, the Program Director (PD) indicated she did not have documentation of observations being conducted at the outside services program. The PD indicated the workshop should have the client's current plans. The PD indicated the group home needed to ensure the outside services met the needs of the clients. The PD indicated she had not attended client #2's meetings at the workshop.</p> <p>On 5/13/16 at 11:00 AM, the Area Director (AD) indicated the PD missed the meetings due to trainings. The AD indicated the expectation was the PD would be present for the meetings either</p>						

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	<p>in person or by phone. The AD stated observations at the outside services were "required." The AD indicated the PD should be involved. The AD stated the PD should conduct observations "at least monthly" at the outside services programs or more frequently if there were issues.</p> <p>2) Please refer to W120. For 4 of 4 clients in the sample (#2, #3, #4 and #6) and one additional client (#1), the facility's QIDP failed to ensure the outside services (day program and workshops) met the needs of each client.</p> <p>3) Please refer to W248. For 3 of 4 clients in the sample (#2, #4 and #6) and one additional client (#1), the facility's QIDP failed to ensure the clients' program plans were available to all relevant staff, including staff of other agencies who work with the clients.</p> <p>4) Please refer to W263. For 1 of 4 clients in the sample with restrictive interventions (#6), the facility's QIDP failed to ensure the specially constituted committee (Human Rights Committee - HRC) ensured written informed consent for client #6's restrictive plan was obtained prior to implementation.</p> <p>9-3-3(a)</p>			

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W 0248  Bldg. 00	<p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 3 of 4 clients in the sample (#2, #4 and #6) and one additional client (#1), the facility failed to ensure the clients' program plans were available to all relevant staff, including staff of other agencies who work with the client.</p> <p>Findings include:</p> <p>1) On 5/9/16 at 2:21 PM, a review of client #6's record at the outside services workshop was conducted. The record did not contain client #6's Individualized Support Plan (ISP). The record included a Behavior Support Plan (BSP) dated 3/1/16 (the current plan was dated 4/11/16).</p> <p>On 5/9/16 at 2:23 PM, a review of client #1's record at the outside services workshop was conducted. The record contained an ISP dated 2/13/15 (his current plan was dated 3/16/16).</p> <p>On 5/11/16 at 11:15 AM, a focused</p>	W 0248	<p>The Program Director (QIDP) will ensure that all clients' current ISPs, BSPs, and other requested documentation is in place at the day program sites to ensure outside services can meet the needs of the clients. The PD will complete observations at least monthly for all day program sites and ensure this current information is available for review.</p> <p>Persons responsible: Area Director, Program Director (QIDP)</p>	06/12/2016

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	<p>review of client #1's record was conducted. Client #1's current ISP was dated 3/16/16.</p> <p>On 5/11/16 at 12:09 PM, a review of client #6's record was conducted. Client #6's current BSP was dated 4/11/16.</p> <p>2) On 5/9/16 at 3:03 PM, a review of client #2's record at the workshop was conducted. The record did not contain an ISP or BSP for client #2.</p> <p>On 5/9/16 at 3:04 PM, a review of client #4's record at the workshop was conducted. The record did not contain an ISP.</p> <p>On 5/11/16 at 10:50 AM, a review of client #2's record at the group home was conducted. Client #2's ISP was dated 3/9/16 and his BSP was dated 4/7/16.</p> <p>On 5/11/16 at 11:46 AM, a review of client #4's record at the group home was conducted. Client #4's ISP was dated 3/9/16.</p> <p>On 5/11/16 at 12:39 PM, the Program Director (PD) indicated the day program and workshops should have the clients' current plans.</p> <p>9-3-4(a)</p>			

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W 0263  Bldg. 00	<p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; 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.</p> <p>Based on record review and interview for 1 of 4 clients in the sample with restrictive interventions (#6), the facility's specially constituted committee (Human Rights Committee - HRC) failed to ensure the facility obtained written informed consent for client #6's restrictive plans.</p> <p>Findings include:</p> <p>On 5/11/16 at 12:09 PM, a review of client #6's record was conducted. Client #6's 4/11/16 Behavior Support Plan (BSP) included restraint ("Use of agency approved physical restraint if imminent danger is caused by [client #6's] absence without permission or notification. For example: If [client #6] is attempting or succeeds in walking in a busy street and staff cannot maintain [client #6's] safety"). The BSP included the use of psychotropic medications (Clonidine for impulsivity, Lamotrigine for mood stabilization and Ziprasidone for mood stabilization/aggression). The BSP</p>	W 0263	<p>The Program Director (QIDP) was retrained on process of getting clients and guardians approvals prior to HRC approval.</p> <p>The Program Director will continue to monitor the HRC process for all clients on an ongoing basis. HRC committee will ensure that clients and/or guardians have been notified prior to signing off on HRC approvals. Program Director and Area Director will meet weekly to review request for HRC and approvals of HRC.</p> <p>Persons responsible: Area Director, Program Director (QIDP)</p>	06/12/2016

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W 0322 Bldg. 00	<p>indicated knives were locked and the freezer in the basement was locked. Client #6's record indicated he had a guardian. There was no documentation the HRC ensured the facility obtained written informed consent for the use of client #6's restrictive BSP.</p> <p>On 5/12/16 at 3:16 PM, the Quality Assurance Specialist indicated in an email, "[Program Director] isn't currently in the office, but I texted her and she said they have not located this yet. Sorry."</p> <p>On 5/12/16 at 3:50 PM, the Program Director indicated in an email, "Still looking."</p> <p>9-3-4(a)</p> <p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review and interview for 1 of 4 clients in the sample (#3), the facility failed to ensure client #3 had an annual physical examination.</p> <p>Findings include:</p> <p>On 5/11/16 at 11:19 AM, a review of client #3's record was conducted. There</p>	W 0322	<p>The Nurse for the home was retrained on ensuring annual physicals are completed timely and all results recorded according to policy and procedure for health and welfare of clients.</p> <p>A review of the client's medical chart will be completed at least annually to ensure all required medical documentation has been completed and is available for review.</p>	06/12/2016

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W 0323 Bldg. 00	<p>was no documentation in client #3's record indicating he had an annual physical examination since his admission to the group home on 9/2/15.</p> <p>On 5/12/16 at 1:25 PM, the nurse indicated she was attempting to obtain documentation of client #3's annual physical. The nurse indicated she contacted client #3's mother however she had not received a copy of the annual physical.</p> <p>9-3-6(a)</p> <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 for 2 of 2 clients in the sample (#3 and #6) who moved into the group home since May 2015, the facility failed to ensure client #3's hearing and vision and client #6's hearing were evaluated annually.</p> <p>Findings include:</p> <p>1) On 5/11/16 at 11:19 AM, a review of client #3's record was conducted. Client #3's record did not include documentation of his vision and hearing</p>	W 0323	<p>Persons Responsible: Nurse, Area Director, Program Director (QIDP)</p> <p>The Nurse for the home was retrained on ensuring vision and dental evaluations are completed timely and all results recorded according to policy and procedure for health and welfare of clients. A review of the client's medical chart will be completed at least annually to ensure all required medical documentation has been completed and is available for review.</p> <p>Persons Responsible: Nurse, Area Director, Program Director (QIDP)</p>	06/12/2016

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	<p>being assessed since he was admitted to the group home on 9/2/15. Client #3's record did not contain documentation of an annual physical.</p> <p>On 5/11/16 at 3:35 PM, the Program Director (PD) indicated in an email client #3 had a hearing evaluation scheduled on 6/6/16 at 11:00 AM. There was no information about client #3's vision evaluation in the email.</p> <p>On 5/11/16 at 12:06 PM, the nurse indicated client #3 had a vision evaluation in August 2015. The nurse indicated she was attempting to obtain a copy of the appointment (the facility did not send documentation of the appointment during the survey). The nurse indicated client #3 was not due for a hearing evaluation until 2017. The nurse indicated she was attempting to obtain a copy of the appointment (the facility did not send documentation of the appointment during the survey). The nurse indicated client #3's vision and hearing should be evaluated annually.</p> <p>2) On 5/11/16 at 12:09 PM, a review of client #6's record was conducted. Client #6's record did not include documentation of his hearing being assessed since he was admitted to the group home on 2/12/16. Client #6's</p>			

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W 0365 Bldg. 00	<p>2/29/16 annual physical did not include documentation of a hearing evaluation.</p> <p>On 5/11/16 at 3:35 PM, the PD indicated in an email client #6 had a hearing evaluation scheduled on 6/8/16 at 11:00 AM.</p> <p>On 5/12/16 at 1:25 PM, the nurse indicated she did not have documentation of client #6's hearing evaluation. The nurse indicated the paperwork she received from the previous group home provider indicated his hearing was evaluated on 10/1/15 however she was unable to locate the appointment form for the hearing evaluation. The nurse indicated she was attempting to contact the previous provider to obtain the documentation of the appointment. The nurse indicated client #6's hearing should be evaluated annually.</p> <p>9-3-6(a)</p> <p>483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. Based on record review and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure staff documented</p>	W 0365	Staff in the home will be retrained on completing accurate medication administration documentation in a timely manner on each client's Medication Administration Records.	06/12/2016

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	<p>the administration of the clients' medications in a timely manner on their Medication Administration Records (MARs).</p> <p>Findings include:</p> <p>On 5/11/16 at 10:47 AM, a review of the clients' May 2016 MARs was conducted and indicated the following:</p> <p>1) Client #1: -On 5/7/16, 5/8/16 and 5/10/16, staff did not initial the MAR for client #1 following his diet (nectar-thickened liquids, Frazier Water Protocol, 1800 calorie, low fat, no concentrated sweets and no added salt) for the 4:00 PM to 12:00 AM timeframe. -On 5/10/16 at 8:00 PM, staff did not initial the MAR for administering client #1's Benztropine 1 mg (milligram). -On 5/10/16 at 8:00 PM, staff did not initial the MAR for administering client #1's Clonidine 0.2 mg. -On 5/8/16 at 8:00 PM, staff did not initial the MAR for administering client #1's Reguloid Powder. -On 5/2/16 and 5/4/16 in the morning (no time indicated), staff did not document client #1's blood sugar checks. -On 5/3/16, 5/5/16 and 5/7/16 two hours after dinner, staff did not document client #1's blood sugar checks. -On 5/7/16 and 5/8/16 at 8:00 PM, staff</p>		<p>The Program Coordinator (HM) will review MARs to monitor that buddy checks are being completed to ensure all documentation is completed following medication passes. Staff will receive correction action if future errors are found. Persons responsible: Area Director, Program Director (QIDP), Program Coordinator</p>	

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	<p>did not initial the MAR for administering client #1's Lidoderm to the affected areas on his feet.</p> <p>-On 5/10/16 at 5:00 PM, staff did not initial the MAR for administering client #1's Lidoderm to the affected areas on his feet.</p> <p>-On 5/7/16 and 5/10/16 during the 3:00 PM to 11:00 PM shift, staff did not initial client #1 receiving Bacitracin ointment to area (not defined) and cover with bandage until healed for minor cuts.</p> <p>2) Client #2:</p> <p>-On 5/7/16 at lunch and 5/7/16 and 5/8/16 at dinner, staff did not initial client #2 following his diet of 1800 calorie, low fat diet.</p> <p>-On 5/11/16 at 6:30 AM, staff failed to initial the administration of the following medications: Bupropion 150 mg, Cetirizine 10 mg, Fosinopril Sodium 40 mg, Glimepiride 2 mg, Metformin 1000 mg, Oxymetazoline Spray 0.05% nasal spray, Pioglitazone 45 mg, Polyethylene Glycol 3350 17 grams, Propranolol 80 mg, and Simvastatin 20 mg.</p> <p>-On 5/6/16 at 8:00 PM, staff failed to initial the MAR for the administration of Sertraline 100 mg.</p> <p>-On 5/7/16 at 8:00 PM, staff failed to initial the MAR for the administration of Victoza 18 mg/3 ml (milliliters) injection for diabetes.</p>			

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	<p>-On 5/1/16 to 5/6/16, 5/9/16 and 5/10/16, staff initialed the administration of Clobetasol 0.05% ointment to both elbows and knees. The order indicated three times weekly for psoriasis.</p> <p>3) Client #3: -On 5/8/16 at 8:00 PM, the following medications were not initialed as administered: Acidophilus Capsule, Charcoal caps, Ferrous Sulfate 325 mg, Lithium Carbonate 450 mg, Lithium Carbinate 300 mg, Lorazepam 1 mg, Megared Krill Oil 500 mg, Metformin 1000 mg, Olanzapine 20 mg, Quetiapine 200 mg, Senna Plus tablet, Simethicone 125 mg, Topiramate 100 mg, lotion to feet, Amoxicillin 875 mg, Prevident 5000 toothpaste and Chlorhexidine 0.12% rinse. -On 5/7/16 and 5/10/16 in the PM (no time indicated), the MAR was not initialed for Prevident 5000 and Chlorhexidine 0.12 % rinse. -On 5/10/16 at 8:00 PM, the MAR was not initialed for the administration of Amoxicillin 875 mg. -On 5/7/16, 5/8/16 and 5/10/16, the MAR was not initialed for the use of a humidifier at bedtime.</p> <p>4) Client #4: -On 5/10/16 at lunch and 5/6/16, 5/7/16, 5/8/16 and 5/10/16 at dinner, client #4's</p>			

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	<p>MAR was blank for him following his regular with double portions at breakfast and dinner diet.</p> <p>-On 5/6/16 at 8:00 PM, the MAR was blank for the administration of Aripiprazole 7.5 mg.</p> <p>-On 5/10/16 at 8:00 PM, the MAR was blank for eyelid scrub with warm wash cloth using baby shampoo.</p> <p>-On 5/5/16 to 5/8/16 and 5/10/16 in the evening (no time indicated), the MAR was blank for use of Ketoconazole 2% shampoo (wash scalp and face every day with shower).</p> <p>5) Client #5: -On 5/6/16, 5/7/16 and 5/8/16 at dinner, client #5's MAR was blank for the implementation of his diet order (low fat, 1800 calorie, no concentrated sweets and calorie free fluids.</p> <p>-On 5/8/16 at 8:00 PM, the following medications were not initialed as administered: Clozapine 200 mg, Divalproex 500 mg, Fenofibrate 160 mg, Fish Oil 1000 mg, Metformin 1000 mg, Oyster Cal 500 mg, Ammon Lact 12 % lotion 225 gm (grams) to heels daily, Vicks Vapor Rub to both great toenails, staff monitoring toothbrushing, use of CPAP (continuous positive airway pressure) and Lantus Solostar 45 u (units).</p> <p>-On 5/6/16 at 8:00 PM, the MAR was</p>			

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NAME OF PROVIDER OR SUPPLIER  TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
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	<p>blank for Ammon Lact 12% lotion.</p> <p>-On 5/7/16 at 8:00 PM, the MAR was blank for Vicks Vapor rub.</p> <p>-On 5/7/16 at 8:00 PM, the MAR was blank for his CPAP.</p> <p>6) Client #6: -On 5/9/16, there was no daily weight recorded.</p> <p>7) Client #7: -On 5/8/16 at 8:00 PM, the following medications were not initialed as administered: Finasteride 5 mg and Oys Cal-D 500/200.</p> <p>8) Client #8: -On 5/7/16, 5/8/16 and 5/10/16 at dinner and 5/8/16 at lunch, the MAR was blank for client #8 following his 1800 calorie, low fat, low cholesterol diet. -On 5/6/16 at 8:00 PM, Levocetirizine 5 mg was not initialed as administered. -On 5/10/16 at 8:00 PM, Aripiprazole 20 mg and Oxymetazoline Spray 0.05% nasal spray were not initialed as administered. -On 5/9/16 at 7:00 AM and 5/6/16, 5/7/16 and 5/10/16 at 8:00 PM, the MAR was blank for the administration of Refresh Optive eye drops. -On 5/7/16 and 5/8/16 at 8:00 PM, the MAR was blank for Erythromycin eye ointment.</p>			

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W 0369	<p>-On 5/7/16, 5/8/16 and 5/10/16 at 8:00 PM, the use a his CPAP was not documented.</p> <p>-On 5/7/16 and 5/8/16, the use of his orthodic inserts was not documented.</p> <p>-On 5/8/16 in the evening (no time indicated), there was no documentation the batteries were changed in his hearing aids every 10 days.</p> <p>On 5/11/16 at 10:43 AM, the nurse indicated the clients' MARs should be initialed when medications/treatments were administered. The nurse stated, "it would be a documentation error." The nurse indicated the Program Coordinator was supposed to review the MARs weekly. The nurse stated "I try to look at them when I am at the house." The nurse indicated she was at the group home on 5/10/16 but did not review the MARs.</p> <p>On 5/11/16 at 12:34 PM, the Quality Assurance Specialist indicated the blank spots on the MAR were documentation errors. The QAS indicated the Program Coordinator should review the MARs regularly.</p> <p>9-3-6(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION</p>				

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Bldg. 00	<p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 1 of 18 medications/treatments administered to client #3, the facility failed to ensure staff administered client #3's medication as ordered by the physician.</p> <p>Findings include:</p> <p>On 5/10/16 from 5:55 AM to 7:36 AM, an observation was conducted at the group home. At 6:36 AM, client #3 received his medications from staff #10. During the medication pass to client #3, staff #10 did not administer client #3's Flonase nasal spray (allergies).</p> <p>On 5/11/16 at 11:19 AM, a review of client #3's record was conducted. Client #3's 2/15/16 Physician's Orders indicated he was prescribed Flonase Allergy Relief 50 mcg (micrograms) 0.05%, one spray into each nostril daily. Client #3's May 2016 Medication Administration Record (MAR) indicated staff #10 initialed the MAR on 5/10/16 at 8:00 AM as administering client #3's Flonase as ordered.</p> <p>On 5/11/16 at 2:27 PM, the Program Director sent a Bureau of Developmental</p>	W 0369	<p>Staff in the home will be retrained on completing accurate medication administration for each client for their health and safety.</p> <p>The Program Coordinator (HM) will review MARs to monitor that buddy checks are being completed to ensure all medications are administered according to Physicians Orders and that documentation is completed following medication passes.</p> <p>Staff will receive correction action if future errors are found.</p> <p>Persons responsible: Area Director, Program Director (QIDP), Program Coordinator</p>	06/12/2016

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	<p>Disabilities Services (BDDS) incident report for review. The 5/11/16 BDDS report indicated, "Med error. [Client #3] did not receive his Flonase. Staff retraining on medication administration."</p> <p>On 5/11/16 at 10:36 PM, the nurse indicated client #3 not receiving his Flonase as ordered was a medication error.</p> <p>On 5/11/16 at 12:38 PM, the Quality Assurance Specialist indicated client #3 not receiving his Flonase as ordered was a medication error.</p> <p>On 5/11/16 at 12:38 PM, the Program Director indicated client #3 not receiving his Flonase as ordered was a medication error.</p> <p>9-3-6(a)</p>			