

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/19/2015
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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
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W 000  Bldg. 00	<p>This visit was for the post certification revisit (PCR) to the pre-determined full recertification and state licensure survey and included the investigation of complaint #IN00159314 completed on 2/4/2015.</p> <p>Complaint #IN00159314: Not Corrected.</p> <p>Dates of Survey: 3/11, 3/12, 3/13, 3/16, 3/17, 3/18, and 3/19/2015.</p> <p>Provider Number: 15G495 AIM Number: 100244970 Facility Number: 001009</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 24, 2015 by Dotty Walton, QIDP.</p>	W 000		
W 104  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 observation, record review, and</p>	W 104	Indiana Mentor maintenance will work to replace the missing closet	04/18/2015

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

TITLE

(X6) DATE

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

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	<p>interview, for 4 of 4 sampled clients (clients A, B, C, and D) and 4 additional clients (clients E, F, G, and H), the governing body failed to exercise operating direction over the facility to ensure the plan of correction was implemented for clients A, B, C, D, E, F, G, and H's group home.</p> <p>The governing body failed to ensure client C's bedroom closet had a door.</p> <p>The governing body failed to exercise operating direction over the facility to ensure clients A, B, C, D, E, F, G, and H were reimbursed for services the facility was to provide.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 3/11/15 from 4:20pm until 6:25pm, observations were conducted and client C's closet door was missing to expose his personal belongings inside his closet.</li> <li>On 3/12/15 at 9:30am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated client C's bedroom closet door was missing and had been removed.</li> <li>On 3/11/15 from 4:20pm until</li> </ol>		<p>door. The Home Manager and Program Director will be retrained on ensuring that all maintenance issues are addressed in a timely manner and followed up on, if remaining incomplete. Ongoing, the Program Director will complete a monthly walk thru of the group home to ensure that no issues are noted. Ongoing, the Area Director will ensure that a quarterly walk-thru is completed to ensure that all maintenance issues are taken care of in a timely matter and do not remain incomplete. The Program Director and Home Manager will be retrained on Client Finances, including ensuring that the client is not paying for items that Indiana MENTOR should provide on a daily basis. Ongoing, Indiana MENTOR will provide meals for each client, even when going out in the community in a group setting. The Area Director previously submitted for the funds to be reimbursed. Once these checks are received from the corporate office, they will be placed in the client's checking accounts for their personal use. All financial transactions are monitored by the Home Manager, reconciled on a monthly basis by the Program Director, and then reviewed by the Client Finance Specialist at the completion of each month. Once a month the Client Finance Specialist will notify the Area Director of all clients, if any, that are over</p>	

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	<p>6:25pm, observation was conducted with clients A, B, C, D, E, F, G, and H. During the observation period clients A, B, C, D, E, F, G, and H's personal finances were requested for review. No changes were recorded since the 2/4/2015 survey audit.</p> <p>On 3/12/15 at 11:00am, a review of clients A, B, D, and F's personal finances were reviewed with the QIDP. The QIDP indicated clients A, B, C, D, E, F, G, and H's expenditure on 1/28/15 when the group home went out to eat supper together had not been reimbursed and he was unsure of the reimbursement status at this time. The QIDP indicated the group home did not cook supper on 1/28/15 and the clients should not have had the expense of paying for their supper meal from their personal funds.</p> <p>On 3/12/15 at 11:00am, clients A, B, C, D, E, F, G, and H's receipts from their 1/28/15 supper outing were reviewed with the QIDP. The QIDP indicated the group home did not provide a supper meal at the group home on 1/28/15 and clients A, B, C, D, E, F, G, and H went out to eat supper with the facility staff. The QIDP provided the following receipts and expenditures from clients A, B, C, D, E, F, G, and H's personal funds. The review indicated: For client A \$6.30</p>		resources, so that the Area Director can follow up on the plan of correction. Ongoing, the Area Director will complete quarterly reviews of a random sample of client finances to ensure that all is completely accurately and correctly. Responsible Party: Home Manager, Program Director, Client Finance Specialist, and Area Director.	

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	<p>and \$1.70. For client B \$6.84 and \$1.16. For client C no receipt and the RM indicated staff paid for client C's supper because he did not have funds available. For client D \$6.30 and \$1.70. For client E \$7.72 and \$1.28. For client F \$6.30 and \$1.70. For client G no receipt and the RM indicated client G carried her own money to pay for her supper. For client H \$6.30 and \$1.45.</p> <p>On 3/12/15 at 11:00, clients A, B, C, and D's "Cash on Hand Record(S)" indicated the following expenses from clients A, B, C, and D's personal funds entrusted to the facility and the QIDP indicated the clients from the group home purchased their meal and the facility did not provide a meal at the group home:</p> <p>-The 12/2014 dining out receipts indicated the following: Client A on 12/23/14 was \$8.92 and on 12/5/14 was \$6.30, client B on 12/5/14 was \$4.35 and \$1.95 and was not at the group home on 12/23/14, client C on 12/23/14 was \$8.92 and on 12/5/14 was \$4.35 and \$1.95, client D on 12/23/14 was \$8.16 and on 12/5/14 was \$6.30, and client F on 12/23/14 was \$8.16 and on 12/5/14 was \$4.35 and \$1.95.</p> <p>-The 11/2014 dining out receipts indicated the following: Client A on</p>			

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	<p>11/8/14 was \$8.06 and on 11/15/14 was \$7.62, client B on 11/15/14 was \$7.62, client C on 11/8/14 was \$8.06 and on 11/15/14 was \$7.62, client D on 11/15/14 was \$7.62.</p> <p>On 3/12/15 at 11:00am, the facility's 12/2007 policy and procedure "Managing an Individual's Funds" indicated the purpose for safeguarding a client's funds was "protecting individual's money from being misused by others...." The policy and procedure indicated "the misuse of property and/or resources...Buying groceries...using an individuals money...Prohibited practices include the following...Requiring an individual served by the company to purchase items for which the company is eligible for reimbursement." The policy indicated the client pays for room and board from social security funds and the facility rate was all inclusive which included meals.</p> <p>On 3/12/15 at 11:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated clients A, B, C, D, E, F, G, and H went out to eat monthly and each client paid for their individual dinner meal. The QIDP indicated clients A, B, C, D, E, F, G, and H should not pay for services the facility should provide.</p>			

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W 137 Bldg. 00	<p>On 3/12/15 at 2:45pm, the QIDP provided a 2/4/15 "request for payment" typed sheet for clients A, B, C, D, E, F, G, and H and stated "no action" had been completed to reimburse the clients for costs the facility should have provided. The QIDP indicated the facility had not completed corrective measures for the plan of correction.</p> <p>This deficiency was cited on 2/4/2015. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p> <p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, interview, and record review for 4 of 4 sampled clients (clients A, B, D, and F) and 4 additional clients (clients C, E, G, and H), the facility failed to ensure clients A, B, C, D, E, F, G, and H had access to their personal items.</p> <p>Findings include:</p>	W 137	The IDT will convene to discuss client A's current Behavior Support Plan. It will be discussed if the plan needs revising to indicate how or when staff will intervene with client A's hoarding and manipulative behaviors. All staff will be retrained on client rights. This training will include but is not limited to ensuring that no client possessions are removed or stored where a client does not have access to them,	04/18/2015

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	<p>On 3/11/15 from 4:20pm until 6:25pm, clients A, B, C, D, E, F, G, and H walked throughout the group home. At 4:20pm, GHS (Group Home Staff) #1 indicated the file drawers were for the facility staff. GHS #1 opened the file cabinet drawers to expose clients A, B, C, D, E, F, G, and H's personal socks inside two of the four drawers and client A's hearing aid. At 4:20pm, GHS #1 indicated client A was to have 2 pairs of socks to carry daily. GHS #1 stated if client A did not have his one extra pair of socks "he would take everyone else's." GHS #1 stated the facility staff secured clients A, B, C, D, E, F, G, and H's socks to prevent client A from taking the other clients' socks. At 4:35pm, clients E and H attempted to open the file cabinet drawers. At 4:35pm, GHS #1 stated "Hey, wait a minute. That cabinet is (for) staff. You can't get in there." GHS #1 closed the file cabinet drawers which clients E and H had grasped the handles to open. From 4:20pm until 6:25pm, client A did not wear or was he offered his hearing aids.</p> <p>On 3/12/15 at 10:00am, client A's record review was conducted. Client A's 8/18/14 Individual Support Plan (ISP), 8/18/14 Risk assessment, and 8/18/14 BSP (Behavior Support Plan) indicated client A had the identified targeted behavior of Hoarding. Client A's BSP</p>		<p>per their individual ISP and BSP. All personal possessions were removed from the filing cabinet and placed back into the client's room. The Interdisciplinary team will meet regarding client A's Behavior Support Plan and address the targeted behavior of hoarding. The team will specifically address how the staff will respond to Client A's hoarding socks and/or other items. Once the Behavior Support Plan is updated, the staff will be retrained on all of the changes the team made. The Home Manager or Program Director will complete random Active Treatment observations three times per week for the first four weeks, and then once a week on going to ensure that all clients are not restricted with any of their rights. Ongoing, no personal possessions of the clients will be kept in the filing cabinets where the clients are unable to get to them. Responsible Party: Home Manager, Program Director, and Area Director</p>	

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	<p>indicated "To prevent [client A] from hoarding/throwing items: Explain to [client A] that he will be allowed to hold 1 pair of his own socks and take them with him as long as he does not throw the items. Each morning review with [client A] that he can take 1 pair of socks with him but if he throws them he will not be able to have them back for the rest of the day...." Client A's 9/24/12 hearing assessment indicated he wore hearing aids. Client A's record did not include staff taking items away from client A, staff searching client A's person for items, and staff withholding client A's personal possessions in a secured location.</p> <p>On 3/12/15 at 11:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP stated client A's ISP and BSP did not indicate he needed staff to secure and/or take away his personal possessions. The QIDP indicated client A's plans did not include limiting client A's access to his socks. The QIDP indicated clients A, B, C, D, E, F, G, and H should not have had their personal socks kept in a secured file cabinet. The QIDP indicated clients A, B, C, D, E, F, G, and H had not been assessed and no consents were available for review for their personal socks to be kept secured by</p>			

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W 218 Bldg. 00	<p>the facility staff.</p> <p>This deficiency was cited on 2/4/2015. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must include sensorimotor development. Based on observation, record review, and interview, for 1 of 4 sampled clients (client D) who was visually impaired, the facility failed to assess client D's functional ability related to his blindness.</p> <p>Findings include:</p> <p>On 3/11/15 from 4:20pm until 6:25pm, observation was conducted at the group home. During the observation period client D was assisted by GHS (Group Home Staff) #1, GHS #3, and the QIDP (Qualified Intellectual Disabilities Professional) to walk, reposition himself in his chair, administer medications, and eat his supper meal. At 4:20pm, GHS #1 indicated client D was blind and non verbal.</p> <p>On 3/12/15 at 11:45am, client D's record</p>	W 218	The Program Director, Program Nurse, and/or Home Manager will work with client D's interdisciplinary team to get a sensorimotor assessment scheduled and completed. Once the results of the assessment are available, the staff will be retrained on how to best provide active treatment and the completion of ADL's for client D. The Program Director (QIDP) will review the Individualized Support Plan, High Risk Plan, and the Behavior Support Plan to show the correct diagnosis and the results of the sensorimotor assessment. Before the assessment is completed, the Home Manager, Program Director, Behavior Specialist, and/or Program Nurse will complete are training with the staff on how to verbally assist client D with active treatment and the completion of ADL's. The	04/18/2015

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	<p>review was conducted. Client D's 10/16/14 ISP (Individual Support Plan) indicated he was blind. Client D's 10/2014 CFA (Comprehensive Functional Assessment) and 10/2014 BSP (Behavior Support Plan) did not indicate client D was blind. Client D's 1/6/15 "Physician's Order" indicated a diagnosis of "Blindness." Client D's 3/10/14 Vision evaluation indicated client D was blind. Review of the record did not indicate a sensorimotor assessment for client D's functional blindness. Client D's record did not indicate what or how staff were to assist client D to function in his environment related to his blindness.</p> <p>On 3/12/15 at 11:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client D was blind and no sensorimotor assessment was available for review for client D's functional blindness.</p> <p>On 3/19/15 at 3:25pm, an interview was conducted with the QIDP and the Area Director (AD). The AD and the QIDP both indicated the facility staff were retrained on assisting client D related to his blindness. The AD indicated client D had not been assessed for his sensorimotor skills related to his</p>		<p>Home Manager or Program Director will complete random Active Treatment observations three times per week for the first four weeks. Ongoing, the Home Manager or Program Director will complete no less than one Active Treatment observation per week to ensure that staff are appropriately assisting client D. Ongoing, the Program Nurse will review other client's needs and ensure that all assessments are completed where needed. Responsible Party: Home Manager, Program Director, Program Nurse, and/or Behavior Specialist</p>	

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W 249 Bldg. 00	<p>functional abilities related to client D's blindness.</p> <p>This deficiency was cited on 2/4/2015. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview, and record review, for 3 of 4 sampled clients (clients A, B, and D) and 4 additional clients (clients E, G, and H), the facility failed to use formal and informal opportunities to implement client A, B, D, E, G, and H's ISPs (Individual Support Plans) and risk plans when opportunities existed.</p> <p>Findings include:</p> <p>1. On 3/11/15 from 4:20pm until 6:25pm, GHS (Group Home Staff) #2 administered clients A, B, D, E, G, and</p>	W 249	<p>The Direct Support Professionals will be retrained on completing and documenting formal and informal training goals for each client, specifically the medication goals.</p> <p>The Program Director, in conjunction with the IDTs, will create an appropriate medication administration goal for clients A, D, E, G, and H.</p> <p>After the retraining occurs, the Home Manager will complete two (2) weekly observations to ensure that the goals are being completed with each client as specified for four (4) weeks. These will then be</p>	04/18/2015

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	<p>H's evening medications. From 5:22pm until 6:08pm, clients A, B, E, G, and H individually walked to enter/exit the medication room and carried their own glasses of water. At 5:40pm, GHS #2 carried client D's medications from the medication room into the living room to administer the medications to client D. Before each client received their medications GHS #2 compared each client's medication packets to each client's individual 3/2015 MARs (Medication Administration Records), assembled each medication, and each client individually took their medications. No teaching and/or training was completed during the administration period including the names of each medication, reasons for the medication uses, dosages, and side effects.</p> <p>On 3/12/15 at 10:00am, client A's record was reviewed. Client A's 8/18/14 ISP (Individual Support Plan) indicated goals/objectives to count to 10, to serve himself at dinner time the correct amount per item, to identify the bottle he uses for his oral care, to hold his hearing aid at least one minute. The ISP did not include a specific medication goal to teach client A regarding his medications.</p> <p>On 3/12/15 at 12:15pm, client B's record was reviewed. Client B's 4/7/14 ISP</p>		<p>reviewed by the Program Director ensuring that there are no further training needs to be addressed.</p> <p>After the initial four (4) weeks, the Home Manager and/or Program Director will complete weekly medication administration observations ongoing, and will ensure that all needed retrainings will be completed.</p> <p>Ongoing each DSP will work with each client on their specific Individualized Support Plan that states each goal.</p> <p>Responsible Party: Program Director and Home Manager</p>	

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	<p>indicated an objective to identify the reason she takes Lamictal (for behaviors) independently.</p> <p>On 3/12/15 at 11:45am, client D's record was reviewed. Client D's 10/16/14 ISP indicated an objective to get his own water to take his medications, and no specific medication goal to teach client D regarding his medications.</p> <p>On 3/11/15 at 6:08pm, clients E, G, and H's 3/2015 MAR and documented program file at the group home were reviewed. No medication goals/objectives were available for review for clients E, G, and H.</p> <p>On 3/12/15 at 11:00am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated clients A, B, D, E, G, and H should have been taught about their medications. The QIDP indicated each client had a goal/objective to teach the clients some aspect of medication administration.</p> <p>This deficiency was cited on 2/4/2015. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>			

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W 331 Bldg. 00	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 2 of 4 sampled clients (client D and F), the facility's nursing services failed to develop protocols specific to clients D and F to monitor and to manage their pain and failed to ensure client D's self inflicted open/scabbed areas had been addressed by the nursing professional.</p> <p>Findings include:</p> <p>On 3/11/15 from 4:20pm until 6:25pm, observations and interviews were conducted at the group home. Client D was observed with flaky pale skin with scabbed and open red areas on his head and face. During the observation period client D made whining sounds when he walked, shifted his seating position, and/or moved to stand upright. During the observation period client D rubbed and scratched his face and head with his left and right hands. At 4:50pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. At 4:50pm, the QIDP indicated client D was blind and he (the QIDP) was unsure if client D was in pain.</p>	W 331	<p>The IDT will convene to discuss client D's medical concerns.</p> <p>The Home Manager and Program Nurse will have client D go to the Primary Care physician for a referral to a possible dermatologist to determine if any additional health issues can be ruled out.</p> <p>The Direct Support Staff will be retrained on the PRN medications for each client.</p> <p>The direct support staff will be retrained on the weekly documentation of skin integrity/assessments and open wounds for all clients, but especially for client D in particular.</p> <p>The Program Nurse will work with the Program Director (QIDP) to create a pain assessment for client D and F. All direct care staff will be retrained on these pain assessments.</p> <p>For the first four weeks, the Home Manager, Program Director, and/or Program Nurse will complete three (3) weekly medication administration observations with each client as specified for four (4) weeks. These will then be reviewed by the Program Director ensuring that there are no further training needs.</p>	04/18/2015

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	<p>The QIDP stated client D "had over fifteen (15) scabs and red areas" on client D's face and head areas on his skin. The QIDP indicated he (the QIDP) was "unsure" how client D expressed pain. The QIDP indicated client D did not have a pain assessment available for staff to use to determine if client D was in pain. From 4:20pm until 6:25pm, clients D and F were non verbal and did not communicate with facility staff. At 5:40pm, GHS #2 administered client D's evening medications and did not offer as needed pain medication or three (3) different as needed cream medications for itching/scratching and open/scabbed areas.</p> <p>On 3/11/15 at 6:00pm, GHS #2 stated she "had never seen [clients D and F] in pain." GHS #2 stated she was "unsure how [clients D and F] expressed pain" and/or discomfort. GHS #2 indicated clients D and F scratched themselves which left open skin areas. GHS #2 indicated clients D and F did not have pain assessments available for review and indicated client D did not have a tracking sheet to document his open areas. GHS #2 stated the areas were from "his behaviors." GHS #2 indicated she was unsure if client D's open/scabbed skin areas should be recorded.</p>		<p>After the initial four (4) weeks, the Home Manager and/or Program Director will complete two (2) weekly medication administration observations for four (4) additional weeks, and will ensure that all needed retrainings will be completed.</p> <p>After the additional four (4) weeks, the Home Manager and/or Program Director will complete weekly medication administration observations ongoing, and will ensure that all needed retrainings will be completed.</p> <p>Responsible Party: Home Manager, Program Director, and Program Nurse</p>		

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	<p>On 3/12/15 at 11:00am, an interview with the QIDP was conducted. The QIDP indicated clients D and F were non verbal. The QIDP indicated he had spoken with the nurse who indicated clients D and F did not have pain assessments available for review. The QIDP indicated client D did not have his open red areas and scabbed skin areas documented. The QIDP indicated clients D and F should have their pain documented and their skin areas documented. The QIDP indicated the agency nurse was not aware of client D's open red and scabbed skin areas to his face and head.</p> <p>Client D's record was reviewed on 3/12/15 at 11:45am. Client D's 10/16/14 ISP (Individual Support Plan) did not identify client D having the potential for pain. Client D's 12/2014 nursing review did not address client D's pain. Client D's 1/6/15 Physician's Order and 3/2015 MAR (Medication Administration Record) both indicated "Triamcinolone 0.1% cream, apply topically to skin daily as needed for itching, Halobetasol Prop (Propionate) 0.05% cream, apply topically to red areas as needed for itching, Desoximetasone 0.25% cream, apply to back, neck, and right thigh twice daily as needed for recurrence of dry, red, scaly, itching skin, Ammonium Lactate</p>			

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	<p>12% cream, apply to dry skin twice daily as needed, Clindamycin Phosp (Phosphate) 1% lotion, apply 2 times a day to affected areas (administered at 7am and 9pm), weekly skin assessment call nurse if any open areas every Saturday, Assess trim and file fingernails weekly to prevent impaired skin integrity every Saturday." Client D's record did not indicate "as needed" creams had been administered to client D. Client D's record indicated he used over the counter Acetaminophen 325mg (milligrams) for pain. Client D's 6/16/10 "Impaired Skin Integrity Protocol" indicated staff were to monitor client D for "open areas to the skin" and "pain." No information was available for review to determine if client D was in pain.</p> <p>Client F's record was reviewed on 3/12/15 at 10:25am. Client F's 8/29/14 ISP indicated he was non verbal and did not express his wants/needs. Client F's ISP did not identify client F had the potential for pain. Client F's 12/2014 nursing review did not address client F's pain and use of pain medication. Client F's 1/6/15 Physician's Order and 3/2015 MAR both indicated "Arthritis Pain 650mg/Tylenol Arthritis Caplet, give 1 tablet by mouth every 6 hours as needed for Osteoarthritis knee pain, Ibuprofen 800mg tablet, take one tablet by mouth</p>			

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W 368 Bldg. 00	<p>every 8 hours as needed for pain" Both medications had not been administered to client F. Client F's 6/16/10 "Impaired Skin Integrity Protocol" indicated staff were to monitor client F's "skin for open areas, discolorations, itching, pain, and/or decreased sensation." The protocol indicated "Signs/Symptoms...pain." No information was available for review to help determine if client F was in pain.</p> <p>This deficiency was cited on 2/4/2015. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00159314.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on observation, record review, and interview, for 1 of 13 medications administered (for client D), the facility failed to administer medications without error and as prescribed by client D's personal physician.</p> <p>Findings include:</p>	W 368	<p>All staff will be retrained on medication administration, including ensuring client's health and safety according to their Individualized Support Plan.</p> <p>All direct care staff will be retrained on passing all client's medications appropriately according to their Individualized Support Plan.</p>	04/18/2015

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	<p>On 3/11/15 at 5:40pm, GHS #2 selected client D's oral medications of Calcium Carbonate for nutritional supplement and Omeprazole for acid reflux. GHS #2 punched each tablet into a medication cup, crushed client D's Calcium Carbonate tablet, and poured the crushed calcium tablet into client D's apple sauce. GHS #2 then poured client D's Omeprazole capsule whole and did not open the capsule into the same apple sauce containing the crushed Calcium Carbonate. At 5:40pm, GHS #2 left the medication room carrying the apple sauce with the medications, walked to the living room, and administered the mixture with a spoon to client D who sat in a recliner. At 5:45pm, client D's 3/2015 MAR (Medication Administration Record) indicated "Calcium Carb (Carbonate) 600/400D take one tablet by mouth twice daily for Osteoporosis, crush and put in pudding or apple sauce)" and "Omeprazole 20mg (milligrams) capsule, take one capsule by mouth twice daily for Reflux, mix in pudding or apple sauce."</p> <p>On 3/12/15 at 11:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client D had physician's orders for his medications to be crushed, his capsule should have been</p>		<p>For the first four weeks, the Home Manager, Program Director, and/or Program Nurse will complete three (3) weekly medication administration observations to ensure that the medication are being appropriately administered for each client as specified in their ISP for four (4) weeks.</p> <p>After the initial four (4) weeks, the Home Manager and/or Program Director will complete two (2) weekly medication administration observations for four (4) additional weeks, and will ensure that all needed retrainings will be completed.</p> <p>After the additional four (4) weeks, the Home Manager and/or Program Director will complete weekly medication administration observations ongoing, and will ensure that all needed retrainings will be completed.</p> <p>Responsible Party: Home Manager, Program Director, and Area Director</p>	

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W 436 Bldg. 00	<p>opened and put into apple sauce or pudding because client D was at risk to choke. The QIDP indicated client D should not have received his Omeprazole capsule whole. The QIDP indicated the facility followed Core A/Core B Living in the Community policy and procedure for medication administration.</p> <p>Client D's record was reviewed on 3/12/15 at 11:45am. Client D's 11/6/15 Physician's Order and 3/2015 MAR (Medication Administration Record) both indicated "Calcium Carb (Carbonate) 600/400D take one tablet by mouth twice daily for Osteoporosis, crush and put in pudding or apple sauce)" and "Omeprazole 20mg (milligrams) capsule, take one capsule by mouth twice daily for Reflux, mix in pudding or apple sauce."</p> <p>On 3/12/15 at 11:00am, a record review of the facility's 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good</p>			

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	<p>repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 2 of 3 sampled clients (clients A and F) with adaptive equipment, the facility failed to have available, teach, and encourage clients A and F to wear their prescribed hearing aids.</p> <p>Findings include:</p> <p>On 3/11/15 from 4:20pm until 6:25pm, observation was conducted at the group home and clients A and F did not wear their prescribed hearing aids. During the observation period clients A and F were not taught or encouraged to wear their prescribed hearing aids. During the observation period clients A and F watched television, completed medication administration, and sat in the living room. At 6:08pm, GHS (Group Home Staff) #1 indicated client A was hard of hearing and refused to wear his hearing aids. GHS #1 indicated clients A and F had hearing aids and staff kept both clients A and F's hearing aids secured inside the staff filing cabinet. At 6:08pm, GHS #1 and GHS #2 located client A's hearing aid inside the staff filing cabinet</p>	W 436	<p>All Direct Care Staff will be retrained on Indiana MENTOR's policy and procedure for ensuring the individuals are using/encouraged to use adaptive equipment as prescribed.</p> <p>This retraining will include using the adaptive equipment, prompting the client's to properly use the equipment, and what to do when they refuse.</p> <p>The Program Director will be retrained on including a formal training objective for those individuals who refuse/need desensitization.</p> <p>The Program Director will complete a training objective for clients A and F for use of their hearing aids as prescribed.</p> <p>The Program Director will complete a training objective for client B for use of their glasses as prescribed.</p> <p>The Home Manager will remove the adaptive equipment from the locked cabinet, and place it in a location that is accessible to the client.</p> <p>Ongoing, the Home Manager and/or Program Director will complete random Active Treatment observations three times per week for the first four weeks, and then once a week on going to ensure that all adaptive equipment is used</p>	04/18/2015

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	<p>and did not prompt or encourage client A to wear his hearing aid. GHS #1 and GHS #2 both indicated they could not locate client F's hearing aids. GHS #1 and the QIDP (Qualified Intellectual Disabilities Professional) both indicated the group home staff had signed client F's 3/2015 MAR (Medication Administration Record) to indicate client F's hearing aid was cleaned and the battery was checked "daily" from 3/1/15 through 3/11/15. GHS #1 indicated client F had not had his hearing aid available to him.</p> <p>On 3/12/15 at 10:00am, client A's record was reviewed. Client A's 8/18/14 ISP (Individual Support Plan) and 8/2014 CFA (Comprehensive Functional Assessment) indicated client A wore prescribed hearing aids. Client A's ISP indicated a goal/objective for client A to hold his hearing aids for one minute. Client A's 3/31/14 "Audiology" assessment indicated "Reason for visit: Hearing Aids." The audiology assessment indicated client A was fitted for a left ear hearing aid and the care and maintenance of the aid were reviewed.</p> <p>On 3/12/15 at 10:25am, client F's record was reviewed. Client F's 8/29/14 ISP indicated client F was prescribed hearing aids and refused to wear them. Client F's ISP did not indicate a goal/objective to</p>		<p>properly.</p> <p>Ongoing the Home Manager and/or Program Director will complete random documentation reviews three times per week for the first four weeks, and then once a week on going to ensure that all adaptive equipment is used properly.</p> <p>Responsible Party: Home Manager and Program Director.</p>	

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	<p>teach client F to wear his prescribed hearing aids. Client F's 2/29/12 Hearing evaluation indicated he wore prescribed hearing aids.</p> <p>On 3/12/15 at 11:00am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated clients A and F wore prescribed hearing aids to hear. The QIDP indicated clients A and F should have been taught and encouraged to wear their prescribed hearing aids during informal opportunities. The QIDP indicated client A and F's hearing aids should have been accessible for clients A and F and not secured inside the locked medication cabinet.</p> <p>This deficiency was cited on 2/4/2015. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-7(a)</p>			