STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REM-INDIANA INC	860 W 65TH LN MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00407643 and complaint #IN00408581. Complaint #IN00407643: Federal and State deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W154, and W156. Complaint #IN00408581: Federal and State deficiencies related to the allegation(s) are cited at W102, W104, W122, W125, W149, W153, W154, and W156. Dates of Survey: May 22, 23, 24, 25, 26, 30, 31, June 1, 2, and 5, 2023. Facility Number: 001113 Provider Number: 15G599 Aims Number: 100245610 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 6/14/23.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review, and interview for 2 of 3 sample clients (A and B), the governing body failed to meet the Condition of Participation: Governing Body. The governing body failed to assess client A's legal and guardianship needs in regards to her health care	W 0102	The governing body and management exercises general policy and operating direction over the facilities condition of participation, policy, procedure, and implementation of assessing	07/05/2023

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

Lindsey Van Dyken | Area Director | 06/30/2023

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	needs, to implement its policy and procedure to prevent, report, and thoroughly investigate a change of condition and an injury of unknown origin for client A and an allegation of neglect for client B. Findings include: 1. The governing body failed to implement its policy and procedure to prevent, report, and thoroughly investigate a change of condition and an injury of unknown origin for client A and an allegation of neglect for client B. Please see W104. 2. The governing body failed to meet the Condition of Participation: Client Protections for 2 of 3 sample clients (A and B). The governing body failed to assess client A's legal status and the appropriateness of guardianship to ensure her health care needs would be met, to implement its policy and procedure to prevent, report, and thoroughly investigate a change of condition and an injury of unknown origin for client A and an allegation of neglect for client B, to immediately report a change of condition and an unwitnessed fall for client A to facility administration in accordance with state law, to thoroughly investigate an injury of unknown origin for client A and an allegation of neglect for client B, and to report findings of an investigation for an injury of unknown origin for client A and an allegation of neglect for client B to administration within 5 business days. Please see W122. This federal tag relates to complaint #IN00407643 and complaint #IN00408581. 9-3-1(a)		legal guardianship needs in regards to health care needs; preventing, reporting, and thoroughly investigating changes in condition, injuries of unknown origin, and allegations of neglect. Re-training of written policy and procedures will occur prior to 7/5/23 with direct support staff, and management to prevent, thoroughly investigate, and develop corrective measures regarding medical needs, including changes in condition, injuries of unknown origin, neglect of clients, and all needs regarding client protections. Re-training on immediate reporting of all incidents; including injuries of unknown origin, suspected and observed falls, and ALL changes in condition including medical, behavioral, and psychiatric. All reports will be reviewed by IDT team to ensure individual needs are being communicated and immediately addressed. Responsible Person: Regional Director, Area Director, Program Director, Quality Improvement, Nursing, and Behavior.	

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W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview for 2 of 3 sample clients (A and B), the governing body failed to implement its policy and procedure to prevent, report, and thoroughly investigate a change of condition and injury of unknown origin for client A and an allegation of neglect for client B. Findings include: 1. The governing body failed to implement its policy and procedure to prevent, report, and thoroughly investigate a change of condition and injury of unknown origin for client A and an allegation of neglect for client B. Please see W149. 2. The governing body failed to ensure facility staff immediately reported a change of condition and an unwitnessed fall for client A to facility administration in accordance with state law. Please see W153. 3. The governing body failed to thoroughly investigate an injury of unknown origin for client A and an allegation of neglect for client B. Please see W154. This federal tag relates to complaint #IN00407643 and complaint #IN00408581. 9-3-1(a)	W 0104	The governing body and management exercises general policy, and operating direction over the facilities training and review of individuals served change of condition, injuries of unknown origin; including unwitnessed falls, and all allegations of Abuse/Neglect/Exploitation, Direct Support Staff and Management will all be re-trained on immediate reporting of all incidents; including injuries of unknown origin, suspected and observed falls, and ALL changes in condition including medical, behavioral, and psychiatric. Retraining will include competency based testing to ensure staff comprehension of expectations. The Program Supervisor and Program Director will complete weekly in home checks to observe DSP active compliance with re-trainings. Responsible Person: Regional Director, Area Director, Program Director, Program Supervisor	07/05/2023
W 0122	483.420(a) CLIENT PROTECTIONS			

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Bldg. 00	The facility must ensure the rights of all clients. Therefore the facility must Based on observation, record review, and interview, the facility failed to meet the Condition of Participation: Client Protections for 2 of 3 sample clients (A and B). The facility failed to assess client A's legal status and the appropriateness of guardianship to ensure her health care needs would be met, to implement its policy and procedure to prevent, report, and thoroughly investigate a change of condition and an injury of unknown origin for client A and an allegation of neglect for client B, to immediately report a change of condition and an unwitnessed fall for client A to facility administration in accordance with state law, to thoroughly investigate an injury of unknown origin for client A and an allegation of neglect for client B, and to report findings of an investigation for an injury of unknown origin for client A and an allegation of neglect for client B to administration within 5 business days. Findings include: 1. The facility failed to assess client A's legal status and the appropriateness of guardianship to ensure her health care needs would be met. Please see W125. 2. The facility failed to implement its policy and procedure to prevent, report, and thoroughly investigate a change of condition and an injury of unknown origin for client A and an allegation of neglect for client B. Please see W149. 3. The facility failed to ensure staff immediately reported a change of condition and an unwitnessed fall for client A to facility	W 0122	The governing body and management exercises general policy, and operating direction over the facilities responsibility to provide client protections through training and review of individuals served change of condition, injuries of unknown origin; including unwitnessed falls, and all allegations of Abuse/Neglect/Exploitation, Direct Support Staff and Management will all be re-trained on immediate reporting of all incidents; including injuries of unknown origin, suspected and observed falls, and ALL changes in condition including medical, behavioral, and psychiatric. Retraining will include competency based testing to ensure staff comprehension of expectations. The Program Supervisor and Program Director will complete weekly in home checks to observe DSP active compliance with re-trainings. Responsible Person: Regional Director, Program Director, Area Director, Program Supervisor	07/05/2023

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	administration in accordance with state law. Please see W153. 4. The facility failed to thoroughly investigate an injury of unknown origin for client A and an allegation of neglect for client B. Please see W154. 5. The facility failed to report findings of an investigation for an injury of unknown origin for client A and an allegation of neglect for client B to administration within 5 business days. Please see W156. This federal tag relates to complaint #IN00407643 and complaint #IN00408581. 9-3-2(a)			
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review, and interview for 1 of 3 sample clients (A), the facility failed to assess client A's legal status and the appropriateness of guardianship to ensure her health care needs would be met. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) Reports and related investigations were reviewed on 5/22/23 at 1:26 pm.	W 0125	The governing body and management exercises general policy, and operating direction over the facilities responsibility to provide client protections through training and review of individuals served change of condition, injuries of unknown origin; including unwitnessed falls, and all allegations of Abuse/Neglect/Exploitation, Direct Support Staff and	07/05/2023

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	1. A BDDS report dated 4/23/23 indicated the following: "Direct Support Professional (DSP) [#6] called [Qualified Intellectual Disabilities Professional (QIDP) #1] to report changes in [client A's] behavior and condition: she was presenting as lethargic, having difficulty walking, and was unusually quiet. [QIDP #1] instructed [DSP #6] to call on-call nurse and observe her. [DSP #4] called to report that they had taken [client A's] vitals (blood pressure: 107/60, heart rate 72, oxygen 94, blood sugar 140), and also that [client A's] lips had developed a bluish tint. [QIDP #1] instructed [DSP #4] to take [client A] to [hospital] ER (emergency room). [QIDP #1] drove to meet [DSP #4] at the hospital and called [client A's] guardians to inform them of the situation. [Client A] received a CT (computerized tomography) scan to check for a stroke and took blood and urine samples for testing. An examination of her left leg showed an untreated fracture estimated to be from December, before she came into the care of Indiana Mentor. [Client A] was admitted for continued observation." An observation was conducted in client A's hospital room on 5/23/23 from 11:36 am to 11:45 am. Client A was reclined in her hospital bed with restraints on both forearms. Client A appeared lethargic and was difficult to understand. Client A repeatedly asked for coffee. When asked about her injury, client A indicated she did not know what happened to her leg. When asked if she fell, client A stated, "I don't remember." Registered Nurse Manager (RNM) #1 assisted the surveyor in examining client A's left leg. RNM #1 indicated client A had an incision with staples in her left knee, another incision with 3 staples 3 inches below the left knee and slightly to the		Management will all be re-trained on immediate reporting of all incidents; including injuries of unknown origin, suspected and observed falls, and ALL changes in condition including medical, behavioral, and psychiatric. Retraining will also cover calling 911 for immediate medical services and transportation instead of staff transporting individuals to the hospital and will include competency based testing to ensure staff comprehension of expectations. The Program Supervisor and Program Director will complete weekly in home checks to observe DSP active compliance with re-trainings. Responsible Person: Regional Director, Program Director, Area Director	

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	inside of the shin, and 3 separate incisions with staples around her left ankle. Client A's hospital records were reviewed on 5/23/23 at 11:45 am and indicated the following: A note entered by Hospital Registered Nurse (HRN) #2 dated 4/23/23 at 9:33 am indicated the following: "Pt (Patient's) lower leg is shortened and externally rotated. Pt does not have any pain when she moves her leg - left lower skin has area of palpable deformity. MD (physician) aware. X-ray ordered." A note entered by Physician Assistant #1 dated 4/23/23 at 10:12 am indicated the following: "X-ray shows distal tibia and proximal fibula fracture which are likely new. No hip fracture. I spoke to [surgeon #1] who accepts consult. Patient will be placed in a splint.... She will need admission." A note entered by Surgeon #1 dated 5/1/23 indicated the following: "Postoperative Diagnosis: Displaced spinal fracture of the left distal tibial metaphysis (growth plate in the lower part of the shin bone). Procedure: Intramedullaryl nail fixation (used to fix fractures) of the left tibia...." Client A's hospital physician notes dated 5/25/23 indicated the following: 4/23/23 at 2:18 pm by ER RN #1: "Spoke with [guardian #1] pt's POA (Power of Attorney) and brother. [Guardian #1] gave consent for his daughter-in-law [relative #2] to be able to discuss all aspects of care and medical treatment plan. Update on plan for admission - all questions answered."			

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	4/23/23 at 2:52 pm by ER RN #1: "Spoke with brother [guardian #1] - updated on plan of care. Pt. resting in bed. Staff remains at bedside." 4/23/23 at 7:43 pm: The review indicated client A was transferred from the Emergency Room and was admitted to the hospital. 4/25/23 by MD #1: "Plan of care for the next 24 hours: Plan was surgery given spinal fracture. Patient's brother [guardian #1] has requested transfer to [hospital #2] in [town] where patient received electroconvulsive therapy (ECT) he wants the patient transferred to [hospital #2] to receive her surgery there and continue electroconvulsive therapies. Consult case manager to help with transfer. However, I did explain to [guardian #1] that orthopedic surgeon (sic) are available at this facility to do the surgery, and there is no higher level of care required. He understands and still wants the patient to be transferred." 4/26/23 by MD #1: "Pt seen and examined. Pt is alert, complains of leg pain." "Plan of Care for the next 24 hours: ...[Guardian #1] understands that the surgery might be delayed as transfer cam (sic) take time. He still wants the patient to be transferred." 4/27/23 by MD #1: "Patient is alert. She complains of leg pain." 4/28/23 by MD #1: "Patient is alert. She complains of leg pain and is asking when will the surgery be done. I explained to her that her brother has requested the transfer and does not want surgery at this facility. Will consult ethics committee to help this case." 4/28/23 by MD #2: "Pt is awake and confused and states that her left leg hurts. Possible transfer to [hospital #2]. Case discussed with nurse." 4/29/23 by MD #2: "Patient is awake and alert. Pleasantly confused. Transfer to [hospital #2] in process. Complains of left leg pain. Order Norco			

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	(pain reliever) 5/325 mg (milligrams) PO (by mouth) every 6 hours as needed." 4/29/23 by MD #1: "Patient is alert. She complains of leg pain and is asking when will the surgery be done. I explained to her that her brother has requested the transfer and does not want surgery at this facility. No new complaints at this time. Vision is normal. She can count fingers appropriately. Although complains of vision problems." Plan of Care for the next 24 hours: ..."Patient remains in pain everyday on my evaluation and wants the surgery to be done." 4/30/23 by MD #1: "Patient is alert. She complains of leg pain and is asking when will the surgery be done. I explained to her that her brother has requested the transfer and does not want surgery at this facility. Patient feels that her surgery is being delayed...." 5/1/23 by MD #1: "Patient is alert. Complains of left leg pain." "Plan of Care for the next 24 hours: ...Patient brother has agreed for doing surgery at this hospital." 5/2/23 by Surgeon #1: "Patient has no complaints today. Patient reports that she has improved since the last assessment I performed and denies any pain today...." 5/3/23 by MD #2: "Awake and alert. Able to make needs known. Physical therapy in process. Tolerating well. Remains on Norco and Morphine for pain. Tolerating well. Lab and imaging reviewed. Discharge planning in process. Discussed wit (sic) nurse. Will continue supportive care." 5/4/23 by MD #2: "Patient at baseline mentally. Pain control with Norco. Discharge plan for home tomorrow with family. Discussed with nursing. Continue supportive care." 5/9/23 by MD #1: "Patient seen and examined alert and awake. Leg pain is improving. No other complaints. Plan of Care for the next 24 hours:			

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	Continue PT/OT (physical therapy/occupational therapy). Discharge to SNF (skilled nursing facility) when social issues are resolved. SW (social worker) on case." 5/15/23 by MD #2: "Awake and alert. Patient not qualify for the in-house rehab. Possible discharge to SNF for rehab. Social worker on the case. Lab imaging reviewed. Discussed with nurse. Okay to discharge on neuro stand point." 5/16/23 by MD #1: "Transfer to ortho floor." 5/19/23 by MD #2: "Awake and alert. [Guardian #1] at bed side. [Guardian #1] requesting patient to see dentist due to denture and having problem chewing her food. Nurse made aware to consult dietician and social worker. [Guardian #1] states patient has (ECT) for many years at [hospital #2] and would like patient transferred to [hospital #2]. Case worker to follow up." Client A's hospital case management notes dated 5/25/23 indicated the following: 4/25/23 at 4:28 pm: "Writer s/w (spoke with) MD for further information on consult. Provider communicated this consult is a family request and not because higher level of care not (sic) indicated at this time. MD further communicates pt was planned for surgery with [surgeon #1], but [guardian #1] requested transfer. MD communicates she did speak w/ [guardian #1] regarding this request." 4/25/23 at 4:31 pm: "Call to brother x2 (second time) to further discuss transfer and that when family request transport chart (charge) is subject to self pay (pt/family) and up front payments. No answer." 4/25/23 at 4:32 pm: "Call to [ambulance company] for estimate to process regarding when transfer is a pt/family request. Information received as below regarding ambulance transport when it's a family request:			

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	'Insurance will not cover a family request; cost is out of pocket.'" 4/25/23 at 4:36 pm: "Third attempt to [guardian #1] to discuss further. No answer. Need to s/w brother to address further information." 4/26/23 at 12:16 pm: "Call to [guardian #1] regarding the transfer request from 4/25/23. [Guardian #1] confirmed he requested transfer to [hospital #2] r/t surgery and [guardian #1] also verbalizes possible interest in ECT and had ECT there before.... [Guardian #1] informed writer will make call attempt to transfer center now and call brother back s/p to update of information received. [Guardian #1] communicated understanding and agreement of information discussed." 4/26/23 at 12:22 pm: "Writer spoke with [hospital #2] to inform of request for transfer. Writer was then informed, 'No beds right now. May call back in 6 hours.'" 4/26/23 at 12:32 pm: "Writer called and updated [guardian #1]." 4/26/23 at 5:45 pm: "On-call social worker received a call to place transportation on hold with [ambulance company] in the event they receive a bed at [hospital #2]. Nurse will call with pick up time if bed is received. Medical necessity form faxed. Family will be responsible for cost of the transportation since the transfer is family request. Continue with discharge planning." 4/27/23 at 1:01 pm: "Call received from [guardian #1]. He states that [name] informed him that there are beds at [hospital #2]. He states that writer should call her to facilitate a transfer. Writer call to [number]. This is a fax number. Writer called [hospital #2]. Spoke to [name], informed that there is no transfer started for this patient, and they are not willing to start a new transfer case because they are full with people in house waiting on beds. Writer encouraged to call back in 6			

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	hours." 4/28/23 at 9:48 am: "Spoke with [hospital #2] representative at [number] who stated that they are at capacity and have several people waiting in their queue for transfer and are not accepting outside transfers at this time. He suggested to check back in 4 to 6 hours." 4/28/23 at 12:38 pm: "Social worker acknowledged consult for APS (Adult Protective Services). Social worker tried to contact APS investigator, no answer, voicemail left.... 4/28/23 at 2:13 pm: "APS investigator contacted social worker.... APS investigator advised social worker to contact Indiana Mentor for more information.... [AD #1] also stated they have medical rights pertaining to appointments but not decisions on surgery and things of that nature, but they are currently talking with the state to see if they have any rights to make medical decisions and will call social worker with information. Social worker will follow." 4/28/23 at 2:13 pm: "Spoke to [name] at [hospital #2] who stated that they are at capacity and have several people waiting in their queue for transfer and are not accepting outside transfers at this time. She suggested to check back tomorrow." 5/3/23 at 10:12 am: "Social worker tried to contact [APS investigator #2] in regards to pt's case. No answer, voicemail left, social worker will follow." 5/4/23 at 1:35 pm: "Social worker tried to contact [APS investigator #2] in regards to pt's case. No answer, voicemail left, social worker will follow." 5/4/23 at 3:17 pm: "[APS investigator #2] contacted social worker and stated that herself, her director, and their legal team are still discussing pt's case and will call back on Monday (5/8/23) with updates. Social worker will follow." 5/9/23 at 10:19 am: "Social worker tried to contact [APS investigator #2] in regards to pt's case. No answer, voicemail left, social worker will follow."			

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	5/10/23 at 4:16 pm: "Social worker tried to contact [APS investigator #2] in regards to pt's case. No answer, voicemail left, social worker will follow." 5/12/23 at 4:22 pm: "Received telephone call from [APS investigator #2] stating that patient is under the guardianship of [guardian #1], and [guardian #1] can make all decisions. If the hospital feels that [guardian #1] is not making correct decisions, hospital can contact APS, but, at this time, [APS investigator #2] states that she was told [guardian #1] is making a decision for rehab post hospitalization." 5/15/23 at 11:00 am: "Case discussed in unit (meeting). Patient is not a good candidate for acute inpatient rehab. [Guardian #1] to choose SNF for continued therapy...." 5/15/23 at 3:39 pm: "Message left for guardian requesting the name of the facility guardian would like patient sent to. Awaiting telephone call back." 5/16/23 at 10:23 am: "Patient transferred from [5th floor to 3rd floor]. Patient is from a group home and will (need) skilled care. Patient will require PASRR (pre-admission screening and resident review) completed. Patient will need continued therapies. Continue with discharge planning." 5/16/23 at 4:14 pm: "Messages have been left for [guardian #1] to return call to social services to discuss discharge planning. Continue with discharge planning." 5/16/23 at 7:03 pm: "PASRR completed and submitted for review. Continue with discharge planning." 5/17/23 at 3:11 pm: "PASRR/Level 2 representative contacted social worker and stated she will be doing an onsite assessment of pt today. Social worker notified unit nurse, social worker will follow." 5/18/23 at 1:55 pm: "Social worker contacted pt's brother and sister-in-law (guardian #2) regarding			

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	SNF placement. [Guardian #1] was very hostile and upset that social worker didn't know the certifications/degrees of all staff at [SNF #1]. [Guardian #2] was able to calm down [guardian #1] and asked for social worker to email SNF list. Social worker emailed list, social worker will follow." 5/22/23 at 2:34 pm: "[Guardian #1] contacted social worker and stated that he wants pt transferred to [hospital #2], and he has already talked with [hospital #2] about transfer. Social worker notified unit nurse and case manager." Client A's hospital multidisciplinary notes dated 5/25/23 indicated the following: 4/24/23 at 9:45 am: "Writer spoke with [QIDP #1] from Indiana Mentor.... Writer informed him that the patient has 2 left leg fractures, and we are waiting for the surgeon to make a plan for surgery if necessary. [QIDP #1] asked if it would be possible to have a bone density scan while here at [hospital #1]. Writer will pass on to [doctor]. [QIDP #1] also mentioned that the patient has old left leg fractures, one from December 2022 and another from February 2023...." 4/24/23 at 10:23 am: "[Guardian #1] called for an update. Writer informed him the patient has a spiral fracture of the left tibia, and we are waiting for a surgical plan from [surgeon #1]. [Guardian #1] stated he and his wife are currently in [state] and would like to be notified as soon as there is a plan, so that he can fly home to be here for surgery.... Writer notified [guardian #1] that I spoke with [QIDP #1] from Indiana Mentor, and she stated that the patient has old left leg fractures, one from December 2022 and another from February 2023. [Guardian #1] said that is not true. [Guardian #1] stated that they took [client A] to the ER and had x-rays taken, but there was no fracture. [Guardian #1] mentioned that he and			

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	his wife are not happy with this current group home, and they are unsure about sending [client A] back there upon discharge. [Guardian #1] stated that the patient is absolutely not to have surgery until he is here in [state]. He will be on a flight home from [state] Tuesday (4/25/23) morning and will be coming straight to the hospital." 4/25/23 at 9:21 am: "Writer spoke to [guardian #1]. He does not want the patient to have the planned ORIF surgery tomorrow. He wants the patient transferred to [hospital #2] to have surgery there. He said the patient had received Electroconvulsive therapy there in the past, and he wants her transferred to have ECT therapy again, and to have the ORIF and then to receive therapy after surgery. [Guardian #1] would like to speak to [doctor] to make a plan moving forward...." 4/25/23 at 3:34 pm: "Writer notified [surgeon #1] that [guardian #1] will be traveling home from [state] tonight and will be at patient's bedside tomorrow morning. [Surgeon #1] stated to keep patient NPO (nothing by mouth) tonight, and he will come in and talk to [guardian #1] in person in the morning to try to get him to agree to surgery." 4/25/23 at 6:49 pm: "Writer called [guardian #1] and left a voicemail notifying him that [surgeon #1] will be up on the floor early in the AM (probably around 7:00, and would like to speak to him at the patient's bedside." 4/26/23 at 8:00 am: "[Surgeon #1] in to see patient, stated to keep patient NPO, is aware of brother wanting to transfer pt to [hospital #2]." 4/26/23 at 12:43 pm: "[Guardian #1] called for update, informed him the surgeon was calling him this morning to see if he could do surgery. He stated she is not having surgery here. Does not want it here. She will go to [hospital #2]. Called [surgeon #1], left message to notify him of what			

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	her brother said and to ask if I could let her eat." 4/30/23 at 8:10 am: "Writer set patient up for breakfast. Patient said, 'I don't want that. I am not hungry.' Writer notified her that she did not eat yesterday either. Patient said, 'I don't want to eat. I feel like I am gonna die.' Writer notified patient that she needs to eat to get stronger. Patient said, 'My brother don't like me. We fight all the time.' Writer was able to get patient to drink her whole milk and half the [supplement]. Patient said, 'Leave me alone now please.' 4/30/23 at 10:02 am: "Patient complaining of pain to left lower leg. Patient stated, 'It hurts real bad.' PRN (as needed) Norco given for pain. Patient repositioned and leg propped on pillows. Will continue to monitor." 4/30/23 at 4:29 pm: "[Guardian #1] here visiting and writer had a conversation with him about how delaying surgery of the left tibia is affecting the patient. Writer informed him the patient is depressed and not eating and is getting weaker every day. [Guardian #1] agreed to let [surgeon #1] do the surgery tomorrow. Writer called [surgeon #1] and notified him. [Surgeon #1] said to have patient NPO at midnight, and he will add the patient for Monday (5/1/23). Time unknown. Writer also notified [surgeon #1] that I will get the consent signed for surgery...." 4/30/23 at 4:54 pm: "Consent is signed for surgery Monday (5/1/23) and is in the patient's chart." 5/1/23 at 8:23 pm: "Patient came back at 8:00 pm from having ORIF surgery. Received patient alert, oriented, and talking. Surgical nurse requested for dressing supplies to reinforce surgical dressing as it was saturated with blood. Supplies provided. Will continue to monitor." 5/13/23 at 9:41 am: "[Doctor] here rounding and spoke about discharge planning. Writer notified her that patient is working with PT/OT 3 times per week and is unable to stand for 30 seconds at a			

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	time. [Doctor] stated that social work is working on SNF placement for therapy...." 5/14/23 at 1:43 pm: "Pt has BM (bowel movement), digs in it, smear on self, bed, railing, bedside table and throws across room. Bilateral restraints applied, notified [doctor]." 5/19/23 at 1:58 am: "Pt digging in rectum. Stool stuck under nails, smeared on bed rails and sheets." 5/19/23 at 10:09 am: "Telephone call to [guardian #1] regarding medication that needs to be refilled, left message." Regional Director (RD) #1 was interviewed on 6/5/23 at 9:00 am and stated, "We had an IDT (Interdisciplinary Team) meeting with BDDS and the guardian to address some issues between the guardian and staff. We discussed the hospitalization with [guardian #1], and he was adamant that he would not allow the surgery to happen until [client A] was transferred to [hospital #2] for shock therapy." RD #1 stated, "We were blocked from a lot of communication (since 5/1/23)." RD #1 stated, "[Guardian #1] requested we send all of her possessions to them to remove her from services. We are trying to set up an IDT to make sure she has all of her prescriptions and medications, and he has not responded." Hospital Social Worker (HSW) #1 was interviewed on 5/23/23 at 11:54 am and stated, "[Guardian #1] wanted [client A] to go to [hospital #2] for shock therapy. There were not beds available. The doctor had an ethics committee meeting to discuss the delay of care. [Guardian #1] finally gave consent when APS (Adult Protective Services) got involved." HSW #1 stated, "We're trying to get her to a skilled nursing facility for rehab. [Guardian #1] was angry because he			

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	wanted to know the certifications for all of the staff of each nursing home." HSW #1 stated, "[Guardian #1] wants her in a locked room. It's not necessary." HSW #1 stated, "The doctors have cleared her to be discharged. We're waiting for the guardian to choose a facility." HSW #1 stated, "We have notified APS of the delay of care." HSW #1 was interviewed by phone on 6/1/23 at 2:45 pm and indicated client A was still in the hospital. HSW #1 indicated client A had been hospitalized for 38 days. HSW #1 indicated there was no medical reason for client A to be in the hospital. RNM #1 was interviewed on 5/23/23 at 11:45 am. After consulting surgeon #1 by phone, RNM #1 stated, "There has been a delay of care." RNM #1 stated, "[Surgeon #1] said [client A] would have had a better chance of being able to walk again if she'd had the surgery sooner rather than later." This federal tag relates to complaint #IN00408581. 9-3-2(a)			
W 0149 Bldg. 00	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 2 of 2 allegations of abuse and neglect reviewed, the facility failed to implement its policy and procedure to prevent, report, and thoroughly investigate a change of condition and an injury of unknown origin for client A and an allegation of neglect for client B.	W 0149	The facility has and implements written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Direct Support Staff and Management will all be re-trained on immediate reporting of all incidents; including injuries of	07/05/2023

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	Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) Reports and related investigations were reviewed on 5/22/23 at 1:26 pm. 1. A BDDS report dated 4/23/23 indicated the following: "Direct Support Professional (DSP) [#6] called [Qualified Intellectual Disabilities Professional (QIDP) #1] to report changes in [client A's] behavior and condition: she was presenting as lethargic, having difficulty walking, and was unusually quiet. [QIDP #1] instructed [DSP #6] to call on-call nurse and observe her. [DSP #4] called to report that they had taken [client A's] vitals (blood pressure: 107/60, heart rate 72, oxygen 94, blood sugar 140), and also that [client A's] lips had developed a bluish tint. [QIDP #1] instructed [DSP #4] to take [client A] to [hospital] ER (emergency room). [QIDP #1] drove to meet [DSP #4] at the hospital and called [client A's] guardians to inform them of the situation. [Client A] received a CT (computerized tomography) scan to check for a stroke and took blood and urine samples for testing. An examination of her left leg showed an untreated fracture estimated to be from December, before she came into the care of Indiana Mentor. [Client A] was admitted for continued observation." An investigation dated 5/16/23 indicated the investigation was completed by Quality Improvement Field Services Specialist (QIFSS) #1. The investigation indicated QIFSS #1 interviewed DSP #5 by phone on 4/27/23. The investigation indicated the following: "...[DSP #5] states [DSP #4] took [client A] to the ER due to [client A] not acting right, slurring		unknown origin, suspected and observed falls, and ALL changes in condition including medical, behavioral, and psychiatric. Retraining will also be provided to Program Director and Area Director on Indiana Mentor minimum standard guidelines that covers all components of a thorough investigation of all of these incidents that must begin immediately and be reviewed by Area Director, Regional Director, and Quality. Retraining will also cover calling 911 for immediate medical services and transportation instead of staff transporting individuals to the hospital and will include competency based testing to ensure staff comprehension of expectations. The Program Supervisor and Program Director will complete weekly in home checks to observe DSP active compliance with re-trainings. Responsible Person: Regional Director, Program Director, Area Director, Program Director	

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	words, having accidents (which happens but is very rare), and was going to the bathroom a lot. [DSP #5] states [client A] did not mention her legs or feet hurting.... [DSP #5] states she understands Mentor's ANE (abuse, neglect, and exploitation) policy.... [DSP #5] states she took [client A's] vitals on 4/23/23 - blood pressure, O2 (oxygen), and blood sugar - all vitals were good. [DSP #5] states she called [QIDP #1] while she was taking vitals, [QIDP #1] instructed [DSP #6] to call the nurse, but the nurse did not answer. [DSP #5] states [client A] sat in a chair in the living room, she seemed to be doing better. [DSP #5] states, when [DSP #4] arrived shortly after [DSP #4] called [QIDP#1] again to due being able to get [client A] to the restroom. [QIDP #1] instructed [DSP #4] to take [client A] to the hospital. [DSP #5] states she knows to report all falls to her supervisor immediately. [DSP #5] states she was not aware of any injuries to [client A's] legs. [DSP #5] states [client A] lost her balance but never falls to the floor, she will grab a wall, chair, or person that is near her. [DSP #5] states [client A] never reported a fall to her. [DSP #5] states no one reported a fall to her." The investigation indicated QIFSS #1 interviewed DSP #6 by phone on 5/1/23. The investigation indicated the following: "...[DSP #6] states [client A] was walking, but she was shaking on Saturday night [4/22/23]/Sunday morning [4/23/23]. [DSP #6] states [client A] was shuffling her feet as if she could not pick them up. [DSP #6] states [client A] was not answering questions like she normally would.			

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	[DSP #6] states [client A] urinated on herself when [DSP #6] started her shift. [DSP #6] states at 3:00 am, [client A] kept trying to go to the bathroom but wasn't walking right. [DSP #6] states after they went to put her back in bed, [DSP #5] said she walked into [client A's] room, and she was on the floor. [DSP #6] states [client A] was dead weight, and they had to get a wheelchair to put her in. [DSP #6] states [client A] was incoherent when she was talking to her. [DSP #6] states [client A] loves to talk, but she was not talking. [DSP #6] states [DSP #4] took [client A] to the hospital. [DSP #6] states [DSP #5] took [client A's] vitals, she thought the vitals were ok, but could not remember. [DSP #6] states [client A] was cold. [DSP #6] states she believes she called [QIDP #1], and he told her to call [Registered Nurse (RN) #1]. [DSP #6] states she called [RN #1], and she didn't answer.... [DSP #6] states she knows to report a fall to her supervisor, but she did not witness a fall.... [DSP #6] states she understands the ANE policy." The investigation indicated QIFSS #1 interviewed QIDP #1 by phone on 4/28/23. The investigation indicated the following: "... [QIDP #1] states he got a call on Sunday 4/23/23 from [DSP #6], and then [DSP #4] provided him with an update a short time later. After being informed that [client A's] lips were turning blue, he instructed [DSP #4] to take [client A] to the hospital.... [QIDP #1] states a fall was never reported to him.... The investigation indicated the following:			

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	"Conclusion of Facts: Evidence supports [client A] was taken to the ER due to her being incoherent on 4/23/23. Evidence supports [client A] showed no signs of distress prior to 4/23/23. Evidence supports staff contacted their supervisor on 4/23/23 to report [client A's] condition at the time. Evidence supports staff monitored [client A's] vitals the morning of 4/23/23 and all vitals remained within normal range. Evidence supports [DSP #4] took [client A] to the ER on 4/23/23 immediately following [QIDP #1's] instruction. Evidence supports there was no fall reported in the home between 4/21/23 - 4/23/23. Evidence supports [client A] did not fall between 4/21/23 - 4/23/23.... Evidence supports [client A] has a spiral fracture of the left tibia. Evidence supports [client A] has a mildly displaced fracture of the distal fibula metadiaphysis (ankle) with additional proximal fracture of the left fibular metaphysis (growth plate). Evident supports [client A] had screws and rods in her left fibula prior to January 2023. Evidence supports both fractured bones are aged - one as old as December 2022, the other as old as February 2023.... Evidence supports staff followed all policies and procedures during this incident.... This investigation substantiates [client A's] leg is broken. This investigation substantiates [client A] did have a medical emergency. It is unclear however how [client A's] leg was broken, there is no evidence to substantiate any ANE allegations from the staff...."			

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	DSP #6 was interviewed on 5/24/23 at 6:57 am and stated, "I worked from 11:00 pm to 9:00 am on the overnight shift 4/22/23 to 4/23/23." DSP #6 stated, "[Client A] usually used the bathroom on the toilet. That night she was shaking and shuffling. It wasn't normal." DSP #6 stated, "We toilet them at midnight. It was between 12:30 and 1:00 am." DSP #6 stated, "[Client A] had urinated on herself. She was shaking. I wouldn't call it incoherent, but she was going off. She wasn't answering questions." DSP #6 stated, "[DSP #5] checked her vitals, but it might have been later in the morning." DSP #6 stated, "We gave her water. We thought she was just dehydrated. We called the nurse in the morning." - The interview indicated DSPs #5 and #6 did not contact the on-call nurse immediately when they noticed client A's change in behavior and health status. DSP #6 stated, "[DSP #5] said she walked in the room, and [client A] was on the floor. I wasn't present. It was probably between 4:30 and 5:00 am. That's when we get them up." DSP #6 indicated DSP #5 called her to assist client A. DSP #6 stated, "I helped [DSP #5] get [client A] up from the floor. She was not able to walk. We had to use a wheelchair. She didn't say anything about her leg hurting. We kept asking about what was wrong, but she was only talking about her family." DSP #6 indicated RN #1 and QIDP #1 were contacted when client A was found on the floor. DSP #5 was interviewed by phone on 5/30/23 at 12:45 pm and stated, "We went to get her up at 6:00 am, and she was acting like she couldn't stand." DSP #5 stated, "When I walked in the room, she was sitting on the floor. She wasn't laying down. It was like she was sitting on the			

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	edge of the bed and slid down to the floor. She wouldn't stand up, so I had to go get [DSP #6], and we had to get her up into the wheelchair." When asked if she reported the fall, DSP #5 stated, "They asked if she fell, and I said no. The way she was sitting on the floor, it wasn't a fall. She was sitting against the bed like she slid down to the floor." - The interview indicated DSPs #5 and #6 did not report client A's suspected fall to the on-call nurse immediately. DSP #4 was interviewed on 5/23/23 at 7:05 am and stated, "I was here on Friday 4/21/23 and Saturday 4/22/23, and [client A] was fine. When I came in on 4/23/23 at 7:00 am, she was acting tired. She wasn't moving or talking. She didn't pick up her spoon to eat." DSP #4 stated, "The overnight staff said they used a wheelchair to bring her to the table. She couldn't fully wake up. Her lips were purple. The overnight called [RN #1]. She said to take the vitals. Between 6:00 am and 7:00 am, she got worse." DSP #4 stated, "I called [QIDP #1]. I took [client A] to the ER in my car. They got her a room right away. She was not responding. She didn't have enough hydration to give a urine sample. The hospital staff said there were several breaks. They said it was swollen." When asked if client A usually required assistance with ambulation, DSP #4 stated, "[Client A] walked normally. She would sometimes say she was dizzy or her legs hurt. We thought she was acting out, so we kind of dismissed it." DSP #4 stated, "She's never fallen." - The interview indicated DSP #4 transported client A to the hospital in her own vehicle. - The interview indicated the group home staff did not call 911 for assistance when they noticed client A's change in status and color.			

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	An observation was conducted in client A's hospital room on 4/23/23 from 11:36 am to 11:45 am. Client A was reclined in her hospital bed with restraints on both forearms. Client A appeared lethargic and was difficult to understand. Client A repeatedly asked for coffee. When asked about her injury, client A indicated she did not know what happened to her leg. When asked if she fell, client A stated, "I don't remember." Registered Nurse Manager (RNM) #1 assisted the surveyor in examining client A's left leg. RNM #1 indicated client A had an incision with staples in her left knee, another incision with 3 staples 3 inches below the left knee and slightly to the inside of the shin, and 3 separate incisions with staples around her left ankle. Client A's hospital records were reviewed on 4/23/23 at 11:45 am and indicated the following: A note entered by Hospital Registered Nurse (HRN) #2 dated 4/23/23 at 9:33 am indicated the following: "Pt (Patient's) lower leg is shortened and externally rotated. Pt does not have any pain when she moves her leg - left lower skin has area of palpable deformity. MD (physician) aware. X-ray ordered." A note entered by Physician Assistant #1 dated 4/23/23 at 10:12 am indicated the following: "X-ray shows distal tibia and proximal fibula fracture which are likely new. No hip fracture. I spoke to [surgeon #1] who accepts consult. Patient will be placed in a splint.... She will need admission." A note entered by Surgeon #1 dated 5/1/23 indicated the following: "Postoperative Diagnosis: Displaced spinal fracture of the left distal tibial metaphysis (growth			

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	plate). Procedure: Intramedullaryl nail fixation (used to fix fractures) of the left tibia...." - The review indicated the facility failed to thoroughly investigate client A's injury of unknown origin. - The review indicated the facility failed to complete an investigation of client A's injury of unknown origin within 5 business days. QIDP #1 was interviewed on 5/24/23 at 2:30 pm. When asked why the BDDS report indicated client A's fractures were sustained in December 2022, QIDP #1 stated, "That was based on what the nurses at the hospital were telling me from their initial investigations and scans of her leg." QIDP #1 stated, "No staff have reported any breaks or falls for her." QIDP #1 stated, "If she was on the floor, that would be considered a fall." QIDP #1 stated, "If staff see abnormal symptoms, there should be a call to the nurse. That was the first thing I recommended when her change of behavior was reported to be the morning of 4/23/23. I want to say it was around 7:00 am." QIDP #1 stated, "I directed staff to take her to take her. I said to get her to the hospital. It was [DSP #4's] choice to take her in her own car." RN #1 was interviewed on 5/24/23 at 2:30 pm. When asked if she was notified of client A's change in health status, RN #1 stated, "I was not notified by anyone." When asked if client A should have been transported to the hospital in a staff's car, RN #1 stated, "If there are lips that are blue and altered consciousness, there should definitely be a call to 911 to have an ambulance to pick her up." Area Director (AD) #1 was interviewed on 5/24/23 at 2:30 pm and stated, "If [client A] was found on			

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	the floor, it should be reported as a fall." AD #1 stated, "Staff should report if they notice any changes in health status to get directives of calling the on-call nurse or to call 911." Regional Director (RD) #1 was interviewed by phone on 6/5/23 at 9:00 am and stated, "If staff find someone on the floor, they should report it to administration just like any other incident. We should treat it as a fall. If we didn't see it happen, we should take all the steps as though it were a fall." RD #1 stated, "The investigator should have looked into the fall more closely." RD #1 stated, "[Client A's] change of condition should have been reported immediately. Possibly she was in need of medical attention. Even if it's not needed, we should be proactive and not wait for something potentially worse to occur." RD #1 indicated the investigation should have addressed staff's failure to report client A's change of condition when it was first noticed. RD #1 stated, "Lips turning blue should be a 911 call immediately. It should be a 911 call prior to calling the supervisor. [Client A] should not have been transported by car. 911 should have been called." RD #1 indicated the investigation should have addressed staff's failure to immediately call 911 when client A's change in status was noticed. 2. A BDDS report dated 4/20/23 indicated the following: "[DSP #4] called [QIDP #1] at 8:12 am on 4/20/23 to report that, while transporting clients from their group home to day services, she was cut off in traffic and had to brake suddenly, causing [client B] to bump her head on part of the metal grate that is part of the lift assembly. [DSP #4] reported that [client B] had no apparent cuts or bruises, and [client B] did not report any hurts or distress. [DSP #4] also stated that [client B's] wheelchair			

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	had been safely secured before they left the group home. [QIDP #1] instructed [DSP #4] to finish the trip to day services and unload the other clients before taking [client B] to [hospital] ER. [DSP #4] text (sic) [QIDP #1] at 9:14 am to report that [client A] had been taken to a room with oxygen and was being prepped for a scan of her head. [DSP #4] texted again at 10:02 am to report that the ER had released [client B]. [QIDP #1] instructed [DSP #4] to return [client B] to day services." An investigation dated 4/28/23 indicated the investigation was completed by QIDP #1. The investigation indicated QIDP #1 interviewed client B on 4/21/23 and indicated the following: "[Client B] states she remembers she bumped the back of her head on Thursday 4/20/23. [Client B] states she didn't think her seat belt was right. [Client B] states she didn't think her belt was across her belly. [Client B] states she bumped the back of her head when staff hit the brakes. [Client B] states staff pulled over to check on her. [Client B] states staff took her to the hospital." The investigation indicated Area Director (AD) #1 interviewed DSP #4 on 4/24/23 and indicated the following: "[DSP #4] states she transported the individuals on 4/20/23. [DSP #4] states she followed van procedures when securing [client B] in the van. [DSP #4] states [client B's] belt was properly strapped when she left the house. [DSP #4] states she placed the belt across [client B's] stomach when she strapped her in. [DSP #4] states [client B] does move around when she is driving and sometimes moves her belt. [DSP #4] states it could have moved while she			

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	was driving. [DSP #4] states [client B's] wheelchair leaned back, causing [client B] to bump her head on the metal grate of the lift. [DSP #4] states she pulled over to check [client B] then notified [QIDP #1].... [DSP #4] states she was trained by previous [QIDP] on how to properly secure individuals with wheel chairs in the van. Review of van training showed [DSP #4] was trained on 10/5/22. Review of van service report shows there is no issues with the equipment in the van. Review of discharge paperwork: [Client B] had no injuries and a clear CT scan. She was discharged from the ER." The investigation indicated the following: "Conclusions of Fact: Evidence supports [DSP #4] loaded [client B] into the van and followed protocol as she had been trained per her report. Evidence supports that [DSP #4] had to slam on her brakes causing [client B] to hit her head. Evidence supports that [DSP #4] pulled over to check [client B] for injury. Evidence supports that [client B] was taken to the hospital to get checked for any possible head injury. Evidence supports that [DSP #4] followed proper notification protocol. Evidence supports that [client B] had no injuries and was discharged from the hospital. Evidence supports the van was checked, and all equipment is working properly. Evidence supports that [DSP #4] needs to be retrained on the wheelchair van protocol to ensure she is doing every step correctly. This investigation is deemed inconclusive as there was no other witness observing [DSP #4]			

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	strap [client B] in the van. [DSP #4] will be re-trained on procedures to ensure she (sic) competing (sic) every step correctly. [QIDP #1 and AD #1] will ensure van observations are completed weekly. This investigation is unsubstantiated for any ANE involvement." The investigation was signed by QIDP #1 on 4/28/23. The investigation was signed by AD #1 on 5/2/23. - The review indicated the investigation was conducted by QIDP #1 who provided instruction to staff at the time of the incident. - The review indicated the investigation was not completed within 5 business days. Client B was interviewed on 5/22/23 at 7:08 pm and stated, "My chair tipped back, and I bumped my head. It tipped back when she put the brakes on." When asked if the chair tipped or slid, client B stated, "The front wheels came off the floor a little bit." DSP #4 was interviewed on 5/23/23 at 7:05 am and stated, "[Client B] had pulled herself up to the bench seats. She unlocks her wheels and moves the wheelchair up, so she can lean on the seats. When I put on the brakes, the chair moved." DSP #4 stated, "She hit her head on the grate, and I called [QIDP #1]. He tried to call [RN #1] two times. He told me to take her to the ER. They checked her out, and I took her back to day service." DSP #4 stated, "The front left lock (secures a hooked strap to the floor and is used to secure the wheelchair in place) isn't locking. I showed them in training." DSP #4 stated "[QIDP #1] and a day service staff retrained me, but we used a different van." An observation was conducted in the group home			

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	on 5/23/23 from 6:30 am to 7:30 am. Client B was present in the home throughout the observation period. The surveyor observed DSP #4 loading client B onto the van in her wheelchair using the lift and securing her in the vehicle. DSP #4 pointed to the floor locks on the front left and rear right of the wheelchair and stated, "They weren't locking properly. [QIDP #1] had them switched out." DSP #4 stated, "I told [House Manager (HM) #1] before she left in November they weren't working. I didn't tell anyone else. I couldn't get them tightened down that day [4/20/23]." DSP #4 indicated she did not call anyone to assist her with tightening the straps for client B's wheelchair. DSP #4 indicated client B moved her wheelchair while the van was moving. DSP #4 stated, "I was the only staff that day [4/20/23]. Now we have a second staff who can sit in the back to make sure she isn't unlocking her wheels or moving around." - The interview did not indicate DSP #4 reported she was unable to tighten the floor locks of the vehicle after HM #1 did not take action in November 2022. - The interview did not indicate DSP #4 reported to administration when she was unable to tighten the floor locks on 4/20/23. Client B's staff notes were reviewed on 5/23/23 at 1:15 pm and did not indicate concussion tracking was completed for client B in the days after she hit her head on 4/20/23. RN #1 was interviewed on 5/24/23 at 2:30 pm and stated, "When someone hits their head, they usually go straight to the ER. I would see them in the day or two following to see how they are doing. Staff do not do regular monitoring." QIDP #1 was interviewed on 5/24/23 at 2:30 pm			

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	and stated, "We were doing the fall protocol. We do the observation for 7 days. It goes over signs and symptoms of possible neurological problems resulting from head injury." - The documentation of the fall protocol was requested on 5/24/23 at 2:30 pm and was not available at the time of the survey. QIDP #1 was interviewed on 5/24/23 at 2:30 pm and stated, "[DSP #4] called me after the incident. She pulled over to the shoulder of the road before calling. She said she had to make a panic stop to avoid a collision because someone stopped suddenly in front of her. She told me that she stopped to go in back and look at [client B]. She seemed to have bumped her head. It didn't seem serious. She said she was very close to the day program. I told her to go to day program and let the other clients off. She then took her to [hospital]. She was seen and cleared there." QIDP #1 stated, "[DSP #4] didn't say anything about have issues with the tie down straps. I took the van to be inspected. They said the van was looking well. I did a retraining with [DSP #4]. I noticed it could have been a little tighter. I told her to get the tie downs tighter. She can use the knobs on the side and get them wrenched in. We implemented a plan of checking the van 3 times a week. I or the [House Manager] would watch the van being loaded and unloaded." QIDP #1 stated, "[DSP #4's] issues with the tie down straps were not shared with me. If staff aren't sure how to do something, they should ask a supervisor for more training." QIDP #1 stated, "[DSP #4] should not have driven with the client if the straps weren't tight." Area Director (AD) #1 was interviewed on 5/24/23 at 2:30 pm and stated, "[DSP #4] should have reported to a supervisor to let them know she			

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	didn't know how to use the straps or was uncomfortable." AD #1 stated, "I've been in the house many times. She came to the office that morning and spoke with us and never reported anything about the straps being loose that morning." Regional Director (RD) #1 was interviewed on by phone on 6/5/23 at 9:00 am and stated, "If staff don't know how to use the safety belts with the wheelchair, they should not transport at all. They should call someone for help." RD #1 stated, "If something has been reported to a house manager and nothing was done, the staff should report to the QIDP, AD, RD, anyone. They just shouldn't transport." AD #1 was interviewed on 5/24/23 at 2:30 pm and stated, "Staff report concerns immediately by phone. Right now, they contact [QIDP #1]. There is a nurse on-call." AD #1 stated, "The investigation for [client A] was completed by quality assurance. I completed the investigation for [client B]." AD #1 stated, "The investigation should include an interview with the staff involved, the individuals. There is a review of pertinent documentation that would apply to an investigation: the BSP (behavior support plan), high risk plan, whatever is pertinent." AD #1 stated, "Investigations should be completed within 7 business days. We ensure each staff and individual signs off on their interview statements." RD #1 was interviewed by phone on 6/5/23 at 9:00 am and stated, "Investigations should be completed within 5 business days." The facility's Quality and Risk Management policy dated September 2017 was reviewed on 5/30/23 at			

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	12:30 pm and indicated the following: "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. Indiana Mentor follows BDDS incident reporting policy as outlined in the Provider Standards. An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS: Alleged, suspected, or actual abuse, neglect, or exploitation of an individual. An incident in the category shall also be reported to Adult Protective Services (APS).... The provider shall suspend staff involved in an incident from duty pending investigation by the provider. This may include: Failure to provide appropriate supervision, care, or training;.... Event with the potential for causing significant harm or injury and requiring medical or psychiatric treatments or services to or for an individual receiving services;.... Injury to an individual when the origin or cause of the injury is unknown, and the injury required medical evaluation or treatment; A significant injury to an individual, including: A fracture.... 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. Investigations will be completed for all deaths, allegations of abuse, neglect, exploitation, or mistreatment. Additional investigations will be completed for incidents with significant injuries of unknown origin and incidents that may be			

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	requested by outside entities. Investigations will be completed using the Indiana Mentor Investigator Minimum Standards guidelines. Investigation summary report will minimally include: - Immediate safety measures put into place following event/alleged event. - Nature of the event/allegation. - A collection of all interviews, witness statements, pictures, or any physical evidence. - Review of all information reviewed - e.g.. daily support records, staff notes, medication administration records, behavior tracking, or any other evidence reviewed. - Resolution of any discrepancies. - Summary of conclusion/findings to include when allegation of abuse, neglect, or exploitation and whether allegation is substantiated or unsubstantiated. All staff completing investigations will receive Indiana Mentor core training for investigations. All investigations require a reviewer to ensure investigation is completed thoroughly and completely and meet minimum standards. Investigations will be signed/dated in IMS (digital tracking system) by investigator and reviewer. Area Director will be notified via IMS of the completion of investigation by the investigator within 5 business days. Response action plans will be developed by Area Directors to address any action that needs to be taken in response to the incident and results of the investigation." This federal tag relates to complaint #IN00407643 and complaint #IN00408581. 9-3-2(a)			

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	15G599	A. BUILDING 00 B. WING	06/05/2023

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W 0153 Bldg. 00	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 2 allegations of abuse and neglect reviewed, the facility staff failed to immediately report a change of condition and an unwitnessed fall for client A to facility administration in accordance with state law. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) Reports and related investigations were reviewed on 5/22/23 at 1:26 pm. A BDDS report dated 4/23/23 indicated the following: "Direct Support Professional (DSP) [#6] called [Qualified Intellectual Disabilities Professional (QIDP) #1] to report changes in [client A's] behavior and condition: she was presenting as lethargic, having difficulty walking, and was unusually quiet. [QIDP #1] instructed [DSP #6] to call on-call nurse and observe her. [DSP #4] called to report that they had taken [client A's] vitals (blood pressure: 107/60, heart rate 72, oxygen 94, blood sugar 140), and also that [client A's] lips had developed a bluish tint. [QIDP #1] instructed [DSP #4] to take [client A] to [hospital] ER (emergency room). [QIDP #1] drove to meet [DSP #4] at the hospital and called [client A's] guardians to inform them of the situation. [Client A] received a CT (computerized tomography) scan	W 0153	The facility ensures 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. The procedure includes completion of a thorough investigation of all allegations of abuse, neglect, and exploitation; and suspension of any alleged staff person. All new employees are trained on the policy and procedure for reporting during new hire orientation and with periodic re-training. The facility follows a protocol and regulation for the supervisor to be notified immediately and an incident report to be completed and sent to the Bureau of Developmental Disabilities, Adult Protective Services, and entire team for the individual within 24 hours for all allegations of abuse, neglect, and exploitation. The facility will provide re-training to Area Director, Program Director, Program Supervisor, and Direct Support Professionals on Indiana Mentor's abuse, neglect	07/05/2023

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	to check for a stroke and took blood and urine samples for testing. An examination of her left leg showed an untreated fracture estimated to be from December, before she came into the care of Indiana Mentor. [Client A] was admitted for continued observation." An investigation dated 5/16/23 indicated the investigation was completed by Quality Improvement Field Services Specialist (QIFSS) #1. The investigation indicated QIFSS #1 interviewed DSP #5 by phone on 4/27/23. The investigation indicated the following: "...[DSP #5] states [DSP #4] took [client A] to the ER due to [client A] not acting right, slurring words, having accidents (which happens but is very rare), and was going to the bathroom a lot. [DSP #5] states [client A] did not mention her legs or feet hurting.... [DSP #5] states she understands Mentor's ANE (abuse, neglect, and exploitation) policy.... [DSP #5] states she took [client A's] vitals on 4/23/23 - blood pressure, O2 (oxygen), and blood sugar - all vitals were good. [DSP #5] states she called [QIDP #1] while she was taking vitals, [QIDP #1] instructed [DSP #6] to call the nurse, but the nurse did not answer. [DSP #5] states [client A] sat in a chair in the living room, she seemed to be doing better. [DSP #5] states, when [DSP #4] arrived shortly after [DSP #4] called [QIDP#1] again to due being able to get [client A] to the restroom. [QIDP #1] instructed [DSP #4] to take [client A] to the hospital. [DSP #5] states she knows to report all falls to her supervisor immediately. [DSP #5] states she was not aware of any injuries to [client A's] legs. [DSP #5] states [client A] lost her balance but never falls to the floor, she will grab a wall, chair,		and exploitation policy including the mandate of reporting immediately, and to contact law enforcement immediately any time a crime has been reported. The Program Supervisor will monitor progress notes 3 times per week and notify the Program Director if any incidents of abuse, neglect or mistreatment are documented in the notes and have not been reported. The Program Supervisor and Program Director will complete unannounced site visits weekly to ensure staff are implementing training. Responsible Staff: Program Supervisor, Program Director, Area Director	

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	or person that is near her. [DSP #5] states [client A] never reported a fall to her. [DSP #5] states no one reported a fall to her." The investigation indicated QIFSS #1 interviewed DSP #6 by phone on 5/1/23. The investigation indicated the following: "...[DSP #6] states [client A] was walking, but she was shaking on Saturday night [4/22/23]/Sunday morning [4/23/23]. [DSP #6] states [client A] was shuffling her feet as if she could not pick them up. [DSP #6] states [client A] was not answering questions like she normally would. [DSP #6] states [client A] urinated on herself when [DSP #6] started her shift. [DSP #6] states at 3:00 am, [client A] kept trying to go to the bathroom but wasn't walking right. [DSP #6] states after they went to put her back in bed, [DSP #5] said she walked into [client A's] room, and she was on the floor. [DSP #6] states [client A] was dead weight, and they had to get a wheelchair to put her in. [DSP #6] states [client A] was incoherent when she was talking to her. [DSP #6] states [client A] loves to talk, but she was not talking. [DSP #6] states [DSP #4] took [client A] to the hospital. [DSP #6] states [DSP #5] took [client A's] vitals, she thought the vitals were ok, but could not remember. [DSP #6] states [client A] was cold. [DSP #6] states she believes she called [QIDP #1], and he told her to call [Registered Nurse (RN) #1]. [DSP #6] states she called [RN #1], and she didn't answer.... [DSP #6] states she knows to report a fall to her supervisor, but she did not witness a fall....			

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	[DSP #6] states she understands the ANE policy." The investigation indicated QIFSS #1 interviewed QIDP #1 by phone on 4/28/23. The investigation indicated the following: "... [QIDP #1] states he got a call on Sunday 4/23/23 from [DSP #6], and then [DSP #4] provided him with an update a short time later. After being informed that [client A's] lips were turning blue, he instructed [DSP #4] to take [client A] to the hospital.... [QIDP #1] states a fall was never reported to him...." The investigation indicated the following: "Conclusion of Facts: Evidence supports [client A] was taken to the ER due to her being incoherent on 4/23/23. Evidence supports [client A] showed no signs of distress prior to 4/23/23. Evidence supports staff contacted their supervisor on 4/23/23 to report [client A's] condition at the time. Evidence supports staff monitored [client A's] vitals the morning of 4/23/23 and all vitals remained within normal range. Evidence supports [DSP #4] took [client A] to the ER on 4/23/23 immediately following [QIDP #1's] instruction. Evidence supports there was no fall reported in the home between 4/21/23 - 4/23/23. Evidence supports [client A] did not fall between 4/21/23 - 4/23/23.... Evidence supports [client A] has a spiral fracture of the left tibia. Evidence supports [client A] has a mildly displaced fracture of the distal fibula metadiaphysis (growth plate) with additional proximal fracture of the left fibular metaphysis (ankle).			

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	Evident supports [client A] had screws and rods in her left fibula prior to January 2023. Evidence supports both fractured bones are aged - one as old as December 2022, the other as old as February 2023.... Evidence supports staff followed all policies and procedures during this incident.... This investigation substantiates [client A's] leg is broken. This investigation substantiates [client A] did have a medical emergency. It is unclear however how [client A's] leg was broken, there is no evidence to substantiate any ANE allegations from the staff...." DSP #6 was interviewed on 5/24/23 at 6:57 am and stated, "I worked from 11:00 pm to 9:00 am on the overnight shift 4/22/23 to 4/23/23." DSP #6 stated, "[Client A] usually used the bathroom on the toilet. That night she was shaking and shuffling. It wasn't normal." DSP #6 stated, "We toilet them at midnight. It was between 12:30 and 1:00 am." DSP #6 stated, "[Client A] had urinated on herself. She was shaking. I wouldn't call it incoherent, but she was going off. She wasn't answering questions." DSP #6 stated, "[DSP #5] checked her vitals, but it might have been later in the morning." DSP #6 stated, "We gave her water. We thought she was just dehydrated. We called the nurse in the morning." - The interview indicated DSPs #5 and #6 did not contact the on-call nurse immediately when they noticed client A's change in behavior and health status. DSP #6 stated, "[DSP #5] said she walked in the room, and [client A] was on the floor. I wasn't present. It was probably between 4:30 and 5:00 am. That's when we get them up." DSP #6 indicated DSP #5 called her to assist client A.			

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	DSP #6 stated, "I helped [DSP #5] get [client A] up from the floor. She was not able to walk. We had to use a wheelchair. She didn't say anything about her leg hurting. We kept asking about what was wrong, but she was only talking about her family." DSP #6 indicated RN #1 and QIDP #1 were contacted when client A was found on the floor. DSP #5 was interviewed by phone on 5/30/23 at 12:45 pm and stated, "We went to get her up at 6:00 am, and she was acting like she couldn't stand." DSP #5 stated, "When I walked in the room, she was sitting on the floor. She wasn't laying down. It was like she was sitting on the edge of the bed and slid down to the floor. She wouldn't stand up, so I had to go get [DSP #6], and we had to get her up into the wheelchair." When asked if she reported the fall, DSP #5 stated, "They asked if she fell, and I said no. The way she was sitting on the floor, it wasn't a fall. She was sitting against the bed like she slid down to the floor." - The interview indicated DSPs #5 and #6 did not report client A's suspected fall to the on-call nurse immediately. DSP #4 was interviewed on 5/23/23 at 7:05 am and stated, "I was here on Friday 4/21/23 and Saturday 4/22/23, and [client A] was fine. When I came in on 4/23/23 at 7:00 am, she was acting tired. She wasn't moving or talking. She didn't pick up her spoon to eat." DSP #4 stated, "The overnight staff said they used a wheelchair to bring her to the table. She couldn't fully wake up. Her lips were purple. The overnight called [RN #1]. She said to take the vitals. Between 6:00 am and 7:00 am, she got worse." DSP #4 stated, "I called [QIDP #1]. I took [client A] to the ER in my car. They got her a room right away. She was not			

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	responding. She didn't have enough hydration to give a urine sample. The hospital staff said there were several breaks. They said it was swollen." When asked if client A usually required assistance with ambulation, DSP #4 stated, "[Client A] walked normally. She would sometimes say she was dizzy or her legs hurt. We thought she was acting out, so we kind of dismissed it." DSP #4 stated, "She's never fallen." - The interview indicated DSP #4 transported client A to the hospital in her own vehicle. - The interview indicated the group home staff did not call 911 for assistance when they noticed client A's change in status and color. QIDP #1 was interviewed on 5/24/23 at 2:30 pm and stated, "If staff see abnormal symptoms, there should be a call to the nurse. That was the first thing I recommended when her change of behavior was reported to be the morning of 4/23/23. I want to say it was around 7:00 am." QIDP #1 stated, "I directed staff to take her to take her. I said to get her to the hospital. It was [DSP #4's] choice to take her in her own car." RN #1 was interviewed on 5/24/23 at 2:30 pm. When asked if she was notified of client A's change in health status, RN #1 stated, "I was not notified by anyone." When asked if client A should have been transported to the hospital in a staff's car, RN #1 stated, "If there are lips that are blue and altered consciousness, there should definitely be a call to 911 to have an ambulance to pick her up." AD #1 was interviewed on 5/24/23 at 2:30 pm and stated, "If [client A] was found on the floor, it should be reported as a fall." AD #1 stated, "Staff should report if they notice any changes in health status to get directives of calling the on-call nurse			

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	or to call 911." AD #1 was interviewed on 5/24/23 at 2:30 pm and stated, "Staff report concerns immediately by phone. Right now, they contact [QIDP #1]. There is a nurse on-call." Regional Director (RD) #1 was interviewed by phone on 6/5/23 at 9:00 am and stated, "If staff find someone on the floor, they should report it to administration just like any other incident. We should treat it as a fall. If we didn't see it happen, we should take all the steps as though it were a fall." RD #1 stated, "[Client A's] change of condition should have been reported immediately. Possibly she was in need of medical attention. Even if it's not needed, we should be proactive and not wait for something potentially worse to occur." RD #1 stated, "Lips turning blue should be a 911 call immediately. It should be a 911 call prior to calling the supervisor. [Client A] should not have been transported by car. 911 should have been called." RD #1 indicated the investigation should have addressed staff's failure to immediately call 911 when client A's change in status was noticed. This federal tag relates to complaint #IN00408581. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 2 of 2 allegations of abuse and neglect reviewed, the facility failed to thoroughly investigate an injury of unknown origin for client A and an allegation	W 0154	The facility has procedures which includes completion of a thorough investigation of all allegations of abuse, neglect, and exploitation; and suspension of any alleged	07/05/2023

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	of neglect for client B. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) Reports and related investigations were reviewed on 5/22/23 at 1:26 pm. 1. A BDDS report dated 4/23/23 indicated the following: "Direct Support Professional (DSP) [#6] called [Qualified Intellectual Disabilities Professional (QIDP) #1] to report changes in [client A's] behavior and condition: she was presenting as lethargic, having difficulty walking, and was unusually quiet. [QIDP #1] instructed [DSP #6] to call on-call nurse and observe her. [DSP #4] called to report that they had taken [client A's] vitals (blood pressure: 107/60, heart rate 72, oxygen 94, blood sugar 140), and also that [client A's] lips had developed a bluish tint. [QIDP #1] instructed [DSP #4] to take [client A] to [hospital] ER (emergency room). [QIDP #1] drove to meet [DSP #4] at the hospital and called [client A's] guardians to inform them of the situation. [Client A] received a CT (computerized tomography) scan to check for a stroke and took blood and urine samples for testing. An examination of her left leg showed an untreated fracture estimated to be from December, before she came into the care of Indiana Mentor. [Client A] was admitted for continued observation." An investigation dated 5/16/23 indicated the investigation was completed by Quality Improvement Field Services Specialist (QIFSS) #1. The investigation indicated QIFSS #1 interviewed DSP #5 by phone on 4/27/23. The investigation indicated the following:		staff person. Direct Support Staff and Management will all be re-trained on immediate reporting of all incidents; including injuries of unknown origin, suspected and observed falls, and ALL changes in condition including medical, behavioral, and psychiatric. The facility will provide re-training to the Program Supervisor, Program Director, and Area Director on interviewing all involved parties, all housemates, and all staff when completing a thorough investigation. The facility will have evidence that all alleged violations are thoroughly investigated. All completed investigations will be reviewed by Area Director, Regional Director, and Quality. The Program Supervisor will monitor progress notes 3 times per week and notify the Program Director if any incidents of abuse, neglect or mistreatment are documented in the notes and have not been reported. The Program Supervisor and Program Director will complete unannounced site visits weekly to ensure staff are implementing training. Responsible Staff: Program Supervisor, Program Director, Area Director	

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	"...[DSP #5] states [DSP #4] took [client A] to the ER due to [client A] not acting right, slurring words, having accidents (which happens but is very rare), and was going to the bathroom a lot. [DSP #5] states [client A] did not mention her legs or feet hurting.... [DSP #5] states she understands Mentor's ANE (abuse, neglect, and exploitation) policy.... [DSP #5] states she took [client A's] vitals on 4/23/23 - blood pressure, O2 (oxygen), and blood sugar - all vitals were good. [DSP #5] states she called [QIDP #1] while she was taking vitals, [QIDP #1] instructed [DSP #6] to call the nurse, but the nurse did not answer. [DSP #5] states [client A] sat in a chair in the living room, she seemed to be doing better. [DSP #5] states, when [DSP #4] arrived shortly after [DSP #4] called [QIDP#1] again to due being able to get [client A] to the restroom. [QIDP #1] instructed [DSP #4] to take [client A] to the hospital. [DSP #5] states she knows to report all falls to her supervisor immediately. [DSP #5] states she was not aware of any injuries to [client A's] legs. [DSP #5] states [client A] lost her balance but never falls to the floor, she will grab a wall, chair, or person that is near her. [DSP #5] states [client A] never reported a fall to her. [DSP #5] states no one reported a fall to her." The investigation indicated QIFSS #1 interviewed DSP #6 by phone on 5/1/23. The investigation indicated the following: "...[DSP #6] states [client A] was walking, but she was shaking on Saturday night [4/22/23]/Sunday morning [4/23/23]. [DSP #6] states [client A] was shuffling her feet as if she could not pick them up.			

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	[DSP #6] states [client A] was not answering questions like she normally would. [DSP #6] states [client A] urinated on herself when [DSP #6] started her shift. [DSP #6] states at 3:00 am, [client A] kept trying to go to the bathroom but wasn't walking right. [DSP #6] states after they went to put her back in bed, [DSP #5] said she walked into [client A's] room, and she was on the floor. [DSP #6] states [client A] was dead weight, and they had to get a wheelchair to put her in. [DSP #6] states [client A] was incoherent when she was talking to her. [DSP #6] states [client A] loves to talk, but she was not talking. [DSP #6] states [DSP #4] took [client A] to the hospital. [DSP #6] states [DSP #5] took [client A's] vitals, she thought the vitals were ok, but could not remember. [DSP #6] states [client A] was cold. [DSP #6] states she believes she called [QIDP #1], and he told her to call [Registered Nurse (RN) #1]. [DSP #6] states she called [RN #1], and she didn't answer.... [DSP #6] states she knows to report a fall to her supervisor, but she did not witness a fall.... [DSP #6] states she understands the ANE policy." The investigation indicated QIFSS #1 interviewed QIDP #1 by phone on 4/28/23. The investigation indicated the following: "... [QIDP #1] states he got a call on Sunday 4/23/23 from [DSP #6], and then [DSP #4] provided him with an update a short time later. After being informed that [client A's] lips were turning blue, he instructed [DSP #4] to take [client A] to the hospital.... [QIDP #1] states a fall was never reported to him....			

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	The investigation indicated the following: "Conclusion of Facts: Evidence supports [client A] was taken to the ER due to her being incoherent on 4/23/23. Evidence supports [client A] showed no signs of distress prior to 4/23/23. Evidence supports staff contacted their supervisor on 4/23/23 to report [client A's] condition at the time. Evidence supports staff monitored [client A's] vitals the morning of 4/23/23 and all vitals remained within normal range. Evidence supports [DSP #4] took [client A] to the ER on 4/23/23 immediately following [QIDP #1's] instruction. Evidence supports there was no fall reported in the home between 4/21/23 - 4/23/23. Evidence supports [client A] did not fall between 4/21/23 - 4/23/23.... Evidence supports [client A] has a spiral fracture of the left tibia. Evidence supports [client A] has a mildly displaced fracture of the distal fibula metadiaphysis (growth plate) with additional proximal fracture of the left fibular metaphysis (ankle). Evident supports [client A] had screws and rods in her left fibula prior to January 2023. Evidence supports both fractured bones are aged - one as old as December 2022, the other as old as February 2023.... Evidence supports staff followed all policies and procedures during this incident.... This investigation substantiates [client A's] leg is broken. This investigation substantiates [client A] did have a medical emergency. It is unclear however how [client A's] leg was broken, there is no evidence to substantiate any			

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	ANE allegations from the staff...." DSP #6 was interviewed on 5/24/23 at 6:57 am and stated, "I worked from 11:00 pm to 9:00 am on the overnight shift 4/22/23 to 4/23/23." DSP #6 stated, "[Client A] usually used the bathroom on the toilet. That night she was shaking and shuffling. It wasn't normal." DSP #6 stated, "We toilet them at midnight. It was between 12:30 and 1:00 am." DSP #6 stated, "[Client A] had urinated on herself. She was shaking. I wouldn't call it incoherent, but she was going off. She wasn't answering questions." DSP #6 stated, "[DSP #5] checked her vitals, but it might have been later in the morning." DSP #6 stated, "We gave her water. We thought she was just dehydrated. We called the nurse in the morning." - The interview indicated DSPs #5 and #6 did not contact the on-call nurse immediately when they noticed client A's change in behavior and health status. DSP #6 stated, "[DSP #5] said she walked in the room, and [client A] was on the floor. I wasn't present. It was probably between 4:30 and 5:00 am. That's when we get them up." DSP #6 indicated DSP #5 called her to assist client A. DSP #6 stated, "I helped [DSP #5] get [client A] up from the floor. She was not able to walk. We had to use a wheelchair. She didn't say anything about her leg hurting. We kept asking about what was wrong, but she was only talking about her family." DSP #6 indicated RN #1 and QIDP #1 were contacted when client A was found on the floor. DSP #5 was interviewed by phone on 5/30/23 at 12:45 pm and stated, "We went to get her up at 6:00 am, and she was acting like she couldn't stand." DSP #5 stated, "When I walked in the			

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	room, she was sitting on the floor. She wasn't laying down. It was like she was sitting on the edge of the bed and slid down to the floor. She wouldn't stand up, so I had to go get [DSP #6], and we had to get her up into the wheelchair." When asked if she reported the fall, DSP #5 stated, "They asked if she fell, and I said no. The way she was sitting on the floor, it wasn't a fall. She was sitting against the bed like she slid down to the floor." - The interview indicated DSPs #5 and #6 did not report client A's suspected fall to the on-call nurse immediately. DSP #4 was interviewed on 5/23/23 at 7:05 am and stated, "I was here on Friday 4/21/23 and Saturday 4/22/23, and [client A] was fine. When I came in on 4/23/23 at 7:00 am, she was acting tired. She wasn't moving or talking. She didn't pick up her spoon to eat." DSP #4 stated, "The overnight staff said they used a wheelchair to bring her to the table. She couldn't fully wake up. Her lips were purple. The overnight called [RN #1]. She said to take the vitals. Between 6:00 am and 7:00 am, she got worse." DSP #4 stated, "I called [QIDP #1]. I took [client A] to the ER in my car. They got her a room right away. She was not responding. She didn't have enough hydration to give a urine sample. The hospital staff said there were several breaks. They said it was swollen." When asked if client A usually required assistance with ambulation, DSP #4 stated, "[Client A] walked normally. She would sometimes say she was dizzy or her legs hurt. We thought she was acting out, so we kind of dismissed it." DSP #4 stated, "She's never fallen." - The interview indicated DSP #4 transported client A to the hospital in her own vehicle. - The interview indicated the group home staff did not call 911 for assistance when they noticed			

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	client A's change in status and color. An observation was conducted in client A's hospital room on 4/23/23 from 11:36 am to 11:45 am. Client A was reclined in her hospital bed with restraints on both forearms. Client A appeared lethargic and was difficult to understand. Client A repeatedly asked for coffee. When asked about her injury, client A indicated she did not know what happened to her leg. When asked if she fell, client A stated, "I don't remember." Registered Nurse Manager (RNM) #1 assisted the surveyor in examining client A's left leg. RNM #1 indicated client A had an incision with staples in her left knee, another incision with 3 staples 3 inches below the left knee and slightly to the inside of the shin, and 3 separate incisions with staples around her left ankle. Client A's hospital records were reviewed on 4/23/23 at 11:45 am and indicated the following: A note entered by Hospital Registered Nurse (HRN) #2 dated 4/23/23 at 9:33 am indicated the following: "Pt (Patient's) lower leg is shortened and externally rotated. Pt does not have any pain when she moves her leg - left lower skin has area of palpable deformity. MD (physician) aware. X-ray ordered." A note entered by Physician Assistant #1 dated 4/23/23 at 10:12 am indicated the following: "X-ray shows distal tibia and proximal fibula fracture which are likely new. No hip fracture. I spoke to [surgeon #1] who accepts consult. Patient will be placed in a splint.... She will need admission." A note entered by Surgeon #1 dated 5/1/23 indicated the following:			

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	"Postoperative Diagnosis: Displaced spinal fracture of the left distal tibial metaphysis. Procedure: Intramedullary nail fixation (used to fix fractures) of the left tibia...." - The review indicated the facility failed to thoroughly investigate client A's injury of unknown origin. - The review indicated the facility failed to complete an investigation of client A's injury of unknown origin within 5 business days. QIDP #1 was interviewed on 5/24/23 at 2:30 pm. When asked why the BDDS report indicated client A's fractures were sustained in December 2022, QIDP #1 stated, "That was based on what the nurses at the hospital were telling me from their initial investigations and scans of her leg." QIDP #1 stated, "No staff have reported any breaks or falls for her." QIDP #1 stated, "If she was on the floor, that would be considered a fall." QIDP #1 stated, "If staff see abnormal symptoms, there should be a call to the nurse. That was the first thing I recommended when her change of behavior was reported to be the morning of 4/23/23. I want to say it was around 7:00 am." QIDP #1 stated, "I directed staff to take her to take her. I said to get her to the hospital. It was [DSP #4's] choice to take her in her own car." RN #1 was interviewed on 5/24/23 at 2:30 pm. When asked if she was notified of client A's change in health status, RN #1 stated, "I was not notified by anyone." When asked if client A should have been transported to the hospital in a staff's car, RN #1 stated, "If there are lips that are blue and altered consciousness, there should definitely be a call to 911 to have an ambulance to pick her up." Area Director (AD) #1 was interviewed on 5/24/23			

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	at 2:30 pm and stated, "If [client A] was found on the floor, it should be reported as a fall." AD #1 stated, "Staff should report if they notice any changes in health status to get directives of calling the on-call nurse or to call 911." Regional Director (RD) #1 was interviewed by phone on 6/5/23 at 9:00 am and stated, "If staff find someone on the floor, they should report it to administration just like any other incident. We should treat it as a fall. If we didn't see it happen, we should take all the steps as though it were a fall." RD #1 stated, "The investigator should have looked into the fall more closely." RD #1 stated, "[Client A's] change of condition should have been reported immediately. Possibly she was in need of medical attention. Even if it's not needed, we should be proactive and not wait for something potentially worse to occur." RD #1 indicated the investigation should have addressed staff's failure to report client A's change of condition when it was first noticed. RD #1 stated, "Lips turning blue should be a 911 call immediately. It should be a 911 call prior to calling the supervisor. [Client A] should not have been transported by car. 911 should have been called." RD #1 indicated the investigation should have addressed staff's failure to immediately call 911 when client A's change in status was noticed. 2. A BDDS report dated 4/20/23 indicated the following: "[DSP #4] called [QIDP #1] at 8:12 am on 4/20/23 to report that, while transporting clients from their group home to day services, she was cut off in traffic and had to brake suddenly, causing [client B] to bump her head on part of the metal grate that is part of the lift assembly. [DSP #4] reported that [client B] had no apparent cuts or bruises, and [client B] did not report any hurts or distress.			

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	[DSP #4] also stated that [client B's] wheelchair had been safely secured before they left the group home. [QIDP #1] instructed [DSP #4] to finish the trip to day services and unload the other clients before taking [client B] to [hospital] ER. [DSP #4] text (sic) [QIDP #1] at 9:14 am to report that [client A] had been taken to a room with oxygen and was being prepped for a scan of her head. [DSP #4] texted again at 10:02 am to report that the ER had released [client B]. [QIDP #1] instructed [DSP #4] to return [client B] to day services." An investigation dated 4/28/23 indicated the investigation was completed by QIDP #1. The investigation indicated QIDP #1 interviewed client B on 4/21/23 and indicated the following: "[Client B] states she remembers she bumped the back of her head on Thursday 4/20/23. [Client B] states she didn't think her seat belt was right. [Client B] states she didn't think her belt was across her belly. [Client B] states she bumped the back of her head when staff hit the brakes. [Client B] states staff pulled over to check on her. [Client B] states staff took her to the hospital." The investigation indicated Area Director (AD) #1 interviewed DSP #4 on 4/24/23 and indicated the following: "[DSP #4] states she transported the individuals on 4/20/23. [DSP #4] states she followed van procedures when securing [client B] in the van. [DSP #4] states [client B's] belt was properly strapped when she left the house. [DSP #4] states she placed the belt across [client B's] stomach when she strapped her in. [DSP #4] states [client B] does move around when she is driving and sometimes moves her belt.			

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	[DSP #4] states it could have moved while she was driving. [DSP #4] states [client B's] wheelchair leaned back, causing [client B] to bump her head on the metal grate of the lift. [DSP #4] states she pulled over to check [client B] then notified [QIDP #1].... [DSP #4] states she was trained by previous [QIDP] on how to properly secure individuals with wheel chairs in the van. Review of van training showed [DSP #4] was trained on 10/5/22. Review of van service report shows there is no issues with the equipment in the van. Review of discharge paperwork: [Client B] had no injuries and a clear CT scan. She was discharged from the ER." The investigation indicated the following: "Conclusions of Fact: Evidence supports [DSP #4] loaded [client B] into the van and followed protocol as she had been trained per her report. Evidence supports that [DSP #4] had to slam on her brakes causing [client B] to hit her head. Evidence supports that [DSP #4] pulled over to check [client B] for injury. Evidence supports that [client B] was taken to the hospital to get checked for any possible head injury. Evidence supports that [DSP #4] followed proper notification protocol. Evidence supports that [client B] had no injuries and was discharged from the hospital. Evidence supports the van was checked, and all equipment is working properly. Evidence supports that [DSP #4] needs to be retrained on the wheelchair van protocol to ensure she is doing every step correctly. This investigation is deemed inconclusive as			

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	there was no other witness observing [DSP #4] strap [client B] in the van. [DSP #4] will be re-trained on procedures to ensure she (sic) competing (sic) every step correctly. [QIDP #1 and AD #1] will ensure van observations are completed weekly. This investigation is unsubstantiated for any ANE involvement." The investigation was signed by QIDP #1 on 4/28/23. The investigation was signed by AD #1 on 5/2/23. - The review indicated the investigation was conducted by QIDP #1 who provided instruction to staff at the time of the incident. - The review indicated the investigation was not completed within 5 business days. Client B was interviewed on 5/22/23 at 7:08 pm and stated, "My chair tipped back, and I bumped my head. It tipped back when she put the brakes on." When asked if the chair tipped or slid, client B stated, "The front wheels came off the floor a little bit." DSP #4 was interviewed on 5/23/23 at 7:05 am and stated, "[Client B] had pulled herself up to the bench seats. She unlocks her wheels and moves the wheelchair up, so she can lean on the seats. When I put on the brakes, the chair moved." DSP #4 stated, "She hit her head on the grate, and I called [QIDP #1]. He tried to call [RN #1] two times. He told me to take her to the ER. They checked her out, and I took her back to day service." DSP #4 stated, "The front left lock (secures a hooked strap to the floor and is used to secure the wheelchair in place) isn't locking. I showed them in training." DSP #4 stated "[QIDP #1] and a day service staff retrained me, but we used a different van."			

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	An observation was conducted in the group home on 5/23/23 from 6:30 am to 7:30 am. Client B was present in the home throughout the observation period. The surveyor observed DSP #4 loading client B onto the van in her wheelchair using the lift and securing her in the vehicle. DSP #4 pointed to the floor locks on the front left and rear right of the wheelchair and stated, "They weren't locking properly. [QIDP #1] had them switched out." DSP #4 stated, "I told [House Manager (HM) #1] before she left in November they weren't working. I didn't tell anyone else. I couldn't get them tightened down that day [4/20/23]." DSP #4 indicated she did not call anyone to assist her with tightening the straps for client B's wheelchair. DSP #4 indicated client B moved her wheelchair while the van was moving. DSP #4 stated, "I was the only staff that day [4/20/23]. Now we have a second staff who can sit in the back to make sure she isn't unlocking her wheels or moving around." - The interview did not indicate DSP #4 reported she was unable to tighten the floor locks of the vehicle after HM #1 did not take action in November 2022. - The interview did not indicate DSP #4 reported to administration when she was unable to tighten the floor locks on 4/20/23. Client B's staff notes were reviewed on 5/23/23 at 1:15 pm and did not indicate concussion tracking was completed for client B in the days after she hit her head on 4/20/23. RN #1 was interviewed on 5/24/23 at 2:30 pm and stated, "When someone hits their head, they usually go straight to the ER. I would see them in the day or two following to see how they are doing. Staff do not do regular monitoring."			

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	QIDP #1 was interviewed on 5/24/23 at 2:30 pm and stated, "We were doing the fall protocol. We do the observation for 7 days. It goes over signs and symptoms of possible neurological problems resulting from head injury." - The documentation of the fall protocol was requested on 5/24/23 at 2:30 pm and was not available at the time of the survey. QIDP #1 was interviewed on 5/24/23 at 2:30 pm and stated, "[DSP #4] called me after the incident. She pulled over to the shoulder of the road before calling. She said she had to make a panic stop to avoid a collision because someone stopped suddenly in front of her. She told me that she stopped to go in back and look at [client B]. She seemed to have bumped her head. It didn't seem serious. She said she was very close to the day program. I told her to go to day program and let the other clients off. She then took her to [hospital]. She was seen and cleared there." QIDP #1 stated, "[DSP #4] didn't say anything about have issues with the tie down straps. I took the van to be inspected. They said the van was looking well. I did a retraining with [DSP #4]. I noticed it could have been a little tighter. I told her to get the tie downs tighter. She can use the knobs on the side and get them wrenched in. We implemented a plan of checking the van 3 times a week. I or the [House Manager] would watch the van being loaded and unloaded." QIDP #1 stated, "[DSP #4's] issues with the tie down straps were not shared with me. If staff aren't sure how to do something, they should ask a supervisor for more training." QIDP #1 stated, "[DSP #4] should not have driven with the client if the straps weren't tight." Area Director (AD) #1 was interviewed on 5/24/23 at 2:30 pm and stated, "[DSP #4] should have			

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	reported to a supervisor to let them know she didn't know how to use the straps or was uncomfortable." AD #1 stated, "I've been in the house many times. She came to the office that morning and spoke with us and never reported anything about the straps being loose that morning." AD #1 was interviewed on 5/24/23 at 2:30 pm and stated, "Staff report concerns immediately by phone. Right now, they contact [QIDP #1]. There is a nurse on-call." AD #1 stated, "The investigation for [client A] was completed by quality assurance. I completed the investigation for [client B]." AD #1 stated, "The investigation should include an interview with the staff involved, the individuals. There is a review of pertinent documentation that would apply to an investigation: the BSP (behavior support plan), high risk plan, whatever is pertinent." AD #1 stated, "Investigations should be completed within 7 business days. We ensure each staff and individual signs off on their interview statements." This federal tag relates to complaint #IN00407643 and complaint #IN00408581. 9-3-2(a)			
W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 2 of 2 allegations of abuse and neglect reviewed, the facility failed to report findings of an investigation	W 0156	The facility has and implements written policies and procedures on staff treatment of clients that	07/05/2023

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	15G599	A. BUILDING 00 B. WING	06/05/2023

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	for an injury of unknown origin for client A and an allegation of neglect for client B to administration within 5 business days. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) Reports and related investigations were reviewed on 5/22/23 at 1:26 pm. 1. A BDDS report dated 4/23/23 indicated the following: "Direct Support Professional (DSP) [#6] called [Qualified Intellectual Disabilities Professional (QIDP) #1] to report changes in [client A's] behavior and condition: she was presenting as lethargic, having difficulty walking, and was unusually quiet. [QIDP #1] instructed [DSP #6] to call on-call nurse and observe her. [DSP #4] called to report that they had taken [client A's] vitals (blood pressure: 107/60, heart rate 72, oxygen 94, blood sugar 140), and also that [client A's] lips had developed a bluish tint. [QIDP #1] instructed [DSP #4] to take [client A] to [hospital] ER (emergency room). [QIDP #1] drove to meet [DSP #4] at the hospital and called [client A's] guardians to inform them of the situation. [Client A] received a CT (computerized tomography) scan to check for a stroke and took blood and urine samples for testing. An examination of her left leg showed an untreated fracture estimated to be from December, before she came into the care of Indiana Mentor. [Client A] was admitted for continued observation." An investigation dated 5/16/23 indicated the investigation was completed by Quality Improvement Field Services Specialist (QIFSS) #1. The investigation was signed by QIFSS #1 on		prohibits mistreatment, all forms of neglect, including medical, or abuse of the client. These policies and procedures include the proper reporting of investigation results within 5 business days to administration and other state officials as in accordance with State law. Retraining will also be provided to Program Director and Area Director on Indiana Mentor minimum standard guidelines that covers all components of a thorough investigation of all of these incidents that must begin immediately and be reviewed by Area Director, Regional Director, and Quality. Retraining will also cover calling 911 for immediate medical services and transportation instead of staff transporting individuals to the hospital and will include competency based testing to ensure staff comprehension of expectations. The Program Supervisor and Program Director will complete weekly in home checks to observe DSP active compliance with re-trainings. Responsible Person: Regional Director, Program Director, Area Director, Program Supervisor	

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	5/16/23. The investigation was reviewed and signed by Quality Improvement Manager on 5/23/23. 2. A BDDS report dated 4/20/23 indicated the following: "[DSP #4] called [QIDP #1] at 8:12 am on 4/20/23 to report that, while transporting clients from their group home to day services, she was cut off in traffic and had to brake suddenly, causing [client B] to bump her head on part of the metal grate that is part of the lift assembly. [DSP #4] reported that [client B] had no apparent cuts or bruises, and [client B] did not report any hurts or distress. [DSP #4] also stated that [client B's] wheelchair had been safely secured before they left the group home. [QIDP #1] instructed [DSP #4] to finish the trip to day services and unload the other clients before taking [client B] to [hospital] ER. [DSP #4] text [QIDP #1] at 9:14 am to report that [client A] had been taken to a room with oxygen and was being prepped for a scan of her head. [DSP #4] texted again at 10:02 am to report that the ER had released [client B]. [QIDP #1] instructed [DSP #4] to return [client B] to day services." An investigation dated 4/28/23 indicated the investigation was completed by QIDP #1. The investigation was signed by QIDP #1 on 4/28/23. The investigation was reviewed and signed by AD #1 on 5/2/23. - The review indicated the investigation was not completed within 5 business days. Area Director (AD) #1 was interviewed on 5/24/23 at 2:30 pm and stated, "Investigations should be completed within 7 business days." Regional Director (RD) #1 was interviewed by			

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	phone on 6/5/23 at 9:00 am and stated, "Investigations should be completed within 5 business days." This federal tag relates to complaint #IN00407643 and complaint #IN00408581. 9-3-2(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview for 1 of 3 sample clients (C), the facility failed to ensure client C's formal and informal Individual Support Plan (ISP) objectives were implemented at all opportunities. Findings include: Observations were conducted in the group home on 5/22/23 from 4:30 pm to 7:30 pm and on 5/23/23 from 6:30 am to 8:00 am. An observation was conducted in the facility owned and operated day serve on 5/24/23 from 12:00 pm to 12:30 pm. Client C was present in the group home and day service throughout the observation periods. On 5/22/23, client C was in his bed with the bedroom door shut and the lights off from 4:30 pm to 6:50 pm. Other clients in the home went on community outings and were engaged in puzzles and meal preparation activities. Staff did not	W 0249	The facility develops and utilizes the client ISP and teaming input to develop programming goals to ensure the client is provided with continuous Active Treatment in sufficient number and frequency to support the achievement of the objectives identified. Area Director will provide re-training to QIDP on Q reviews to ensure active treatment goals are being developed, revised, and implemented correctly to assist with supporting independence for all individuals. The Program Director and Program Supervisor will provide re-training to Direct Support Professionals on the implementation of goals both whenever the natural opportunity presents and as a part of the	07/05/2023

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	prompt client C to participate in activities. At 6:50 pm, client C walked to the kitchen table. Staff prepared and served client C's drink and plate. Staff encouraged other clients to serve their own meals using hand over hand assistance. Client C was not encouraged to serve himself. On 5/24/23, client C sat at a table in the facility owned and operated day program from 12:00 pm to 12:30 pm. Client C sat with his head tipped down towards his lap. Staff did not encourage client C to engage in activities. Direct Support Professional (DSP) #2 was interviewed on 5/22/23 at 7:15 pm and stated, "[Client C] naps after day service. He says he's tired, so he naps." DSP #2 stated, "[Client C] is an outdoor person. He likes to sit outside." When asked about client C's goals, DSP #2 stated, "He takes out the garbage, and he takes his morning medications." When asked how frequently client C should be prompted to engage in active treatment activities, DSP #2 stated, "3 times." DSP #2 stated, "[Client C] can serve himself when he wants to. We prompt him 3 times then we help if he doesn't want to do it." Client C's record was reviewed on 5/23/23 at 2:30 pm. Client C's Individual Support Plan (ISP) dated 8/10/22 indicated the following goals: "Once a month, [client C] will participate in emergency drills with 3 verbal prompts for 100% of the trials for 3 consecutive months. Once a month, [client C] will participate in a natural disaster emergency drills (sic) with 3 verbal prompts for 100% of the trials for 3 consecutive months. Once a week, [client C] will identify coins with 3 verbal prompts from staff for 60% of trials for 3		individual's normal routines to increase active treatment and success in the identified area by 7/5/2023. The Program Director will provide re-training to Program Supervisor and Direct Support Professionals on active treatment to ensure staff are prompting individuals to participate in activities of daily living to support independence by 7/5/2023. The Program Supervisor will complete observations two times weekly to ensure that staff is implementing programming goals at all opportunities. The Program Director will complete weekly observations for one month to ensure that staff is implementing programming goals at all opportunities. The Program Supervisor will complete meal observations two times weekly to ensure staff are providing active treatment and encouraging independence during meals. The Program Director will complete weekly meal observations for one month to ensure staff are providing active treatment to all individuals. Person Responsible: Area Director, Program Supervisor and Program Director	

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	consecutive months. Daily, in the AM, [client C] will shave with 3 verbal prompts for 80% of trials for 3 consecutive months. Daily in the AM, [client C] will get out of the bath tub with 2 verbal prompts for 80% of trials for 3 consecutive months. On Saturdays and Wednesday, [client C] will take the kitchen trash out to the outside trash cans with 3 verbal prompts for 75% of the trials for 3 consecutive months. Daily for med pass, [client C] will learn his blood pressure medicine for 75% of the trials with 3 verbal prompts. Daily for AM med pass, [client C] will learn his constipation medicine for 75% of the trials with 3 verbal prompts." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 5/24/23 at 2:30 pm and stated, "[Client C] could serve himself with hand over hand assistance from staff. Staff should encourage him to try." QIDP #1 stated, "Staff should prompt clients for activity 3 times." Area Director (AD) #1 was interviewed on 5/24/23 at 2:30 pm and stated, "Active treatment is training the individual in daily living skills, health and safety skills, medications, and cooking. They can participate in some part of their daily living." AD #1 stated, "Staff should prompt activity every 15 minutes in the home and at day program." AD #1 stated, "[Client C] has been up during the night and sleeps more when some staff are working than others. Staff should be attempting to engage and prompt him." AD #1 stated, "[Client C] could serve himself with hand over hand assistance as needed. Staff should encourage him to do it himself before doing it for him."			

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	9-3-4(a)			
W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 3 sample clients (A), the facility failed to ensure client A had vision and hearing exams completed within 30 days of admission. Findings include: Client A's record was reviewed on 5/23/23 at 1:28 pm and indicated an admission date of 1/31/23. Client A's record did not include a record of vision and hearing assessments. Registered Nurse (RN) #1 was interviewed on 5/24/23 at 2:30 pm and stated, "[Client A's] vision and hearing appointments were scheduled, but she was in the hospital." RN #1 stated, "They should be completed within 30 days of admission." 9-3-6(a)	W 0323	The governing body and management exercises general policy, and operating direction over the facility's responsibility to ensure Nursing services are providing all required medical oversight, observation, follow up, and follow through of physician services to ensure annual physical examinations that include evaluation of vision and hearing. Program Supervisor, Program Director, and Nurse will be retrained on ensuring any individuals moving into the group home have a hearing evaluation and vision exam completed within the first 30 days of the their admission. Any new individual will be added onto the master appointment spread sheet by the Nurse. An IDT meeting with the entire team including; Regional Director, Area Director, Program Directors and Program Supervisors of Day Services and QIDP of the home, Behavioral Specialists, Nurse, and Quality Improvement will occur ongoing weekly to address and correct any outstanding medical appointments, upcoming	07/05/2023

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			appointments; ensuring timely scheduling, attendance, documentation, and follow up. The IDT will review the master spreadsheet each meeting to ensure all appointments, follow up's, and supporting documentation have been completed correctly. This ongoing IDT meeting will remain to occur weekly for at minimum two months, but not until all appointments, follow up's, supporting documentation, and staff training is amended to provide programming that not only meets standards, but promotes independence and proper staff support to achieve goals. Responsible Staff: Entire IDT; Program Supervisor, Program Director, Area Director, Regional Director, Nurse, Quality, Behavior.	
W 0351 Bldg. 00	483.460(f)(1) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission). Based on record review and interview for 1 of 3 sample clients (A), the facility failed to ensure client A had a dental exam competed within 30	W 0351	The facility provides general policy and operating direction in ensuring comprehensive dental diagnostic services are provided not later than	07/05/2023

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	days of admission. Findings include: Client A's record was reviewed on 5/23/23 at 1:28 pm and indicated an admission date of 1/31/23. Client A's record did not include documentation of a dental appointment. Registered Nurse (RN) #1 was interviewed on 5/24/23 at 2:30 pm and stated, "A dental assessment should be completed within 30 days of admission." 9-3-6(a)		one month after admission to the facility. /p> /p> /p> Persons Responsible: Area Director, Nurse, Program Supervisor, Program Director	
W 0352 Bldg. 00	483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. Based on record review and interview for 2 of 3 sample clients (B and C), the facility failed to ensure clients B and C had dental assessments completed at least annually. Findings include: 1. Client B's record was reviewed on 5/23/23 at 1:15 pm and indicated her most recent dental assessment was completed in November 2021. Registered Nurse (RN) #1 was interviewed on 5/24/23 at 2:30 pm and stated, "[Client B] was scheduled for a dental appointment in March 2023. I never received an appointment sheet. It was scheduled, but whether it was attended or not, without the appointment sheet, I cannot say."	W 0352	The governing body and management exercises general policy, and operating direction over the facility's responsibility to ensure comprehensive dental diagnostic services being performed upon admit and annually thereafter. The Nurse created a master appointment tracking sheet that she will send out weekly to the IDT. An IDT meeting with the entire team including; Regional Director, Area Director, Program Directors and Program Supervisors of Day Services and QIDP of the home, Behavioral Specialists, Nurse, and Quality	07/05/2023

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	RN #1 stated, "[Client B] should see a dentist yearly." 2. Client C's record was reviewed on 5/23/23 at 2:30 pm and indicated his most recent dental assessment was completed on 1/27/22. RN #1 was interviewed on 5/24/23 at 2:30 pm and stated, "[Client C] was scheduled for an appointment in February 2023. I don't know if he went or not without the appointment sheet." RN #1 stated, "[Client C] should see a dentist every 6 months." Area Director (AD) #1 was interviewed on 5/24/23 at 2:20 pm and stated, "After the appointment, staff are to bring the form to the office to put a copy on [Qualified Intellectual Disabilities Professional (QIDP) #1's] desk and give [RN #1] the original. There was an issue in the past with appointment forms." 9-3-6(a)		Improvement will occur ongoing weekly to address and correct any outstanding medical appointments, upcoming appointments; ensuring timely scheduling, attendance, documentation, and follow up. The IDT will review the master spreadsheet each meeting to ensure all appointments, follow up's, and supporting documentation have been completed correctly. This ongoing IDT meeting will remain to occur weekly for at minimum two months, but not until all appointments, follow up's, supporting documentation, and staff training is amended to provide programming that not only meets standards, but promotes independence and proper staff support to achieve goals. Responsible Staff: Entire IDT; Program Supervisor, Program Director, Area Director, Regional Director, Nurse, Quality, Behavior.	
W 0383 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation, record review, and interview for 2 of 3 sample clients (B and C), plus 3 additional clients (D, E, and F), the facility failed to ensure the keys to clients B, C, D, E, and F's medication storage cart were not readily accessible.	W 0383	This facility keeps all drugs and biologicals locked except when being prepared for administration with trained staff providing oversight to ensure security/safety. The Program Supervisor and all	07/05/2023

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	Findings include: Observations were conducted in the group home on 5/22/23 from 4:30 pm to 7:30 pm and on 5/23/23 from 6:30 am to 7:30 am. Clients B, C, D, E, and F were present in the home throughout the observation periods. Throughout the observation periods the keys to the medication cart were kept in an open box on top of the cart. On 5/23/23 at 6:38 am, Direct Support Professional (DSP) #7 finished administering client F's medications. DSP #7 locked the cart and set the keys on top of the cart. DSP #7 took client F to the living room and returned with client E. After administering client E's medications, DSP #7 put the keys to the medication cart in an open box on top of the cart and left them there. DSP #7 was interviewed on 5/23/23 at 6:58 am and stated, "We keep the medication keys in the yellow box on top of the medication cart." Registered Nurse (RN) #1 was interviewed on 5/24/23 at 2:30 pm and stated, "The key is kept in a basket on top of the medication cart." RN #1 stated, "Clients could access the key on top of the cart." Area Director (AD) #1 was interviewed on 5/24/23 at 2:30 pm and stated, "The key to the medication cart should not be kept where clients can access it." 9-3-6(a)		staff have been trained on medication security, including the proper placement of the medication cabinet key, ensuring only authorized individuals have access to the key, and ensuring the cabinet is always locked unless preparing medications for administration. The Program Supervisor, Program Director, or Nurse will complete observations 2 times per week for one month to monitor for compliance. An observation schedule will be utilized to ensure all observations are completed. Once continued compliance has been achieved, the observations will change to one time per week. Responsible Parties- Area Director, Program Director, QIDP, Program Supervisor, Nurse	
W 0440	483.470(i)(1) EVACUATION DRILLS			

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Bldg. 00	at least quarterly for each shift of personnel. Based on record review and interview for 3 of 3 sample clients (A, B, and C), plus 3 additional clients (D, E, and F), the facility failed to ensure clients A, B, C, D, E, and F participated in evacuation drills at least quarterly for each shift of personnel. Findings include: Clients A, B, C, D, E, and F's evacuation drills were reviewed on 5/22/23 at 6:18 pm. The record indicated the following shifts: 1st shift: 7:00 am to 3:00 pm. 2nd shift: 3:00 pm to 11:00 pm. 3rd shift: 11:00 pm to 7:00 am. The record indicated the following drills were completed: 1st shift: 10/20/22 at 7:00 am. The review indicated fire drills were not run on the first shift in the 3rd quarter of 2022 and in the first quarter of 2023. 2nd shift: 8/23/22 at 7:00 pm. 11/18/22 at 5:00 pm. 2/18/23 at 3:00 pm. 3rd shift: 6/11/22 at 2:00 am. 9/8/22 at 3:00 am. 12/7/22 at 3:00 am. The review indicated a fire drill was not run on the third shift in the 1st quarter of 2023. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 5/24/23 at 2:30 pm and stated, "Fire drills are supposed to be done	W 0440	The facility trains all managers and employees on the implementation of a fire evacuation plan and protocol to keep the clients safe. Evacuation drills are scheduled to be implemented monthly on rotating shifts to ensure each shift has a drill run every quarter. The Program Director will train the Program Supervisor and staff to complete fire/evacuation drills monthly per calendar schedule on rotating shifts. In the future the Program Supervisor will review the safety book on a weekly basis to ensure the evacuation drills have been completed and are located in the safety book. The Program Supervisor will verify the drills are completed on the correct shift and time or run another drill. The Program Director will verify the drill s have been completed by checking the home at least monthly. Responsible Person: Program Director, Program Supervisor	07/05/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REM-INDIANA INC	860 W 65TH LN MERRILLVILLE, IN 46410

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	monthly." Area Director (AD) #1 was interviewed on 5/24/23 at 2:30 pm and stated, "There should be a drill done on every shift for the quarter." 9-3-7(a)			
W 0454 Bldg. 00	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation, record review, and interview for 2 additional clients (E and F), the facility failed to implement universal precautions in regards to hand washing for clients E and F at the time of their medication administration. Findings include: An observation was conducted on 5/23/23 from 6:30 am to 7:30 am. Clients E and F were present in the home throughout the observation period. 1. On 5/23/23 at 6:30 am, Direct Support Professional (DSP) #7 prepared client F's medications. DSP #7 popped all of client F's medications from the pharmacy packaging into a medication cup. DSP #7 spooned applesauce into the medication cup and stirred it. DSP #7 carried client F's medications to the living room and took client F to the medication room in her wheelchair. DSP #7 administered client F's medications. DSP #7 did not encourage client F to wash or sanitize her hands before taking her medications. DSP #7 did not wash or sanitize her hands before or after passing client F's medications.	W 0454	The governing body has rules and regulations regarding the importance of infection control and responsibility of the facility to provide a sanitary environment to avoid sources and transmission of infections. /p> /p> The Program Supervisor, Program Director, or Nurse will complete observations 2 times per week for one month to monitor for compliance. An observation schedule will be utilized to ensure all observations are completed. Once continued compliance has been achieved, the observations will change to one time per week. /p> Person Responsible: Area Director, Nurse, Program Director, Program Supervisor	07/05/2023

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	2. On 5/23/23 at 6:42 am, DSP #7 took client E to the medication room. DSP #7 prepared client E's medications and handed the medication cup to him. Client E took his medications. DSP #7 did not encourage client E to wash or sanitize his hands before taking his medications. DSP #7 did not wash or sanitize her hands before or after passing client E's medications. DSP #7 was interviewed on 5/23/23 at 6:58 am and stated, "Staff sanitize their hands before each medication pass. Sometimes the clients sanitize their hands before taking medications. I ask the ones who can to do it." Registered Nurse (RN) #1 was interviewed on 5/24/23 at 2:30 pm and stated, "Staff should wash their hands for 30 seconds prior to passing medications. Between each individual, they can use hand sanitizer. They wash their hands again after all medication passes are completed. Clients should sanitize their hands before taking their medications." Area Director (AD) #1 was interviewed on 5/24/23 at 2:20 pm and stated, "Staff should wash their hands, and the client should wash their hands before medications. Hand sanitizer can be used." The facility's undated medication administration policy was reviewed on 5/30/23 at 9:30 am and indicated the following: "Before administering any medications, always wash your hands." 9-3-7(a)			
W 9999 Bldg. 00				

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	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met: 460 IAC 9-3-2(c)(3) Resident protections (c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section. This State rule is not met as evidenced by: Based on record review and interview for 2 of 3 employee files reviewed, the facility failed to ensure Direct Support Professionals (DSPs) #5 and #7 had 3 reference checks completed prior to employment at the group home. Findings include: The facility's employee files were reviewed on 5/23/23 at 1:38 pm. 1. DSP #5's record indicated a hire date of 2/23/23. DSP #5's record included 2 references dated 3/21/23 and 1 dated 3/23/23. 2. DSP #7's record indicated a hire date of 5/4/23. DSP #7's record did not include any references. Office Coordinator #1 was interviewed on 5/23/23 at 1:45 pm and indicated she contacted references for DSP #5. Office Coordinator #1 indicated the employee references were completed after DSP #5 began working in the group home.	W 9999	The Facility has policies and procedures in place to ensure employee background checks are completed prior to working at any site with any individual. Office Coordinator has been retrained on the expectation that no new hire is allowed to complete the New Orientation Process without the completion of their reference checks. Person Responsible: Regional Director, Area Director	07/05/2023

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	Area Director (AD) #1 was interviewed on 5/24/23 at 2:30 pm and stated, "There should be 3 references done when employees come in for NEO (new employee orientation) before they start working in the group home." 9-3-2(c)(3)			