STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G331	A. BUILDING 00 B. WING	01/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARENTS AND FRIENDS INC	1709 FARRAND AVE LA PORTE, IN 46350

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W 0000 Bldg. 00	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: January 10, 11, 12, and 13, 2017. Facility number: 000849 Provider number: 15G331 AIM number: 100243820 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/23/17.	W 0000		
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 and interview, the facility's governing body failed to exercise general operating direction over the facility by failing to assure the bedroom belonging to 2 of 3 additional clients (clients #5 and #6) was clean, orderly, and in good condition.	W 0104	In order for this citation to be met now and in the future, staff will ensure residents have appropriate bedding on each night before they go to bed. Staff will assist them in making their beds. If any of the residents refuse to have appropriate bedding (in this case, a fitted	02/12/2017

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

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	Findings include: Client #5 and #6's bedroom was inspected during the 1/9/17 observation period from 3:48 P.M. until 5:45 P.M. The floor was strewn with personal items, clothing, and blankets. The clients' night stands and dressers were covered with clothing and personal items. Client #5 and #6's beds did not have blankets, only vinyl mattress covers. The blinds on the window were crushed. Direct care staff #3 was interviewed on 1/10/17 at 7:03 A.M. Direct care staff #3 stated, "I don't know why it's (client #5 and #6's bedroom) like that." Director of Residential Services #1 was interviewed on 1/10/17 at 10:07 A.M. Director of Residential Services #1 stated, "Their (client #5 and #6's) room should be clean and orderly. It's staff's (direct care staff's) responsibility to see that it is (clean and orderly)." 9-3-1(a)		sheet), then staff will offer again. If the residents still refuse, staff will document the refusals. Staff will then continue to offer on a daily basis. All staff were made aware of this citation on 1/18/17. All staff will have official retraining on this citation on 2/9/17 at the home monthly IHP meeting. the QIDP will have bi monthly unexpected mock surveys at each of the homes. This will allow for the Q to prep staff for real surveys and continue to guide staff in appropriate active treatment. (Residential Director, QIDP, Team Leader and DSPs responsible)	

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W 0137 Bldg. 00	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation, record review, and interview, the facility failed to assure 1 of 3 sampled clients (client #2) wore slippers of appropriate size. Findings include: Client #2 was observed at the group home on 1/9/17 from 3:48 P.M. until 5:45 P.M. During the observation period, client #2 wore slippers which were three inches too large and shuffled himself throughout the facility. Direct care staff #1 and #2 did not prompt or assist the client to put on foot wear that was of appropriate size. Client #2's records were reviewed on 1/10/17 at 8:42 A.M. Review of a 7/13/16 Fall Risk Plan indicated the client was at high risk of falls. Director of Residential Services) #1 was interviewed on 1/10/17 at 10:07 A.M.. Director of Residential Services #1	W 0137	In order for this citation to be met now and in the future for this home and all homes, staff will check to see if all clothing is appropriate and fitting correctly on each shift to assure dignity and safety of each resident. if resident refuse to change to appropriate clothing staff will give resident education on why their clothing may not be appropriate. If resident continues to refuse, staff will document refusal and try again the next shift. Staff were made aware of this citation on 1/18/17 and will receive official retraining on 2/9/17. (QIDP, Residential Director, Team Leader and DSP responsible)	02/12/2017

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	stated, "It is staff's (direct care staff's) responsibility to assure he (client #2) wears shoes or slippers that are the right size." 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, the facility failed to implement a choking risk plan for 1 of 3 additional clients (client #6) during the morning meal. Findings include: Client #6 was observed at the group home during the 1/10/17 observation period from 5:28 A.M. until 7:00 A.M. At 6:11 A.M., client #6 sat down and began stuffing 2" (inch)by 3" pieces of	W 0249	In order to ensure this citation is met now and in the future for this home and all homes, staff will be cognizant of all resident choke risk plans. The Nurse/Q will retrain staff on all risk plans/updates to risk plans after any renewals occur. Staff will follow plans appropriately and assist residents when necessary. Staff were made aware of this citation on 1/18/17 and will have official retraining on 2/9/17. The QIDP will have bi monthly unexpected mock surveys at each of the homes. This will	02/12/2017

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	waffle into his mouth. The client rapidly stuffed his mouth while chewing without swallowing. As the client was stuffing his mouth with pieces of waffle, direct care staff #2 and #3 stood three feet away watching. Direct care staff #2 and #3 did not prompt client #6 to slow his eating and take smaller bites. Client #6's records were reviewed on 1/10/17 at 8:10 A.M. The review of the client's 8/10/16 Choking Risk Assessment indicated client #6 had a history of choking and a high risk for further incidents of choking. The assessment also indicated direct care staff were to prompt client #6 to slow down while eating and to take smaller bites of food. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/10/17 at 8:12 A.M. QIDP #1 stated, "Staff (direct care staff) should have prompted [client #6] to slow down and to take smaller bites." 9-3-4(a)		allow for the Q to prep staff for real surveys and continue to guide staff in appropriate active treatment, along will monitoring to see if risk plans are being implemented appropriately, when applicable. (RN, QIDP, Residential Director, Team Leader and DSPs responsible)	

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W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, the facility failed to ensure medications were locked except when they were being prepared for administration for 1 of 3 additional clients (client #4). Findings include: Client #4 was observed during the group home observation period on 1/9/17 from 3:48 P.M. until 5:45 P.M. At 4:03 P.M., direct care staff #1 was preparing a medication to administer to client #4. At 4:04 P.M., direct care staff #1 had client #4's medication on the medication cart when she left the medication area to get direct care staff #2 to count the number of tablets left in the medication bubble pack. Direct care staff #1 was away from the medication area for 30 seconds. The open medication was left on the medication cart making them accessible to client #4 who standing in front of it. Nurse #1 was interviewed on 1/10/17 at 10:07 A.M. Nurse #1 stated, "Medications are to be locked when they aren't being administered." 9-3-6(a)	W 0382	In order for this citation to be met now and in the future for this home and all others, staff will be retrained on appropriate dispensation, destruction and 6 rights of all medications and locking med cabinet when staff is not next to the medication cabinet. Staff were made aware of this citation on 1/18/17. The official training will be 2/9/17. If an error is made, staff will receive appropriate disciplinary action, leading to dismissal. The QIDP will have bi monthly unexpected mock surveys at each of the homes. This will allow for the Q to prep staff for real surveys and continue to guide staff in appropriate active treatment and medication dispensation guidelines. (Residential Director, QIDP, RN, Team Leader and DSPs responsible)	02/12/2017

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W 0419 Bldg. 00	483.470(b)(4)(iii) CLIENT BEDROOMS The facility must provide each client with bedding appropriate to the weather and climate. Based on observation and interview, the facility failed to assure 2 of 3 additional clients (clients #5 and #6 slept with bed sheets on their beds. Findings include: Clients #5 and #6 were observed at the group home during the 1/10/17 observation period from 5:28 A.M. until 7:00 A.M. At 5:36 A.M., clients #5 and #6 were sleeping in their beds. The beds were noted to not have bed sheets as the clients were sleeping directly on the mattresses. Direct care staff #3 was interviewed on 1/10/17 at 7:03 A.M. Direct care staff #3 stated, "I don't know why they (clients #5 and #6) don't have sheets." Director of Residential Services #1 was interviewed on 1/10/17 at 10:07 A.M. Director of Residential Services #1 stated, "They (clients #5 and #6) are supposed to have sheets on their beds."	W 0419	In order for this citation to be met now and in the future, staff will ensure residents have appropriate bedding on each night before they go to bed. Staff will assist them in making their beds. If any of the residents refuse to have appropriate bedding (in this case, a fitted sheet), then staff will offer again. If the residents still refuses, staff will document the refusals. Staff will then continue to offer on a daily basis. All staff were made aware of this citation on 1/18/17. All staff will have official retraining on this citation on 2/9/17 at the home monthly IHP meeting. the QIDP will have bi monthly unexpected mock surveys at each of the homes. This will allow for the Q to prep staff for real surveys and continue to guide staff in appropriate active treatment. (Residential Director, QIDP, Team Leader and DSPs responsible)	02/12/2017

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	9-3-7(a)			
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, the facility failed to assure 1 of 3 sampled clients with eyeglasses (client #2) wore, or was prompted to wear, his eyeglasses. Findings include: Client #2 was observed at the group home during the 1/9/17 observation period from 3:48 P.M. until 5:45 P.M. and on 1/10/17 from 5:28 A.M. until 7:00 A.M. During the observation periods, client #2 did not wear eyeglasses and direct care staff #1, #2, #3, #4, and #5 did not prompt or assist client #2 to wear eyeglasses. Client #2's record was reviewed on	W 0436	In order for this citation to be met now and in the future and for this home and all others, staff will periodically, throughout their shift, prompt all consumers with adaptive equipment to use/wear their adaptive equipment. If resident refuses to use the adaptive equipment then staff will educate resident about using the equipment, and document the refusals. Staff will then continue to prompt the resident on the next shift. The PAF RN will also get in contact with the vision doctor to assess if resident needs to wear glasses only at certain times, or all the time. Staff will then educate the residents accordingly to prompt residents to use their adaptive equipment. The QIDP will have bi monthly unexpected mock surveys at each of the homes. This will allow for the Q	02/12/2017

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	1/10/17 at 8:42 A.M. A review of client #2's 6/28/16 Vision Exam indicated client #1 was to wear "glasses" (eyeglasses). Nurse #1 was interviewed on 1/12/17 at 7:44 A.M. Nurse #1 stated, "His (client #2's) Optometrist said he (client #2) doesn't have to wear them (eyeglasses) all of the time but I just got that order from the eye doctor this morning (1/12/17)." 9-3-7(a)		to prep staff for real surveys and continue to guide staff in appropriate active treatment. (Residential Director, QIDP, RN, Team Leader and DSPs responsible)	
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview, the facility failed to assure 1 of 9 administered medications was not administered after falling on the floor affecting 1 of 3 sampled clients (client #2). Findings include: Client #2 was observed during the group home observation period on 1/10/17 from 5:28 A.M. until 7:00 A.M. At 6:29	W 0455	In order for this citation to be met now and in the future for this home and all others, staff will be retrained on appropriate dispensation, destruction and 6 rights of all medications and locking medication cabinet when staff are not next to the med cabinet. Staff were made aware of this citation on 1/18/17. The official retraining will be 2/9/17. If an error is made, staff will receive appropriate disciplinary action, leading to dismissal.	02/12/2017

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	A.M., direct care staff #2, while administering medications to client #2, dropped a medication tablet onto the floor. Direct care staff #2 picked the medication tablet up off the floor and administered it to client #2. Nurse #1 was interviewed on 1/10/17 at 9:07 A.M. Nurse #1 stated, "Staff (direct care staff) are to never administer a medication that has dropped onto the floor. Any medication that falls onto the floor is contaminated." 9-3-7(a)		The QIDP will have bi monthly unexpected mock surveys at each of the homes. This will allow for the Q to prep staff for real surveys and continue to guide staff in appropriate active treatment and appropriate protocol for med dispensation. (Residential Director, QIDP, Team Leader and DSPs responsible)	
W 0460 Bldg. 00	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review, and interview, the facility failed to assure 3 of 3 sampled clients (clients #1, #2, and #3), and 3 of 3 additional clients (clients #4, #5, and #6) were offered the listed morning meal items on the 1/10/17 menu. Findings include: Clients #1, #2, #3, #4, #5, and #6 were	W 0460	In order to ensure this tag is being met now and in the future for this home and all group homes, staff will prompt and assist all residents to eat what is one the menu. Staff will offer all choices listed on the approved menu. If there are substitutions, staff need to make sure the substitutions are written on the menu on a daily basis. This will be monitored by the team leader	02/12/2017

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	observed during the group home observation period on 1/10/17 from 5:28 A.M. until 7:00 A.M. At 6:05 A.M., direct care staff #2 prompted the clients to "fix yourself some breakfast." Clients #2, #3, #5, and #6 prepared themselves several waffles and coffee or milk. Client #1 had coffee and client #4 did not prepare or eat anything for breakfast. The 1/10/17 morning menu for clients #1, #2, #3, #4, #5, and #6 was reviewed on 1/10/17 at 6:27 A.M. The review indicated the following foods, and amounts of the foods, were to be offered for the morning meal: 1/2 cup cranberry juice, 3/4 cup hot/cold cereal, 1 slice wheat toast, and 1 cup of skim milk. Further review of the 1/10/17 morning menu failed to indicate food substitutions were noted. Director of Residential Services #1 was interviewed on 1/12/17 at 8:44 A.M. Director of Residential Services #1 stated, "Staff (direct care staff #2 and #3) should have at least offered the foods which were on the menu or noted appropriate sized substitutions." 9-3-8(a)		when the team leader is on duty. The team leader will use her/his check list to check off for appropriate substitutions. The QIDP will have bi monthly unexpected mock surveys at each of the homes. This will allow for the Q to prep staff for real surveys and continue to guide staff in appropriate active treatment, including meal time preparation. (Residential Director, Program Manager, Team Leader and DSPs responsible)	

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