STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G331	B. W	NG		01/13/	/2017
				CTREET	DDRESS, CITY, STATE, ZIP CODE RRAND AVE TE, IN 46350 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5)		
NAME OF F	PROVIDER OR SUPPLIE	R					
DADENT	C AND EDIENDE I	NC					
PARENT	S AND FRIENDS I	NC		LA POF	RTE, IN 46350		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W 0000							
Bldg. 00							
	This visit was fo	or a fundamental	W (0000			
	recertification as	nd state licensure survey.					
		Ž					
	Dates of Survey	y: January 10, 11, 12, and					
	1	y. January 10, 11, 12, and					
	13, 2017.						
	Facility number	: 000849					
	Provider numbe	r: 15G331					
	AIM number: 1	00243820					
	The following for	ederal deficiencies also					
	1						
		lings in accordance with					
	460 IAC 9.						
		this report completed by					
	#15068 on 1/23/17						
W 0104	483.410(a)(1)						
	GOVERNING BO	DDY					
Bldg. 00		ody must exercise general					
		nd operating direction over					
	the facility.						
	Based on observ	vation and interview, the	W (104	In order for this citation to be r		02/12/2017
		ing body failed to			now and in the future, staff wil		
		operating direction over			ensure residents have		
	_	ailing to assure the			appropriate bedding on each	1-E	
	1	•			night before they go to bed. S		
	l -	ging to 2 of 3 additional			will assist them in making their beds. If any of the residents		
	`	\$5 and \$6) was clean,			refuse to have appropriate		
	orderly, and in g	good condition.			bedding (in this case, a fitted		

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

TITLE

(X6) DATE

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

Facility ID:

PRINTED: 05/10/2017 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G331	A. BUILDING 00 B. WING	COMPLETED 01/13/2017
	ROVIDER OR SUPPLIER S AND FRIENDS INC	STREET ADDRESS, CITY, STATE, ZIP CO 1709 FARRAND AVE LA PORTE, IN 46350	DDE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF TAG DEFICIENCY)	ECTION (X5) OULD BE PPROPRIATE COMPLETION DATE
	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)."	sheet), then staff will off If the residents still refu will document the refusa will then continue to offe daily basis. All staff we aware of this citation on All staff will have officia retraining on this citation 2/9/17 at the home mor meeting. the QIDP will monthly unexpected mo surveys at each of the h This will allow for the C staff for real surveys an to guide staff in appropri treatment. (Residential Director, Q Team Leader and DSPs responsible)	fer again. use, staff als. Staff er on a use made use 1/18/17. ul use on a use made

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Facility ID: 000849

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		15G331	B. WI	NG		01/13/	2017
	PROVIDER OR SUPPLIER			1709 F <i>A</i>	ADDRESS, CITY, STATE, ZIP CODE ARRAND AVE RTE, IN 46350		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W 0137 Bldg. 00	The facility must e clients. Therefore that clients have the appropriate person clothing.	F CLIENTS RIGHTS nsure the rights of all , the facility must ensure ne right to retain and use nal possessions and	W	127	In order for this citation to be n	not.	02/12/2017
	interview, the fact 3 sampled clients slippers of appropriate Client #2 was obtone on 1/9/17 to 5:45 P.M. During the observore slippers who large and shout the facility. Directly did not prompt of on foot wear that Client #2's record 1/10/17 at 8:42 Ar 7/13/16 Fall Risk client was at high Director of Residenterviewed on 1	eserved at the group from 3:48 P.M. until evation period, client #2 nich were three inches offled himself throughout eet care staff #1 and #2 or assist the client to put at was of appropriate size. ds were reviewed on A.M. Review of a or Plan indicated the	WO	13/	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 gresident education on why the clothing may not be appropriate. If resident continues to refuse staff will document refusal and 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)	ive ir e. , try	02/12/2017

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G331	B. WING		01/13/2017
			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER		1709 F	ARRAND AVE	
PARENT	S AND FRIENDS IN	NC	LA POF	RTE, IN 46350	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	stated, "It is staff	f's (direct care staff's)			
	responsibility to	assure he (client #2)			
	wears shoes or sl	lippers that are the right			
	size."				
	9-3-2(a)				
W 0249	483.440(d)(1)				
	PROGRAM IMPLE				
Bldg. 00		erdisciplinary team has t's individual program plan,			
		eceive a continuous active			
		consisting of needed			
		services in sufficient			
	·	ency to support the			
		e objectives identified in			
	the individual prog	-	W 0240	In order to ensure this citation	is 02/12/2017
		ation, record review, and	W 0249	met now and in the future for the	02/12/2017
	*	cility failed to implement		home and all homes, staff will	
		an for 1 of 3 additional		cognizant of all resident choke	
	•) during the morning		risk plans. The Nurse/Q will	
	meal.			retrain staff on all risk	or.
				plans/updates to risk plans after any renewals occur. Staff will	
	Findings include	:		follow plans appropriately and	
				assist residents when necessa	
	Client #6 was ob	served at the group		Staff were made aware of this	
	home during the	1/10/17 observation		citation on 1/18/17 and will have	
	period from 5:28	A.M. until 7:00 A.M.		official retraining on 2/9/17. The QIDP will have bi monthly	ie
	At 6:11 A.M., cl	ient #6 sat down and		unexpected mock surveys at	
		' (inch)by 3" pieces of		each of the homes. This will	
		, , , , , , , , , , , , , , , , , , ,			

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	OF DEFICIENCIES F CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G331	l í	ILDING	onstruction 00	(X3) DATE : COMPL 01/13/	ETED
	OVIDER OR SUPPLIER			1709 FA	ADDRESS, CITY, STATE, ZIP CODE ARRAND AVE RTE, IN 46350		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	stuffed his mouth swallowing. As his mouth with p care staff #2 and watching. Direct not prompt client and take smaller Client #6's record 1/10/17 at 8:10 A client's 8/10/16 C Assessment indicated history of choking further incidents assessment also is were to prompt continued while eating and food. QIDP (Qualified Professional) #1 1/10/17 at 8:12 A IIII IIIII IIIII IIIIII IIIIIIII IIIIII	ds were reviewed on A.M. The review of the Choking Risk cated client #6 had a ag and a high risk for of choking. The indicated direct care staff client #6 to slow down to take smaller bites of Intellectual Disabilities was interviewed on A.M. QIDP #1 stated, e staff) should have #6] to slow down and to			allow for the Q to prep staff for real surveys and continue to guide staff in appropriate actit treatment, along will monitorit to see if risk plans are being implemented appropriately, when applicable. (RN, QIDP, Residential Director Team Leader and DSPs responsible)	ve ng	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		15G331	B. WI	NG		01/13/	2017
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			l	ARRAND AVE		
PARENT	S AND FRIENDS IN	NC			RTE, IN 46350		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W 0382	The facility must k biologicals locked prepared for admin Based on observ facility failed to locked except who prepared for admin additional clients. Findings include Client #4 was obhome observation 3:48 P.M. until 5 direct care staff # medication to ad 4:04 P.M., direct #4's medication to ad 4:04 P.M., direct #4's medication of when she left the direct care staff # of tablets left in pack. Direct care the medication a open medication and open medication cart in to client #4 who when the pack who was interested to the medication cart in the me	except when being nistration. ation and interview, the ensure medications were then they were being ninistration for 1 of 3 is (client #4). Exercises a content of the group of the property of the group of the gro	W 0	382	In order for this citation to be now and in the future for this home and all others, staff will retrained on appropriate dispensation, destruction and rights of all medications and locking med cabinet when staff not next to the medication cabinet. Staff were made awa of this citation on 1/18/17. The official training will be 2/9/17. an error is made, staff will receappropriate disciplinary action leading to dismissal. The QID will have bi monthly unexpect mock surveys at each of the homes. This will allow for the to prep staff for real surveys continue to guide staff in appropriate active treatment medication dispensation guidelines. (Residential Director, QIDP, Team Leader and DSPs responsible)	oe 6 f is re elifetive DP ted e Q and	02/12/2017

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		15G331	B. WI	NG		01/13/	/2017	
NAME OF I	DDOMDED OD GUDDI IE.			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
	PROVIDER OR SUPPLIE			1709 F	ARRAND AVE			
PARENT	S AND FRIENDS I	NC		LA POF	RTE, IN 46350			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	` `	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
TAU	REGULATORT OF	CLSC IDENTIFTING INFORMATION)		TAG			DATE	
W 0419 Bldg. 00	bedding appropria	DMS provide each client with ate to the weather and wation and interview, the	W 0	419	In order for this citation to be		02/12/2017	
	facility failed to clients (clients # sheets on their b	assure 2 of 3 additional #5 and #6 slept with bed beds.			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	aff	02/12/2017	
	group home dur observation periods 7:00 A.M. At 5 #6 were sleeping were noted to not clients were sleeping mattresses. Direct care staff 1/10/17 at 7:03 stated, "I don't kand #6) don't had Director of Resignation of Resignation Director of Resignation of Resignation Director Of Resignation Di	the were observed at the ing the 1/10/17 and from 5:28 A.M. until :36 A.M., clients #5 and in their beds. The beds of have bed sheets as the eping directly on the first was interviewed on A.M. Direct care staff #3 know why they (clients #5			residents refuse to have appropriate bedding (in this case, a fitted sheet), then stawill offer again. If the resider still refuses, staff will docume the refusals. Staff will then continue to offer on a daily basis. All staff were made aware of this citation on 1/18 All staff will have official retraining on this citation on 2/9/17 at the home monthly I meeting. the QIDP will have monthly unexpected mock surveys at each of the homes. This will allow for the Q to prestaff for real surveys and continue to guide staff in appropriate active treatment. (Residential Director, QIDP, Team Leader and DSPs	nts ent //17. HP bi s. rep		
		lients #5 and #6) are e sheets on their beds."			responsible)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G331		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 01/13/2017			
	PROVIDER OR SUPPLIE	3	STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, IN 46350		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W 0436	9-3-7(a) 483.470(g)(2)				
Bldg. 00	repair, and teach informed choices eyeglasses, heard communications a devices identified team as needed to Based on observinterview, the far 3 sampled client #2) wore, or was eyeglasses. Findings include Client #2 was observed the communication of the period from 3:44 and on 1/10/17 far. M. During the client #2 did not direct care staff not prompt or as eyeglasses.	curnish, maintain in good clients to use and to make about the use of dentures, ng and other aids, braces, and other by the interdisciplinary by the client. The variance of the view, and cility failed to assure 1 of the services with eyeglasses (client as prompted to wear, his	W 0436	In order for this citation to be represented to be represented by the resident resident resident resident resident resident resident about using equipment, and document the refusals. Staff will then continuous prompt the resident on the resident resident resident about using equipment, and document the refusals. Staff will then continuous prompt the resident on the resident resident needs to we glasses only at certain times, all the time. Staff will then educate the residents according to prompt residents to use the adaptive equipment. The QIE will have bi monthly unexpect mock surveys at each of the homes. This will allow for the	will the ue next et in to ear or ngly ir DP etted

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY					
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER: 15G331	A. BUILDING 00 COMPLETED B. WING 01/13/2017				
		156331				01/13/	2017
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
PARENT:	S AND FRIENDS IN	NC			ARRAND AVE TE, IN 46350		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		,		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	Т	:AG	DEFICIENCY)	_	DATE
	1/10/17 at 8:42 A	A.M. A review of client			to prep staff for real surveys a	and	
		ion Exam indicated			continue to guide staff in appropriate active treatment.		
	client #1 was to	wear "glasses"			appropriate active treatment.		
	(eyeglasses).				(Residential Director, QIDP, RN,		
					Team Leader and DSPs		
		terviewed on 1/12/17 at			responsible)		
		e #1 stated, "His (client					
		t said he (client #2)					
		vear them (eyeglasses) all					
	of the time but I just got that order from the eye doctor this morning (1/12/17)."						
	the eye doctor th	18 IIIOIIIIIIg (1/12/17).					
	9-3-7(a)						
) 5 /(u)						
W 0455	483.470(I)(1)						
DI 1 00	INFECTION CON	TROL active program for the					
Bldg. 00		I, and investigation of					
		municable diseases.					
	Based on observa	ation and interview, the	W 045	55	In order for this citation to be m	net	02/12/2017
	facility failed to				now and in the future for this home and all others, staff will		
		dications was not			be retrained on appropriate		
		er falling on the floor			dispensation, destruction and	6	
	•	sampled clients (client			rights of all medications and		
	#2).				locking medication cabinet whe staff are not next to the med	nen	
	D' 1' ' 1 1				cabinet. Staff were made aw	are	
	Findings include	:			of this citation on 1/18/17. Th	ne	
	Cliant #21-	garryad during the arrays			official retraining will be 2/9/1	7.	
		served during the group n period on 1/10/17 from			If an error is made, staff will receive appropriate disciplina	rv	
		7:00 A.M. At 6:29			action, leading to dismissal.	ı y	
	J.Zo A.IVI. UIIIII	7.00 A.W. At 0.29					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G331	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/13/2017
	PROVIDER OR SUPPLIER S AND FRIENDS IN		1709 F	ADDRESS, CITY, STATE, ZIP CODE ARRAND AVE RTE, IN 46350	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	dropped a medic floor. Direct car medication table administered it to Nurse #1 was int 9:07 A.M. Nurse care staff) are to medication that I	edications to client #2, ation tablet onto the e staff #2 picked the t up off the floor and o client #2. erviewed on 1/10/17 at e #1 stated, "Staff (direct never administer a has dropped onto the cation that falls onto the		The QIDP will have bi monthl 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 actit treatment and appropriate protocol for med dispensation (Residential Director, QIDP, Team Leader and DSPs responsible)	or ve
W 0460 Bldg. 00	Each client must rewell-balanced diet specially-prescribe Based on observenterview, the fact 3 sampled clients and 3 of 3 additions, and #6) were morning meal item.	ation, record review, and cility failed to assure 3 of s (clients #1, #2, and #3), onal clients (clients #4, offered the listed ems on the 1/10/17 menu.	W 0460	In order to ensure this tag is being met now and in the futur for this home and all group homes, staff will prompt and assist all residents to eat what one the menu. Staff will offer choices listed on the approved menu. If there are substitution staff need to make sure the substitutions are written on the menu on a daily basis. This w be monitored by the team lead	is all I ss,

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G331	· /	ILDING	NSTRUCTION 00	(X3) DATE (COMPL 01/13/	ETED
	PROVIDER OR SUPPLIER			1709 FA	DDRESS, CITY, STATE, ZIP CODE ARRAND AVE TE, IN 46350		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	A.M. until 7:00 A direct care staff to "fix yourself's #2, #3, #5, and # several waffles at Client #1 had coprepare or eat an The 1/10/17 mon #2, #3, #4, #5, an 1/10/17 at 6:27 A indicated the folloamounts of the ffor the morning juice, 3/4 cup he wheat toast, and Further review of menu failed to in were noted. Director of Resident interviewed on 1 Director of Resident Staff (dishould have at less than 1 to 1 t	A.M. At 6:05 A.M., #2 prompted the clients ome breakfast." Clients 6 prepared themselves and coffee or milk. ffee and client #4 did not ything for breakfast. ming menu for clients #1, and #6 was reviewed on A.M. The review lowing foods, and boods, were to be offered meal: 1/2 cup cranberry ot/cold cereal, 1 slice 1 cup of skim milk. f the 1/10/17 morning adicate food substitutions dential Services #1 was /12/17 at 8:44 A.M. dential Services #1 rect care staff #2 and #3) hast offered the foods he menu or noted			when the team leader is on du The team leader will use her/h 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 acti treatment, including meal tim preparation. (Residential Director, Program Manager, Team Leader and DSPs responsible)	is e or e	

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		15G331	B. WING		01/13/2017			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE					
PARENTS AND FRIENDS INC			LA PORTE, IN 46350					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
					l			

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