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	12/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 fundamental recertification and state licensure survey. Dates of Survey: December 22 and 23, 2015. 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 on 12/29/15 by #09182.	W 0000		
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 and interview, the facility failed to assure 1 of 3 sampled clients (client #2) wore pants which fit. Findings include: Client #2 was observed at the group home on 12/22/15 from 5:49 A.M. until	W 0137	In order for this citation to be back in compliance, PAF Residential Manager trained Team Leader of this home on making sure staff observe clothing the residents are wearing to see they fit appropriately before leaving the home. If not, staff will ask resident to change clothing. Staff will also look with residents	01/22/2016

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

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	12/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	7:30 A.M. During the observation period, client #2 wore sweat pants which were baggy and too large around the waist. As client #2 walked around the facility, he would stop every five or six steps to pull up his pants. Direct care staff #1 and #2 did not prompt or assist the client to put on a pair of pants which fit. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 12/23/15 at 10:48 A.M.. QIDP #1 stated, "Staff (direct care staff) are to prompt [client #2] to put on a pair of pants that fit." 9-3-2(a)		in their dressers and closets to make sure they all have their correct clothing in their dressers. In order to prevent in the future, staff will continue to observe their clothing they are wearing to see that they fit appropriately before they leave the home. This will be done on a daily basis. The staff will go through the dressers and closets with the residents on a monthly basis to make sure they have their own clothing in their possession. Q, Program Manager, Team Leader and direct care staff responsible)	
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			

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	12/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview, the facility failed to implement medication objectives during times of opportunity for 3 of 3 sampled clients (clients #1, #2, and #3). Findings include: Clients #1, #2, and #3 were observed at the group home on 12/22/15 from 5:49 A.M. until 7:30 A.M. At 6:11 A.M., Direct care staff #1 retrieved client #2's prescribed medication punch cards, popped each pill out and handed the medications to client #2 to take. Direct care staff #1 did not prompt client #2 to report the name of the medication Requip (medication for restless leg syndrome). At 6:23 A.M., Direct care staff #1 was observed to retrieve client #1's medications, pop each pill out and administered them to client #1. Direct care staff #1 did not prompt or assist client #1 in learning her medications. At 6:34 A.M., Direct care staff #1 was observed to retrieve client #3's medications, pop each pill out and administered them to client #3. Direct care staff #1 did not prompt or assist client #3 in identifying his Oyster Shell Calcium (a mineral supplement).	W 0249	In order for this citation to be back in compliance all staff at this home will be retrained on all medication goals at the normal IHP training on 1/14/16. The Q and nurses and team leader will observe staff during medication times to make sure staff are following through on the med goals. In order for this to continue to occur in the future, this will be reviewed at house meetings held by the team leader on a monthly basis. This tag will be met by 1/22/16 (Team Leader, Q, RN, direct support staff responsible)	01/22/2016

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	12/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Client #1's records were reviewed on 12/23/15 at 8:30 A.M. Client #1's Individual Program Plan dated 10/21/15 indicated the following medication administration objective: "Learn medications." Client #2's records were reviewed on 12/23/15 at 9:11 A.M. Client #2's Individual Program Plan dated 7/15/15 indicated the following medication administration objective: "Report name of Requip medication." Client #3's records were reviewed on 12/23/15 at 9:59 A.M. Client #3's Individual Program Plan dated 6/24/15 indicated the following medication administration objective: "Identify his Oyster Shell Calcium." QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 12/23/15 at 10:48 A.M. QIDP #1 stated, "Medication objectives should be implemented at all times the consumers (clients) are administered their medications." 9-3-4(a)			

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	12/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0336 Bldg. 00	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview, the facility failed to assure quarterly nursing exams were conducted at least quarterly (every ninety days) for 3 of 3 sampled clients (clients #1, #2, and #3). Findings include: Client #1's records were reviewed on 12/23/15 at 8:30 A.M. A review of the client's quarterly nursing assessments from 12/1/14 to 12/23/15 indicated quarterly nursing assessments were completed on 12/9/15, 7/31/15, 4/25/15, and 1/14/15. The review failed to indicate the client's quarterly nursing assessments were completed at least quarterly (every three months.) Client #2's records were reviewed on 12/23/15 at 9:11 A.M. A review of the client's quarterly nursing assessments from 12/1/14 to 12/23/15 indicated quarterly nursing assessments were	W 0336	This citation will be back in compliance by 1/22/16. This has already started to occur. The nursing staff, which are new now, have been trained on completing quarterlies from the last date of the last quarterly. This will be done on a consistent basis for the future. Residential Director will review charts on a monthly basis to see these are timely. (RNs responsible)	01/22/2016

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	12/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	completed on 12/9/15, 7/31/15, 4/25/15, and 1/8/15. The review failed to indicate the client's quarterly nursing assessments were completed at least quarterly (every three months.) Client #3's records were reviewed on 12/23/15 at 9:59 A.M. A review of the client's quarterly nursing assessments from 12/1/14 to 12/23/15 indicated quarterly nursing assessments were completed on 11/11/15, 7/27/15, 4/25/15, and 1/8/15. The review failed to indicate the client's quarterly nursing assessments were completed at least quarterly (every three months.) Director of Residential Services #1 was interviewed on 12/23/15 at 10:59 A.M. Director of Residential Services #1 stated, "We had nursing changes in the middle of the year. It was only later that we realized the nursing quarterlies (exams) were not completed." 9-3-6(a)			
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and			

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	12/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	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 3 of 3 sampled clients (clients #1, #2, and #3) and 3 additional clients (clients #4, #5, and #6). Findings include: Direct care staff #1 was observed passing medications during the 12/22/15 observation period from 5:49 A.M. until 7:30 A.M. At 6:18 A.M., direct care staff #1 retrieved client #2's medications and placed them on top of the medication cart. Direct care staff #1 punched out all the tablets for client #2 and placed them on top of the medication cart along with the medication cards. Direct care staff #1 left the medication room for 13 seconds with medications and the medication cards left unattended. The medication area was left accessible to clients #1, #2, #3, #4, #5, and #6. Nurse #1 was interviewed on 12/23/15 at 10:59 A.M. Nurse #1 stated, "Medications are to be locked when they aren't being administered." 9-3-6(a)	W 0382	This citation will be corrected by having the house staff take a medication review class (which locking the med cabinet will be addressed). The nursing staff will specifically go over this citation during the training. In the future, in order for this to be corrected, all staff will lock the cabinet whenever they leave the cabinet, with all meds inside. the team leader and IDT will observe the med cart upon their observations on a weekly basis to make sure the cart is appropriately locked. (team leader, direct care staff, RN and IDT responsible)	01/22/2016

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	12/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 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 to 2 of 2 sampled clients with eyeglasses (clients #1 and #3) wore, or were prompted to wear, their eyeglasses. Findings include: Clients #1 and #3 were observed at the group home during the 12/22/15 observation periods from 5:49 A.M. until 7:30 A.M. and from 3:26 P.M. until 5:30 P.M. During the observation periods, clients #1 and #3 did not wear eyeglasses and direct care staff #1, #2, #3, and #4 did not prompt or assist clients #1 and #3 to wear eyeglasses. Client #1's record was reviewed on	W 0436	In order for this citation to be met and corrected, all staff will be retrained at the IHP inservice on 1/14/16 on asking each individual to wear their adaptive equipment whenever they are suppose to be wearing them. Staff will also be retrained on who has what specific adaptive equipment. If the resident refuses, staff will intermittently ask resident to wear. If continual refusals, the Q will write a goal for prompting the resident. In order for this to be corrected in the future, IDT will observe staff when doing weekly visits to the home to see if the staff ask residents to wear the adaptive equipment.(Q, RN, Program Manager, Team Leader and direct support responsible)	01/22/2016

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	12/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	12/23/15 at 8:30 A.M. A review of the client #1's 7/23/14 Vision Exam indicated client #1 was to wear "glasses" (eyeglasses). Client #3's record was reviewed on 12/23/15 at 9:59 A.M. A review of the client #3's 9/23/15 Vision Exam indicated client #3 "needs glasses.". Nurse #1 was interviewed on 12/23/15 at 10:59 A.M. Nurse #1 stated, "Staff (direct care staff) should assure they (clients #1 and #3) are wearing their eyeglasses if they are available." 9-3-7(a)			
W 0473 Bldg. 00	483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. Based on observation and interview, the facility failed to ensure lunches for 3 of 3 sampled clients (clients #1, #2, and #3), and 3 additional clients (clients #4, #5, and #6), were kept refrigerated. Findings include:	W 0473	In order for this citation to be corrected now, the refrigerator in the freezer will be placed in the garage (where it use to be), where it is accessible to the residents to put their lunches away on a nightly basis after the lunches are made. Staff will be retrained on the appropriateness	01/22/2016

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	12/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Clients #1, #2, #3, #4, #5, and #6 were observed at the group home during the 12/22/15 observation period from 3:29 P.M. until 5:30 P.M. At 3:35 P.M., direct care staff #3 and #4 assisted clients #1, #2, #3, #4, #5, and #6 in preparing lunch meat sandwiches for their lunches the next day. At 3:46 P.M., when done making the sandwiches and packing them into lunch bags without cooling devices, all the clients placed their lunch bags on the floor near the front door of the facility. The lunch bags containing the sandwiches remained on the floor until the observation ended at 5:30 P.M. Director of Residential Services #1 was interviewed on 12/23/15 at 10:49 A.M. Director of Residential Services #1 stated, "The packed lunches should have gone into the refrigerator right away." 9-3-8(a)		of food safety at the IHP training on 1/14/16. In order for this to be corrected in the future, IDT will observe the lunches will be put away appropriately when they visit the home on a weekly basis. (Team Leader, Program Manager, Q, RN, direct support responsible)	