PRINTED: 02/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u>			COMPLETED		
		15G331	B. WI	B. WING			2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ARRAND AVE		
DADENIT	S AND FRIENDS IN	JC			RTE, IN 46350		
				LATOR			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W 0000							
Bldg. 00							
	This visit was for	r a fundamental	W_0	000			
	recertification an	d state licensure survey.					
	Dates of Survey	: December 22 and 23,					
	2015.	. December 22 and 23,					
	2013.						
	Facility number:						
	Provider number	:: 15G331					
	AIM number: 10	00243820					
	The following fe	deral deficiencies also					
	•	ings in accordance with					
		ings in accordance with					
	460 IAC 9.						
	Quality review o	f this report completed					
	on 12/29/15 by #	2 09182.					
W 0137	483.420(a)(12)						
		CLIENTS RIGHTS					
Bldg. 00	The facility must e	nsure the rights of all					
		, the facility must ensure					
		ne right to retain and use					
		nal possessions and					
	clothing.	and the second	117.0	107	In order for this sitution to be		01/02/2016
		ation and interview, the	W^0	13/	In order for this citation to be back in compliance, PAF		01/22/2016
	facility failed to	assure 1 of 3 sampled			Residential Manager trained		
	clients (client #2) wore pants which fit.			Team Leader of this home on		
					making sure staff observe		
	Findings include	:			clothing the residents are wear	ring	
	6				to see they fit appropriately be		
	Client #2 was ab	garyad at the group			leaving the home. If not, staff		
		served at the group			ask resident to change clothing		
	nome on 12/22/1	5 from 5:49 A.M. until			Staff will also look with residen	its	

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.

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G331	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/23/2015
	PROVIDER OR SUPPLIER S AND FRIENDS INC	1709 F	ADDRESS, CITY, STATE, ZIP CODE ARRAND AVE RTE, 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 APPROPRIA 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 dresse. In order to prevent in the future staff will continue to observe the clothing they are wearing to see that they fit appropriately before they leave the home. This will done on a daily basis. The stawill go through the dressers are closets with the residents on a monthly basis to make sure the have their own clothing in their possession. Q. Program Manager, Team Leader and direct care staff responsible)	ers. e, heir ee re I be aff nd ey
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			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G331		` ´	UILDING	onstruction 00	(X3) DATE COMPL 12/23/	ETED	
NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC				1709 F	ADDRESS, CITY, STATE, ZIP CODE ARRAND AVE RTE, IN 46350		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e objectives identified in		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	the individual programmed based on observed to retrimedications, popadministered the care staff #1 did client #1 in learn 6:34 A.M., Direct observed to retrimedications, popadministered the care staff #1 did client #1 in learn 6:34 A.M., Direct observed to retrimedications, popadministered the care staff #1 did client #1 in learn 6:34 A.M., Direct observed to retrimedications, popadministered the care staff #1 did client #1 in learn 6:34 A.M., Direct observed to retrimedications, popadministered the care staff #1 did client #1 in learn 6:34 A.M., Direct observed to retrimedications, popadministered the care staff #1 did	ation, record review, and cility failed to implement etives during times of 3 of 3 sampled clients and #3). It is a sampled clients and #3 were observed at 5 on 12/22/15 from 5:49 A.M. At 6:11 A.M., #1 retrieved client #2's cation punch cards, out and handed the lient #2 to take. Direct not prompt client #2 to 5 of the medication Requip restless leg syndrome). Firect care staff #1 was eve client #1's 5 o each pill out and 5 on the medications. At 5 ot care staff #1 was eve client #3's 5 o each pill out and 5 on the medications at 5 on the medications at 5 on the medication and 5 on the medications. At 5 on the medication and 5 on the medications at 5 on the medications. At 5 on the medications are the medications at 5 on the medications a	W	0249	In order for this citation to be back in compliance all staff at home will be retrained on all medication goals at the normal IHP training on 1/14/16. The and nurses and team leader wobserve staff during medication times to make sure staff are following through on the medigoals. In order for this to continue to occur in the future this will be reviewed at house meetings held by the team leaden a monthly basis. This tag where the properties on a monthly basis are the support staff responsible)	al Q vill on e, ader vill	01/22/2016

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G331	(X2) MULTIPLE C A. BUILDING B. WING	OO OO	(X3) DATE COMPI 12/23	
NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC			1709 F	FADDRESS, CITY, STATE, ZIP COD FARRAND AVE DRTE, IN 46350	E	
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	12/23/15 at 8:30 Individual Progrindicated the foll administration of medications."	·				
	12/23/15 at 9:11 Individual Programdicated the following	ds were reviewed on A.M. Client #2's am Plan dated 7/15/15 owing medication ojective: "Report name ation."				
	12/23/15 at 9:59 Individual Programdicated the following	ds were reviewed on A.M. Client #3's am Plan dated 6/24/15 owing medication ojective: "Identify his cium."				
	Professional) #1 12/23/15 at 10:4 "Medication obje	Intellectual Disabilities was interviewed on 8 A.M. QIDP #1 stated, ectives should be all times the consumers inistered their				
	9-3-4(a)					

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NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, 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	
W 0336 Bldg. 00	clients certified as care plan, a review which must be on frequent basis dep Based on record the facility failed nursing exams we quarterly (every sampled clients of the facility failed nursing exams we quarterly (every sampled clients of the facility failed nursing exams we quarterly (every sampled clients of the facility from 12/1/14 to quarterly nursing completed on 12 and 1/14/15. The indicate the client assessments were quarterly (every Client #2's record 12/23/15 at 9:11 client's quarterly from 12/1/14 to	must include, for those not needing a medical w of their health status a quarterly or more bending on client need. review and interview, d to assure quarterly were conducted at least ninety days) for 3 of 3 (clients #1, #2, and #3). The discrepancy of the roursing assessments 12/23/15 indicated a gassessments were 1/9/15, 7/31/15, 4/25/15, we review failed to not's quarterly nursing the completed at least to see the complete of the complete	W 0336	This citation will be back in compliance by 1/22/16. This halready started to occur. The nursing staff, which are newn have been trained on complet quarterlies from the last date of the last quarterly. This will be done on a consistent basis for future. Residential Director will review charts on a monthly bat to see these are timely. (RNs responsible)	ow, ing of the I sis	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	00	(X3) DATE COMPL		
		15G331	B. W	ING		12/23/	2015
NAME OF PROV	IDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PARENTS A	ND FRIENDS IN	IC			ARRAND AVE RTE, IN 46350		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	•	/9/15, 7/31/15, 4/25/15,					
		review failed to indicate					
	•	erly nursing assessments					
	•	at least quarterly (every					
uni	ree months.)						
Cl	ient #3's record	ds were reviewed on					
12	/23/15 at 9:59	A.M. A review of the					
		nursing assessments					
		12/23/15 indicated					
_		assessments were					
	•	/11/15, 7/27/15, 4/25/15, review failed to indicate					
		erly nursing assessments					
	-	at least quarterly (every					
	ree months.)	at rouse quarterry (every					
	,						
		lential Services #1 was					
		2/23/15 at 10:59 A.M.					
		lential Services #1					
		nursing changes in the					
	-	r. It was only later that ursing quarterlies					
	xams) were not						
	idins) were not	oomprotod.					
9-:	3-6(a)						
	3.460(I)(2)	AND DECODDIVEEDING					
		AND RECORDKEEPING eep all drugs and					

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NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC				1709 F	ADDRESS, CITY, STATE, ZIP CODE ARRAND AVE RTE, IN 46350		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) except when being		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	prepared for admi Based on observ facility failed to locked except wh prepared for adm sampled clients (and 3 additional and #6). Findings include Direct care staff medications duri observation period 7:30 A.M. At 6: #1 retrieved client placed them on the cart. Direct care the tablets for client on top of the medication of the medication of the medication of the medications cards left unatter area was left acce #3, #4, #5, and #1 Nurse #1 was intalled.	mistration. ation and interview, the ensure medications were then they were being ministration for 3 of 3 (clients #1, #2, and #3) (clients (clients #4, #5, #5). #1 was observed passing mg the 12/22/15 od from 5:49 A.M. until 18 A.M., direct care staff at #2's medications and op of the medication staff #1 punched out all tent #2 and placed them dication cart along with ards. Direct care staff #1 on room for 13 seconds and the medication essible to clients #1, #2, 6. #Erviewed on 12/23/15 at see #1 stated, at to be locked when they	W	0382	This citation will be corrected having the house staff take a medication review class (which locking the med cabinet will be addressed). The nursing staff 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 observation on a weekly basis to make suit the cart is appropriately locked (team leader, direct care staff, and IDT responsible)	h e will n re, d, net, e e ons e	01/22/2016

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G331		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/23/2015				
NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, IN 46350				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R 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 Bldg. 00	repair, and teach informed choices eyeglasses, hear communications a devices identified team as needed Based on observinterview, the far of 2 sampled cli (clients #1 and # prompted to we. Findings include Clients #1 and # group home dur observation per 7:30 A.M. and f P.M. During th clients #1 and # and direct care s #2, #3, and #4 d clients #1 and #	furnish, maintain in good clients to use and to make about the use of dentures, ing and other aids, braces, and other by the interdisciplinary by the client. Vation, record review, and ucility failed to assure to 2 ents with eyeglasses (43) wore, or were ar, their eyeglasses. 43 were observed at the ing the 12/22/15 cods from 5:49 A.M. until from 3:26 P.M. until 5:30 to observation periods, 3 did not wear eyeglasses	W 0436	In order for this citation to be rand corrected, all staff will be retrained at the IHP inservice 1/14/16 on asking each individual to wear their adaptive equipment whenever they are suppose to wearing them. Staff will also be retrained on who has what specific adaptive equipment. The resident refuses, staff will intermittently ask resident to wear. If continual refusals, the will write a goal for prompting resident. In order for this to be corrected in the future, IDT will observe staff when doing wee visits to the home to see if the staff ask residents to wear the adaptive equipment. (Q, RN, Program Manager, Team Lear and direct support responsibles)	on dual ent o be le If e Q the e II lkly		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G331		A. BUILDING B. WING	<u>00</u>	COMPLETED 12/23/2015		
NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIAT 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 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 appropriatene	ne e		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u>		COMPLETED	
15G331			B. WING		12/23/2015
	PROVIDER OR SUPPLIE		1709 F	ADDRESS, CITY, STATE, ZIP CODE ARRAND AVE RTE, IN 46350	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
	observed at the 12/22/15 observed. Until 5:30 direct care staff #1, #2, #3, #4, is lunch meat sand the next day. A making the sand into lunch bags all the clients p the floor near the facility. The lusandwiches renthe observation. Director of Resinterviewed on Director of Resistated, "The page	#3, #4, #5, and #6 were group home during the vation period from 3:29 P.M. At 3:35 P.M., 18 and #4 assisted clients 18 at 3:46 P.M., when done dwiches and packing them without cooling devices, laced their lunch bags on the front door of the named on the floor until ended at 5:30 P.M. idential Services #1 was 12/23/15 at 10:49 A.M. idential Services #1 eked lunches should have frigerator right away."		of food safety at the IHP train on 1/14/16. In order for this to corrected in the future, IDT wobserve the lunches will be paway appropriately when the visit the home on a weekly be (Team Leader, Program Manager, Q, RN, direct suppresponsible)	to be vill but y assis.

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