STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G353	A. BUILDING 00 B. WING	05/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	1012 PARKWAY DR ANDERSON, IN 46012

(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 pre-determined full annual recertification and state licensure survey. This visit included the investigation of complaint #IN00195813 and the investigation of complaint #IN00198671. Complaint #IN00195813: Substantiated. Federal and State deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W318, and W331. Complaint #IN00198671: Substantiated. Federal and State deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W318, W331, and W436. Dates of Survey: 4/25, 4/26, 4/27, 4/28, 4/29, and 5/6/2016. Facility Number: 000869 Provider Number: 15G353 AIMS Number: 100244230 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/16/16.	W 0000		

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

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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, the facility failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (clients E, F, G, and H). The governing body failed to ensure the facility staff implemented its policy and procedures to ensure all allegations of abuse, neglect, mistreatment, and/or exploitation were immediately reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for clients A, B, C, D, E, F, G, and H, to provide oversight of the facility's nursing staff to ensure clients A, B, C, D, E, F, G, and H received nursing services according to their identified needs; and to ensure client B's rights were protected. Findings include: 1. Please refer to W104. The governing	W 0102	**W 102 Governing Body** The facility must ensure that specific governing body and management requirements are met. **1. What corrective action will be accomplished?** · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns to the Program Coordinator. o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator	06/05/2016

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	body failed to exercise general policy and operating direction over the facility to ensure clients were not neglected, abused, and/or exploited and staff implemented the agency's policy and procedure for abuse/neglect for immediately reporting allegations of missing client funds; lack of staff supervision and oversight for medical care, appointments, and transportation; to ensure client B's rights to unimpeded access to his personal cigarettes; and the facility's failure to ensure an accurate and complete accounting for personal funds entrusted to the facility for 4 of 4 sampled clients (clients A, B, C, and D) and 4 additional clients (clients E, F, G, and H). 2. Please refer to W122. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections for 4 of 4 sampled clients (A, B, C, and D) and 4 additional clients (clients E, F, G, and H). The governing body failed to ensure clients were not neglected, abused, and/or exploited and to implement their abuse/neglect policy and procedure for immediately reporting allegations of missing client funds; lack of staff supervision and oversight for medical care, appointments, and transportation; to ensure client B's rights to unimpeded		o Staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts, returning change and receipts). o Resident rights o Client D's risk plan for reporting pain. o Administering PRN medications and documenting follow up o Med administration expectations o Notifying the Program Coordinator when medications are getting low or are no longer available in the home o Expectations for securing medication (med cabinet and keys) o Vehicle use and safety/supervision precautions during transport. · The Program Coordinator and Program Director will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. · The Program Director will be retrained on how to configure the MAR's and the expectations for configuring the MAR's. · The Program Director, Program Coordinator and Nurse will be trained on how to complete med cabinet checks. · Med cabinet checks will be completed by the Program Director weekly. Results of the checks will be forwarded to the nurse. · A med cabinet audit will be completed to ensure that the med	

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	access to his personal cigarettes; and the facility's failure to ensure an accurate and complete accounting for personal funds entrusted to the facility. 3. Please refer to W318. The governing body failed to ensure the facility met the Condition of Participation: Health Care Services. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility provided nursing services met the health care needs of clients A, B, C, D, E, F, G, and H. The governing body failed to ensure nursing services assessed and monitored clients A and H's attendance to medical appointments, client A's pressure ulcer area, client D's development of a pain protocol plan, clients A and D's laboratory testing, tuberculin skin testing, medication administration errors, and medication and medication key security for 4 of 4 sampled clients (A, B, C, and D) and 4 additional clients (clients E, F, G, and H). This federal tag relates to complaints #IN00195813 and #IN00198671. 9-3-1(a)		labels match the MAR and that all medication per physician orders are available in the home. · Staff who are responsible for a medication error will be suspended from passing meds until a med practicum can be completed. In addition they will received a written warning for their first error. Staff responsible for a second medication error will be suspended from passing meds, receive a final warning, attend Core A/B again and then must successfully complete a med practicum. Staff responsible for a third medication error will be terminated from employment. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director have been retrained on IN Mentor's resident finance expectations including tracking of money and what to do in the event of missing money · The Program Coordinator and Program Director will be trained on the accident reporting process including IN Mentor's expectations and reporting BDDS reports · The Program Coordinator and Program Director will be trained on the staffing expectations for the home. · Clients A and H have been discharged from IN Mentor services.	

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			· The Program Coordinator and Program Director will be trained on reporting wound concerns to the nurse. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. · A request for funds has been made to replace Client E's missing money. · The van involved in the vehicle accident has been scheduled for repairs. · Client B's cigarettes remain locked per his guardian's request. · Client B's BSP has been updated to include the locked cigarettes and a schedule for him to receive the cigarettes. · HRC approval has been obtained for Client B's cigarettes. · An inventory of Client B's belongings will be completed. The information will be shared with his guardian to determine if she wishes for him to purchase any additional items. · A risk plan/protocol for reporting pain for Client D will be implemented. · Client D will complete a PSA screening. · Client B and C will have TB tests administered. · The medication keys will be kept on staff during their shift instead	

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			of hanging on the wall. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director and Program Coordinator will be retrained on the IDT process. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts and communicating the physician recommendations to the team. · The medical charts for the site will be reviewed by the nurse. · A med chart audit will be completed to identify any missing doctor appointments or physician recommendations that need to be followed up on. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Program Coordinator/QIDP/nurse oversight of the MAR's, intake/elimination and skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT.	

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			· In the event that a client develops a pressure sore, the nurse will monitor and/or assess the client on at least a weekly basis until the sore has resolved. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns to the Program Coordinator. o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o Staff's role in resident finances	

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			(purchasing requested items from guardian/team, obtaining receipts, returning change and receipts). o Resident rights o Client D's risk plan for reporting pain. o Administering PRN medications and documenting follow up o Med administration expectations o Notifying the Program Coordinator when medications are getting low or are no longer available in the home o Expectations for securing medication (med cabinet and keys) o Vehicle use and safety/supervision precautions during transport. · The Program Coordinator and Program Director will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. · The Program Director will be retrained on how to configure the MAR's and the expectations for configuring the MAR's. · The Program Director, Program Coordinator and Nurse will be trained on how to complete med cabinet checks. · Med cabinet checks will be completed by the Program Director weekly. Results of the checks will be forwarded to the nurse. · A med cabinet audit will be completed to ensure that the med labels match the MAR and that all	

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			medication per physician orders are available in the home. · Staff who are responsible for a medication error will be suspended from passing meds until a med practicum can be completed. In addition they will received a written warning for their first error. Staff responsible for a second medication error will be suspended from passing meds, receive a final warning, attend Core A/B again and then must successfully complete a med practicum. Staff responsible for a third medication error will be terminated from employment. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director have been retrained on IN Mentor's resident finance expectations including tracking of money and what to do in the event of missing money · The Program Coordinator and Program Director will be trained on the accident reporting process including IN Mentor's expectations and reporting BDDS reports. · The Program Coordinator and Program Director will be trained on the staffing expectations for the home. · The Program Coordinator and Program Director will be trained on reporting wound concerns to the	

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			nurse. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. · The medication keys will be kept on staff during their shift instead of hanging on the wall. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director and Program Coordinator will be retrained on the IDT process. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts and communicating the physician recommendations to the team. · The medical charts for the site will be reviewed by the nurse. · A med chart audit will be completed to identify any missing doctor appointments or physician recommendations that need to be followed up on. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Program Coordinator/QIDP/nurse oversight of	

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			the MAR's, intake/elimination and skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · In the event that a client develops a pressure sore, the nurse will monitor and/or assess the client on at least a weekly basis until the sore has resolved. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · The Program Director/QIDP will review all ISP's to ensure that they are updated and completed on a yearly basis or more frequently as the needs arise. · The Behavior Clinician will review all BSP's to ensure that they are updated and accurate regarding restrictions that have been implemented. They will be updated on a yearly basis or more frequently as the needs arise. · The Program Director/QIDP will ensure that there is formal programming in place for all residents that address identified needs. · All resident risk plans will be reviewed by the nurse. Revisions will	

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			be implemented as necessary. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns to the Program Coordinator. o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o Staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts, returning change and receipts).	

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			o Resident rights o Client D's risk plan for reporting pain. o Administering PRN medications and documenting follow up o Med administration expectations o Notifying the Program Coordinator when medications are getting low or are no longer available in the home o Expectations for securing medication (med cabinet and keys) o Vehicle use and safety/supervision precautions during transport. · The Program Coordinator and Program Director will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. · The Program Director will be retrained on how to configure the MAR's and the expectations for configuring the MAR's.	
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 4 of 4 sampled clients (clients A, B, C, and D) and 4 additional clients (clients E, F, G, and H), the governing body failed to exercise general policy and operating direction over the facility to ensure clients were not	W 0104	**W 104 Governing Body** The facility must exercise general policy, budget, and operating direction over the facility. **1. What corrective action will be accomplished?** · The Program Coordinator will	06/05/2016

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	neglected, abused, and/or exploited and staff implemented the agency's policy and procedure for abuse/neglect for immediately reporting allegations of missing client funds; lack of staff supervision and oversight for medical care, appointments, and transportation; to ensure client B's rights to unimpeded access to his personal cigarettes; and the facility's failure to ensure an accurate and complete accounting for personal funds entrusted to the facility. Findings include: Please refer to W149. The governing body failed to exercise operating direction over the facility to ensure the facility staff implemented the agency policy and procedure for abuse, neglect, mistreatment, and exploitation. The governing body neglected to provide nursing oversight and to ensure the facility staff assisted clients A and H to their scheduled physician's appointments. The facility staff neglected to report client A's open pressure ulcer areas developed in the group home. The facility staff neglected to immediately report to the administrator and to BDDS (Bureau of Developmental Disabilities Services) for two of two allegations of missing money (for clients B and E), and a motor vehicle accident (clients A, B, C,		do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns to the Program Coordinator. o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o Staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts, returning change and receipts). o Resident rights o Vehicle use and safety/supervision precautions during transport. · The Program Coordinator and Program Director will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse.	

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	D, E, F, G, and H). The facility staff neglected to supervise clients B, C, D, E, F, and G regarding leaving the clients alone on the facility van with the ignition on and to ensure two staff were present to complete the safe transport from day services to the group home. Please refer to W153. The governing body failed to exercise operating direction over the facility to ensure the staff immediately reported to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law, the facility's failure to provide nursing oversight and to ensure the facility staff assisted clients A and H to their scheduled physician's appointments, client A's open pressure ulcer areas developed in the group home, and 2 of 2 allegations of missing personal funds (for clients B and E), and 1 of 1 motor vehicle accident for clients A, B, C, D, E, F, G, and H for 4 of 4 sampled clients (clients A, B, C, and D) and for 4 additional clients (clients E, F, G, and H). Please refer to W137. The governing body failed to exercise operating direction over the facility to ensure client B had unimpeded access to his locked personal cigarettes which were kept secured inside the locked safe inside the medication cabinet for 1 of 4 sampled		· The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director have been retrained on IN Mentor's resident finance expectations including tracking of money and what to do in the event of missing money · The Program Coordinator and Program Director will be trained on the accident reporting process including IN Mentor's expectations and reporting BDDS reports · The Program Coordinator and Program Director will be trained on the staffing expectations for the home. · Clients A and H have been discharged from IN Mentor services. · The Program Coordinator and Program Director will be trained on reporting wound concerns to the nurse. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. · A request for funds has been made to replace Client E's missing money. · The van involved in the vehicle accident has been scheduled	

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	15G353	A. BUILDING 00 B. WING	05/06/2016

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	clients (client B). Please refer to W140. The governing body failed to exercise operating direction over the facility to ensure clients B, E, and H had a complete and accurate accounting for their client finances and approved purchases for 1 of 4 sampled clients (client B) and 2 additional clients (clients E and H). This federal tag relates to complaints #IN00195813 and #IN00198671. 9-3-1(a)		for repairs. · Client B's cigarettes remain locked per his guardian's request. · Client B's BSP has been updated to include the locked cigarettes and a schedule for him to receive the cigarettes. · HRC approval has been obtained for Client B's cigarettes. · An inventory of Client B's belongings will be completed. The information will be shared with his guardian to determine if she wishes for him to purchase any additional items. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director and Program Coordinator will be retrained on the IDT process. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts and communicating the physician recommendations to the team. · The medical charts for the site will be reviewed by the nurse. · A med chart audit will be completed to identify any missing doctor appointments or physician recommendations that need to be followed up on. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and	

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			adaptive equipment. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · In the event that a client develops a pressure sore, the nurse will monitor and/or assess the client on at least a weekly basis until the sore has resolved. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns to the Program Coordinator. o Abuse, neglect and exploitation-what constitutes abuse, report	

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			expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o Staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts, returning change and receipts). o Resident rights o Vehicle use and safety/supervision precautions during transport. · The Program Coordinator and Program Director will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director have been retrained on IN Mentor's resident finance expectations including tracking of money and what to do in the event of missing money · The Program Coordinator and Program Director will be trained on the accident reporting process including IN Mentor's expectations and reporting BDDS reports. · The Program Coordinator and Program Director will be trained on	

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			the staffing expectations for the home. · The Program Coordinator and Program Director will be trained on reporting wound concerns to the nurse. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director and Program Coordinator will be retrained on the IDT process. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts and communicating the physician recommendations to the team. · The medical charts for the site will be reviewed by the nurse. · A med chart audit will be completed to identify any missing doctor appointments or physician recommendations that need to be followed up on. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment.	

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			· The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · In the event that a client develops a pressure sore, the nurse will monitor and/or assess the client on at least a weekly basis until the sore has resolved. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · The Program Director/QIDP will review all ISP's to ensure that they are updated and completed on a yearly basis or more frequently as the needs arise. · The Behavior Clinician will review all BSP's to ensure that they are updated and accurate regarding restrictions that have been implemented. They will be updated on a yearly basis or more frequently as the needs arise. · The Program Director/QIDP will ensure that there is formal programming in place for all residents that address identified needs. · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. **3. What measures will be put**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			into place or what systemic changes will be made to ensure that the deficient practice does not recur: · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns to the Program Coordinator. o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o Staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts, returning change and receipts). o Resident rights o Vehicle use and safety/supervision precautions during transport. · The Program Coordinator and Program Director will be retrained on the appointment process	

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			expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director have been retrained on IN Mentor's resident finance expectations including tracking of money and what to do in the event of missing money · The Program Coordinator and Program Director will be trained on the accident reporting process including IN Mentor's expectations and reporting BDDS reports. · The Program Coordinator and Program Director will be trained on the staffing expectations for the home. · The Program Coordinator and Program Director will be trained on reporting wound concerns to the nurse. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. · The Program Director will be retrained on the role and expectations	

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			of the QIDP. · The Program Director and Program Coordinator will be retrained on the IDT process. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts and communicating the physician recommendations to the team. · The medical charts for the site will be reviewed by the nurse. · A med chart audit will be completed to identify any missing doctor appointments or physician recommendations that need to be followed up on. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · In the event that a client develops a pressure sore, the nurse will monitor and/or assess the client on at least a weekly basis until the sore has resolved. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize.	

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			· The Program Director/QIDP will review all ISP's to ensure that they are updated and completed on a yearly basis or more frequently as the needs arise. · The Behavior Clinician will review all BSP's to ensure that they are updated and accurate regarding restrictions that have been implemented. They will be updated on a yearly basis or more frequently as the needs arise. · The Program Director/QIDP will ensure that there is formal programming in place for all residents that address identified needs. · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Director will monitor to ensure the clients plans and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · Mentor's nurse will be in the home on a weekly basis or more frequently as needed to monitor for concerns and assess residents. · New staff hired to work at the	

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			site will receive client specific training for each individual prior to working a shift. This training includes items such as: risk plans, ISP's, BSP's, restrictions in place, programming, and medication review. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. Copies of the staffings will be forwarded to all team members including the Area Director and/or Quality Assurance for review. · Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review. · Oversight of the skin/wound documentation will be completed by the Program Coordinator, QIDP, and nurse. · The QIDP will monitor and review the resident's needs. As the needs arise, formal programming will be implemented.	
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review, and interview, the facility failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (A,	W 0122	**W 122 Client Protections** The facility must ensure that specific client protections requirements are met.	06/05/2016

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	B, C, and D) and 4 additional clients (clients E, F, G, and H). The facility failed to ensure clients were not neglected, abused, and/or exploited and to implement their abuse/neglect policy and procedure for immediately reporting allegations of missing client funds; lack of staff supervision and oversight for medical care, appointments, and transportation; to ensure client B's rights to unimpeded access to his personal cigarettes; and the facility's failure to ensure an accurate and complete accounting for personal funds entrusted to the facility. Findings include: Please refer to W149. The facility neglected to ensure the facility staff implemented the agency policy and procedure for abuse, neglect, mistreatment, and exploitation. The facility neglected to provide nursing oversight and to ensure the facility staff assisted clients A and H to their scheduled physician's appointments. The facility staff neglected to report client A's open pressure ulcer areas developed in the group home. The facility staff neglected to immediately report to the administrator and to BDDS (Bureau of Developmental Disabilities Services) for two of two allegations of missing money		**1. What corrective action will be accomplished?** · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns to the Program Coordinator. o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o Staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts, returning change and receipts). o Resident rights o Vehicle use and safety/supervision precautions during transport. · The Program Coordinator and Program Director will be retrained on the appointment process expectations, yearly appointment expectations, following physician	

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	(for clients B and E), and a motor vehicle accident (clients A, B, C, D, E, F, G, and H). The facility staff neglected to supervise clients B, C, D, E, F, and G regarding leaving the clients alone on the facility van with the ignition on and to ensure two staff were present to complete the safe transport from day services to the group home. Please refer to W153. The facility failed to immediately report to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law the facility's failure to provide nursing oversight and to ensure the facility staff assisted clients A and H to their scheduled physician's appointments, client A's open pressure skin ulcer developed in the group home, and 2 of 2 allegations of missing personal funds (for clients B and E), and 1 of 1 motor vehicle accident for 4 of 4 sampled clients (clients A, B, C, and D) and for 4 additional clients (clients E, F, G, and H). Please refer to W137. The facility failed to ensure client B had unimpeded access to his locked personal cigarettes which were kept secured inside the locked safe inside the medication cabinet for 1 of 4 sampled clients (client B). Please refer to W140. The facility failed		recommendations and communication expectations with the nurse. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director have been retrained on IN Mentor's resident finance expectations including tracking of money and what to do in the event of missing money · The Program Coordinator and Program Director will be trained on the accident reporting process including IN Mentor's expectations and reporting BDDS reports · The Program Coordinator and Program Director will be trained on the staffing expectations for the home. · Clients A and H have been discharged from IN Mentor services. · The Program Coordinator and Program Director will be trained on reporting wound concerns to the nurse. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. · A request for funds has been made to replace Client E's missing	

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	to ensure clients B, E, and H had a complete and accurate accounting for their client finances and approved purchases for 1 of 4 sampled clients (client B) and 2 additional clients (clients E and H). This federal tag relates to complaints #IN00195813 and #IN00198671. 9-3-2(a)		money. · The van involved in the vehicle accident has been scheduled for repairs. · Client B's cigarettes remain locked per his guardian's request. · Client B's BSP has been updated to include the locked cigarettes and a schedule for him to receive the cigarettes. · HRC approval has been obtained for Client B's cigarettes. · An inventory of Client B's belongings will be completed. The information will be shared with his guardian to determine if she wishes for him to purchase any additional items. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director and Program Coordinator will be retrained on the IDT process. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts and communicating the physician recommendations to the team. · The medical charts for the site will be reviewed by the nurse. · A med chart audit will be completed to identify any missing doctor appointments or physician recommendations that need to be followed up on. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas:	

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			home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · In the event that a client develops a pressure sore, the nurse will monitor and/or assess the client on at least a weekly basis until the sore has resolved. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns	

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			to the Program Coordinator. o Abuse, neglect and exploitation- what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o Staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts, returning change and receipts). o Resident rights o Vehicle use and safety/supervision precautions during transport. · The Program Coordinator and Program Director will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director have been retrained on IN Mentor's resident finance expectations including tracking of money and what to do in the event of missing money · The Program Coordinator and Program Director will be trained on the accident reporting process including IN Mentor's expectations	

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	15G353	A. BUILDING 00 B. WING	05/06/2016

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			and reporting BDDS reports. · The Program Coordinator and Program Director will be trained on the staffing expectations for the home. · The Program Coordinator and Program Director will be trained on reporting wound concerns to the nurse. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director and Program Coordinator will be retrained on the IDT process. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts and communicating the physician recommendations to the team. · The medical charts for the site will be reviewed by the nurse. · A med chart audit will be completed to identify any missing doctor appointments or physician recommendations that need to be followed up on. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed,	

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			family involvement, medical, workshop/day services, financial and adaptive equipment. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · In the event that a client develops a pressure sore, the nurse will monitor and/or assess the client on at least a weekly basis until the sore has resolved. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · The Program Director/QIDP will review all ISP's to ensure that they are updated and completed on a yearly basis or more frequently as the needs arise. · The Behavior Clinician will review all BSP's to ensure that they are updated and accurate regarding restrictions that have been implemented. They will be updated on a yearly basis or more frequently as the needs arise. · The Program Director/QIDP will ensure that there is formal programming in place for all residents that address identified needs. · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · The nurse will monitor staff documentation at a minimum of	

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			weekly and communicate with the necessary team members as needed. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns to the Program Coordinator. o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o Staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts, returning change and receipts). o Resident rights o Vehicle use and safety/supervision precautions during	

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			transport. · The Program Coordinator and Program Director will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director have been retrained on IN Mentor's resident finance expectations including tracking of money and what to do in the event of missing money · The Program Coordinator and Program Director will be trained on the accident reporting process including IN Mentor's expectations and reporting BDDS reports. · The Program Coordinator and Program Director will be trained on the staffing expectations for the home. · The Program Coordinator and Program Director will be trained on reporting wound concerns to the nurse. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · The nurse will review the skin wound documentation submitted by	

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			the staff on a weekly basis to ensure accuracy. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director and Program Coordinator will be retrained on the IDT process. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts and communicating the physician recommendations to the team. · The medical charts for the site will be reviewed by the nurse. · A med chart audit will be completed to identify any missing doctor appointments or physician recommendations that need to be followed up on. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · In the event that a client develops a pressure sore, the nurse will monitor and/or assess the client on at least a weekly basis until the sore has resolved. · The IDT will continue to monitor the needs of all of the	

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			clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · The Program Director/QIDP will review all ISP's to ensure that they are updated and completed on a yearly basis or more frequently as the needs arise. · The Behavior Clinician will review all BSP's to ensure that they are updated and accurate regarding restrictions that have been implemented. They will be updated on a yearly basis or more frequently as the needs arise. · The Program Director/QIDP will ensure that there is formal programming in place for all residents that address identified needs. · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Director will monitor to ensure the clients plans and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · Mentor's nurse will be in the	

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			home on a weekly basis or more frequently as needed to monitor for concerns and assess residents. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: risk plans, ISP's, BSP's, restrictions in place, programming, and medication review. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. Copies of the staffings will be forwarded to all team members including the Area Director and/or Quality Assurance for review. · Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review. · Oversight of the skin/wound documentation will be completed by the Program Coordinator, QIDP, and nurse. · The QIDP will monitor and review the resident's needs. As the needs arise, formal programming will be implemented.	
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			

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	appropriate personal possessions and clothing. Based on observation, interview, and record review, for 1 of 4 sampled clients (client B), the facility failed to ensure client B had unimpeded access to his locked personal cigarettes which were kept secured inside the locked safe inside the medication cabinet. Findings include: Observations and interviews were conducted at the group home on 4/25/16 from 2:55pm until 5:15pm and on 4/26/16 from 6:00am until 8:00am. During the observation periods client B was observed at the group home. During both the observation periods client B requested his cigarettes from GHS (Group Home Staff) #1, #2, #3, #4, #5, and the Residential Manager (RM) throughout the observation periods. During both observation periods client B requested his cigarette from staff and the RM, independently exited the facility outside the back door alone, sat down in a chair outside the back door, lit his cigarette, and smoked each cigarette without a staff being present or within view of client B smoking independently. After each cigarette client B extinguished his cigarette butt and entered the group home.	W 0137	**W137 Protection of Clients Rights** The facility must ensure the rights of all clients. Therefore, the facility must ensure that the clients have the right to retain and use appropriate personal possessions and clothing. **1. What corrective action will be accomplished?** · Client B's cigarettes remain locked per his guardian's request. · Client B's BSP has been updated to include the locked cigarettes and a schedule for him to receive the cigarettes. · HRC approval has been obtained for Client B's cigarettes. · Client B will have formal programming on understanding his smoking schedule. · Resident rights including restricting access to desired items such as cigarettes will be reviewed with the staff. · Resident rights, including restricting access to desired items such as cigarettes and appropriate behavior interventions (least to more restrictive) will be reviewed with the Program Director and Program Coordinator. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same	06/05/2016

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	On 4/25/16 at 4:50pm, GHS #2 indicated client B's cigarettes were kept locked. GHS #2 stated client B's cigarettes were "kept secured per his guardian's request and [client B] smoked at 4pm, 6pm, 8pm, 6am, and 7am" daily. GHS #2 stated client B's smoking restriction was "not documented" in a plan and staff gave client B a cigarette on schedule from client B's locked supply. On 4/26/16 at 7:30am, GHS (Group Home Staff) #1 stated client B's cigarettes were "always kept locked" inside the safe in the medication cabinet. Client B's record was reviewed on 4/27/16 at 12:45pm and on 4/28/16 at 9:10am. Client B's 4/26/16 ISP (Individual Support Plan and 3/10/16 BSP (Behavior Support Plan) did not indicate the identified need for locked cigarettes, a documented plan for the restriction, and did not include consent for his personal cigarettes to be kept locked/secured. On 4/27/16 at 12:45pm, an interview with the Area Director (AD) was conducted. The AD indicated client B's cigarettes were kept locked inside the group home. The AD indicated client B's record did not include a plan or consent		deficient practice. · Resident rights including restricting access to desired items such as cigarettes will be reviewed with the staff. · Resident rights, including restricting access to desired items such as cigarettes and appropriate behavior interventions (least to more restrictive) will be reviewed with the Program Director and Program Coordinator. · The Behavior Clinician will monitor during her monthly observations. · In the event that a restrictive measure needs to be implemented, the IDT will convene to determine what measures need to be addressed. The IDT will outline the guidelines for the restriction. Team member, individual and guardian signatures will be obtained. HRC approval would be obtained for the restriction before it would be implemented. · The Program Director/QIDP will review all ISP's to ensure that they are updated and completed on a yearly basis or more frequently as the needs arise. · The Behavior Clinician will review all BSP's to ensure that they are updated and accurate regarding restrictions that have been implemented. They will be updated on a yearly basis or more frequently as the needs arise. · The Program Director/QIDP will ensure that there is formal programming in place for all residents that address identified	

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	for his personal cigarettes to be kept secured and/or restricted from his unimpeded access. On 5/6/16 at 3:15pm, the AD indicated no further information was available for review. 9-3-2(a)		needs. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Resident rights including restricting access to desired items such as cigarettes will be reviewed with the staff. · Resident rights, including restricting access to desired items such as cigarettes and appropriate behavior interventions (least to more restrictive) will be reviewed with the Program Director and Program Coordinator. · The Behavior Clinician will monitor during her monthly observations. · In the event that a restrictive measure needs to be implemented, the IDT will convene to determine what measures need to be addressed. The IDT will outline the guidelines for the restriction. Team member, individual and guardian signatures will be obtained. HRC approval would be obtained for the restriction before it would be implemented. · The Program Director/QIDP will review all ISP's to ensure that they are updated and completed on a yearly basis or more frequently as the needs arise. · The Behavior Clinician will review all BSP's to ensure that they are updated and accurate regarding restrictions that have been implemented. They will be updated on a yearly basis or more frequently	

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			as the needs arise. · The Program Director/QIDP will ensure that there is formal programming in place for all residents that address identified needs. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Behavior Clinician will monitor as she is in the home for her monthly observations. · The Program Director will monitor when he is in the home to complete his supervisory visits. · The Program Coordinator will monitor on a daily basis when she is in the home. · The Program Director will monitor to ensure the clients plans and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: risk plans, ISP's, BSP's, restrictions in place, programming, and medication review. **1.What is the date by which the systemic changes will be completed?** June 5th, 2016	

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W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on observation, record review, and interview, for 1 of 4 sampled clients (client B) and 2 additional clients (clients E and H), the facility failed to ensure clients B, E, and H had a complete and accurate accounting for their client finances and approved purchases. Findings include: 1. The facility's reportable and investigative records from 11/1/15 through 4/25/16 were reviewed on 4/25/16 at 1:40pm, and 4/27/16 at 12:20pm. The review did not include a report regarding missing money for client E. -On 4/26/16 from 6:00am until 8:00am, observation and interview were conducted at the group home. At 7:30am, client E stated he was missing "$30.00 since before Christmas (2015)" and "they never replaced it." Client E stated "three (3) days before I was to leave on vacation my money was locked up in the safe and (I) was to get it. It (my money) was missing." Client E stated the Residential Manager at the time had the	W 0140	**W140 Client Finances** The facility must establish and maintain a system that assures a full and complete accounting of clients' personal fund entrusted to the facility on behalf of clients. **1. What corrective action will be accomplished?** · Client H has been discharged from IN Mentor services. · The Program Coordinator and Program Director have been retrained on IN Mentor's resident finance expectations including tracking of money and what to do in the event of missing money · A request for funds has been made to replace Client E's missing money. · The Program Director and Program Coordinator will be retrained on the IDT process. · An inventory of Client B's belongings will be completed. The information will be shared with his guardian to determine if she wishes for him to purchase any additional items. · Staff training will be completed regarding: o Staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts,	06/05/2016

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	only access to his money and then "moved" his (client E's) money to her office in the group home and "locked it up there." At 7:30am, GHS #2 and GHS #4 were present and both indicated client E had reported the allegation of missing money when it was missing in 12/2015. At 7:30am, GHS #4 counted client A, B, C, D, F, and G's finances and client E's finances were kept locked inside the Residential Manager's office. On 4/27/16 at 8:30am, an interview with the Area Director (AD) was conducted. The AD indicated she was unaware of an allegation of missing finances for client E and no BDDS report and investigation were available for review. The AD indicated client E's allegation should have been immediately reported and investigated. On 5/6/16 at 9:15am, the AD provided an additional BDDS report for review. -A 4/27/16 BDDS report for an incident on 4/26/16 at 8:30am, indicated client E "spoke with State Surveyor, [client E] indicated that the money was missing before he went home with his family at Christmas. An exact date or amount of money missing was not provided. When the Program Director (aka Residential Manager) spoke with [client E] on 4/26/16, [client E] indicated that he		returning change and receipts). **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Training completed with the staff regarding: o Staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts, returning change and receipts). · The Program Coordinator and Program Director have been retrained on IN Mentor's resident finance expectations including tracking of money and what to do in the event of missing money · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director and Program Coordinator will be retrained on the IDT process. · The Program Coordinator will ensure that finances are updated and cash counted every 3 days. · The Program Director will count the cash on hand and compare it to the finances when they are in the home to complete their observations. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Training completed with the	

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	couldn't remember how much money was missing...." -A 5/2/16 "Summary of Internal Investigation" indicated the 4/26/16 BDDS report information. The investigation indicated "While completing the investigation involving [client E], [GHS (Group Home Staff) #2] also reported an additional concern of money missing for [client B]. Amount that was alleged to be missing was unknown. Date the money became missing was also unknown." The investigation indicated the following: -Interview with GHS #5 was conducted. GHS #5 stated clients E and H "were the two guys who reported concerns with their money to her. Stated she thought [client E] said it was $30.00 and she thought [client H] was missing a couple of dollars. Stated she did not report the missing money to anyone. When asked why she did not report the missing money, [GHS #5] stated [client E] had said he reported the missing money to [the PD aka Residential Manager]." -Interview with client E was conducted. Client E "stated his missing $30.00 hasn't been replaced yet...Stated the money was missing in December....Stated he was looking for the money before he left for his parents and he couldn't find it...Stated [GHS #1, GHS #2, GHS #3, GHS #4,		staff regarding: o Staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts, returning change and receipts). · The Program Coordinator and Program Director have been retrained on IN Mentor's resident finance expectations including tracking of money and what to do in the event of missing money · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director and Program Coordinator will be retrained on the IDT process. · The Program Coordinator will ensure that finances are updated and cash counted every 3 days. · The Program Director will count the cash on hand and compare it to the finances when they are in the home to complete their observations. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Director will monitor to ensure the clients are accounted for during their bi-weekly observations. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. Copies of the staffings will be forwarded to all	

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	15G353	A. BUILDING 00 B. WING	05/06/2016

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	GHS #5, and the QIDP (Qualified Intellectual Disabilities Professional)] and some of the residents were all aware that his money was missing...Stated [the QIDP] told [client E] he (the QIDP) must have forgotten about it...Stated he was upset over the missing money but believed it would eventually be replaced." -Interview with GHS #6 was conducted. GHS #6 stated she "was aware [client E] had concerns with missing money around Christmas time. Stated she thought it was around $30.00...Stated [client E] had not made a big deal about his missing money since Christmas." -Interview with GHS #3 was conducted. GHS #3 stated "the only time she was aware of money concerns is when [client E] lost his $30.00...Stated she can't remember if [client E] told her specifically he had #30.00 missing or if he told another staff and she heard about it...Stated she reported the missing money to the PC [aka Residential Manager] at the time, believed [former Residential Manager] was the PC at the time. Stated she (GHS #3) reported it to the [name of QIDP]...." -"Conclusion" of the investigation indicated "Evidence supports [client E's] finances do not reflect pawning items for $30.00. Evidence supports a receipt from [name of pawn shop] that [client E]		team members including the Area Director and/or Quality Assurance for review. · Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review. · New staff hired to work at the site will receive training on staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts, returning change and receipts). **1.What is the date by which the systemic changes will be completed?** · June 5th, 2016	

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	pawned his TV and DVD player for a combined $40.00...Evidence does support that [client E, GHS #4, and GHS #7] reported the missing money of [client E] to [name of QIDP]. Evidence does support that [GHS #3] reported the missing money of [client E] to [name of the Residential Manager]. Evidence supports [name of RM and QIDP] deny knowing about missing money...Evidence does not indicate what happened to the missing money..." and evidence does support that the missing money from the pawned items was "last seen on 12/11/15." The investigation indicated it was unsubstantiated that clients B and H had missing money because the information was not specific to the amounts, dates, and tracking system. 2. The facility's reportable and investigative records from 11/1/15 through 4/25/16 were reviewed on 4/25/16 at 1:40pm, 4/27/16 at 12:20pm, and on 5/6/16 at 9:15am. The review included the following: -A 5/2/16 BDDS (Bureau of Developmental Disabilities Services) report for an incident on 5/2/16 at 6:00pm indicated "While completing an investigation interview with a staff regarding another client at the [name of group home] and a missing money			

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	allegation, staff informed this Area Director that he believed that [client B] also had missing money. The amount of the money was not reported by staff as he was uncertain how much was reported missing. The date of the missing money was also unknown, however the other allegation" was reported for 12/14/15 through 12/21/15 and based on staff interview "it is possible that [client B's] missing money allegation occurred around the same time period." -A 11/10/15 BDDS report for an incident on 11/10/15 at 12:00pm indicated client B's "guardian contacted the BDDS office" and reported "that consumer received a tax return of $67.00 earlier this year which was to be used to purchase shoes and jeans. She stated that she received notice the withdraw was made but consumer did not get shoes or jeans. She is unsure where the money went. She was unable to provide an exact date during the call but said it was around Memorial Day (2015)." -A 11/16/15 "Summary of Internal Investigation" indicated the following: -An Interview was conducted with client B's guardian. Client B's guardian "stated she knows [client B] got $69.00 in April (2015). Stated the last of May she gave permission to the [Residential Manager			

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	(RM)] at the time to get shoes and clothes for [client B]...Stated she wants the money replaced if [the agency] cannot show that it was spent on [client B]. Stated she thinks someone pocketed the money because to her knowledge the purchases were not made. Stated she was upset due to the staff turnover at the home...." -An Interview with client B was conducted. Client B indicated he did not know how to obtain his money. Client B indicated he had not purchased any new clothing and "showed new boots that he had recently purchased." -Client B's "finances 5/2015 - 6/2015" indicated deposit entry on 5/4/15 of $69.00 and withdrawals for $21.03, $29.85, $8.41, $5.00, $28.70, $11.07, $49.42 for cigarettes and lighter. -"Conclusion: Evidence does not support the misuse of [client B's] funds. Evidence supports [client B] used his tax money to purchase 4 clothing items (shirts), cigarettes, pop, dining out, and snack foods." On 4/27/16 at 12:45pm, an interview with the Area Director (AD) was conducted. The AD indicated the allegations of missing money for clients B, E, and H were not immediately reported and should have been. The AD indicated client B's guardian allegation			

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	was immediately reported but the items approved for the purchase (shoes and jeans) were not completed by the RM who was in charge of the group home during that period of time. The AD indicated the group home had had at least four (4) different Residential Managers and two (2) different QIDPs within the past year. The AD indicated the changes in leadership staff at the group home and staff turnover had made it difficult to determine what had occurred. The AD indicated each client living in the group home should have a complete accounting of their personal finances maintained by the facility. The facility's client finance policy and procedure was requested. On 4/26/16 at 2:10pm, the facility's 4/2011 "Management of Individual Funds" indicated "Procedures are in place in all programs to ensure accountability and to protect individuals from financial exploitation." The policy indicated a "complete and accurate" account including receipts, documentation of disbursements, and deposits were to be documented. On 5/6/16 at 3:15pm, the AD indicated no further information was available for review. 9-3-2(a)			

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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 observation, record review, and interview, for 4 of 4 sampled clients (clients A, B, C, and D) and for 4 additional clients (clients E, F, G, and H), the facility neglected to ensure the facility staff implemented the agency policy and procedure for abuse, neglect, mistreatment, and exploitation. The facility neglected to provide nursing oversight and to ensure the facility staff assisted clients A and H to their scheduled physician's appointments. The facility staff neglected to report client A's open pressure ulcer areas developed in the group home. The facility staff neglected to immediately report to the administrator and to BDDS (Bureau of Developmental Disabilities Services) two of two allegations of missing money (for clients B and E), and a motor vehicle accident (clients A, B, C, D, E, F, G, and H). The facility staff neglected to supervise clients B, C, D, E, F, and G regarding	W 0149	**W 149 Staff Treatment of Clients** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. **1. What corrective action will be accomplished?** · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns to the Program Coordinator. o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program	06/05/2016

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	leaving the clients alone on the facility van with the ignition on and to ensure two staff were present to complete the safe transport from day services to the group home. Findings include: 1. The facility's reportable and investigative records from 11/1/15 through 4/25/16 were reviewed on 4/25/16 at 1:40pm, 4/27/16 at 12:20pm, and on 5/6/16 at 9:15am. The review did not indicate a BDDS report regarding the facility staff and nursing staff's failure to ensure clients A and H attended their scheduled medical appointments. Client A's record was reviewed on 4/27/16 at 12:55pm. Client A's 1/29/16 ISP (Individual Support Plan) and 2016 Risk Plan indicated client A was at risk for skin integrity problems because of his decreased mobility. Client A's ISP, 11/4/15 Physician's Order, and 4/2016 MAR (Medication Administration Record) indicated client A's diagnoses included, but were not limited to: Cerebral Palsy, Seborrhea Dermatitis, Scoliosis, History of GI Bleed, Iron Deficiency Anemia, Edema, Depression, and Constipation. Client A's records indicated "Adaptive Equipment: Electric and manual Wheel Chairs, soft torso back		Coordinator o Staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts, returning change and receipts). o Resident rights o Vehicle use and safety/supervision precautions during transport. · The Program Coordinator and Program Director will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director have been retrained on IN Mentor's resident finance expectations including tracking of money and what to do in the event of missing money · The Program Coordinator and Program Director will be trained on the accident reporting process including IN Mentor's expectations and reporting BDDS reports · The Program Coordinator and Program Director will be trained on the staffing expectations for the home. · Clients A and H have been discharged from IN Mentor services.	

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	brace, Vascular knee small/regular ted hose, wrist splint, depends undergarments, Baclofen Pump...rolling toilet seat, and gel cushion for wheel chair." Client A's record did not include dates and times of his scheduled physician's appointments. On 4/26/16 at 8:30am, an interview with the Area Director (AD) was conducted. The AD indicated client A had been hospitalized on 4/18/16 for his dehydration and Baclofen Pump. The AD indicated the agency nurse indicated she checked client A on 4/18/16 and heard bowel sounds before client A left for the hospital. The AD indicated after client A was admitted to the hospital it was a few days later that the diagnosis of impacted bowels was added. The AD indicated the group home had experienced a change of Residential Managers four or five times within the past 6 to 8 month period of time. The AD indicated clients A and H did miss their scheduled appointments and the current Residential Manager (RM) was attempting to recreate who had appointments and when the appointments were scheduled with the current physician's and specialist's doctor's offices. The AD indicated appointments have been missed and assessments for follow up appointments have been late because the facility staff and previous		· The Program Coordinator and Program Director will be trained on reporting wound concerns to the nurse. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. · A request for funds has been made to replace Client E's missing money. · The van involved in the vehicle accident has been scheduled for repairs. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director and Program Coordinator will be retrained on the IDT process. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts and communicating the physician recommendations to the team. · The medical charts for the site will be reviewed by the nurse. · A med chart audit will be completed to identify any missing doctor appointments or physician recommendations that need to be followed up on. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas:	

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	RM's did not document client specific schedules for appointments. The AD stated the nurse "usually provided oversight however during the same time" two different nurses were hired to supervise the group home and one additional nurse with the agency from another area of the state was attempting to oversee the group home when the assigned nurse had left in order to coordinate the nursing care and services for the clients. Confidential Interview (CI) #2 was conducted. CI #2 stated client A "missed" his physician's appointments and the advocates/guardians were not contacted. CI #2 stated client A "had a Baclofen Pump" to help with his spinal cord fluid, treatment of his spasticity, and Cerebral Palsy. CI #2 stated "how does that run out and nobody notices?" CI #2 stated client A was out of his medication "over 8 weeks." Then since the pump was out when the group home noticed in 2/2016 the physician decided to evaluate a replacement. CI #2 stated client A was given oral Baclofen, after appointments were missed and/or rescheduled, and "we think" it contributed to his vomiting and stomach problems he was hospitalized with now. CI #2 indicated client A had been in the hospital since 4/18/16 for his vomiting and dehydration.		home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Program Coordinator/QIDP/nurse oversight of the skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and addressed appropriately. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · In the event that a client develops a pressure sore, the nurse will monitor and/or assess the client on at least a weekly basis until the sore has resolved. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the	

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	Client H's record was reviewed on 4/27/16 at 12:30pm. Client H's 9/4/15 ISP and 11/23/15 Physician's Order included, but were not limited to the following diagnoses: Chronic Joint Pain, Congestive Heart Failure, Hearing Disability, Severe Rheumatoid Arthritis, and Hypertension. Client H's record did not include his scheduled medical appointments. Confidential Interview (CI) #1 was conducted. CI #1 stated "it was very difficult to get and give medical information to a staff for [client H]. Call backs after a message was left did not exist." CI #1 indicated client H missed the following physician appointments: -A follow up medical appointment on 3/14/16 was rescheduled. -A 2/24/16 medical appointment, CI #1 stated he was a "no show" for the appointment. -A follow up medical appointment on 1/28/16 was rescheduled. -A 12/7/15 Ears, Nose, and Throat medical appointment client H was a "no show." -A medical appointment on 11/20/15 was rescheduled "because of staffing issues." -A 11/4/15 medical appointment was rescheduled. -A 10/16/15 new patient appointment		staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns to the Program Coordinator. o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o Staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts, returning change and receipts). o Resident rights o Vehicle use and safety/supervision precautions during transport. · The Program Coordinator and Program Director will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director have been retrained on IN Mentor's resident	

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	was kept "however 25 minutes late" with staff to the appointment. -A medical appointment on 9/15/15 was rescheduled CI #1 stated "was told transportation issues." 2. The facility's reportable and investigative records from 11/1/15 through 4/25/16 were reviewed on 4/25/16 at 1:40pm, 4/27/16 at 12:20pm, and on 5/6/16 at 9:15am. The review did not indicate a report that client A had open pressure ulcer areas. Client A's record was reviewed on 4/27/16 at 12:55pm. Client A's 1/29/16 ISP (Individual Support Plan) and 2016 Risk Plan indicated client A was at risk for skin integrity problems because of his decreased mobility. Client A's 5/26/15 "Skin Integrity Risk Plan" indicated "the key to keeping the skin intact is keeping it dry and pressure free...repositioning every hour...documenting in therap (a facility computerized clinical record in which staff document each client's information)...." Client A's diagnoses included, but were not limited to: Cerebral Palsy, Scoliosis, and Edema. Client A's 2/12/16 and 4/2016 MAR both indicated client A had problems related to his limited mobility. Client A's record indicated he was seen by the wound clinic in 6/2015, on 6/19/15, and 6/10/15		finance expectations including tracking of money and what to do in the event of missing money · The Program Coordinator and Program Director will be trained on the accident reporting process including IN Mentor's expectations and reporting BDDS reports. · The Program Coordinator and Program Director will be trained on the staffing expectations for the home. · The Program Coordinator and Program Director will be trained on reporting wound concerns to the nurse. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director and Program Coordinator will be retrained on the IDT process. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts and communicating the physician recommendations to the team. · The medical charts for the site will be reviewed by the nurse. · A med chart audit will be completed to identify any missing doctor appointments or physician	

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	for a pressure area on his buttock. Client A's record indicated he was checked monthly by the agency nurse regarding his skin and indicated the following signed by the agency nurse: -On 1/15/16 Skin Check "I checked his left hip which has a tendency to be reddened. It is red but not open." -On 11/9/15 Skin Check "due to a fall this morning that he went to the ER for. He has a cut above his right eyebrow 2cm (centimeters) x .5cm with some swelling, he also has a 10cm x 1cm abrasion on his abdomen...checked his left trochanter area (buttocks) I did not note any open area but there is a slightly red shiny 1.5cm x 1.5cm area there with a darker color area below it but all skin is intact at this time." -On 11/4/15 "...assessed left trochanter...at this time skin is intact and no sore noted." -On 6/29/15 "...on 6/19/15 met with [client A] to discuss his appointment at wound care center...has a reddened area but it is not opened at this time...repositioned every hour in the chair and every 2 hours in bed...will purchase new cushion for his wheelchair...." -On 6/11/15 client A "was taken by staff to Urgent Care evening of 6/10/15 for an evaluation of a pressure ulcer. A referral was given for a wound care facility...." -No documentation was available for		recommendations that need to be followed up on. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Program Coordinator/QIDP/nurse oversight of the skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and addressed appropriately. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · In the event that a client develops a pressure sore, the nurse will monitor and/or assess the client on at least a weekly basis until the sore has resolved. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · The Program Director/QIDP will review all ISP's to ensure that they are updated and completed on a yearly basis or more frequently as the needs arise. · The Program Director/QIDP will ensure that there is formal programming in place for all	

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	15G353	A. BUILDING 00 B. WING	05/06/2016

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	review from the wound care center. -No documentation regarding the sizes, shapes, and colors of client A's pressure areas were available for review. On 4/27/16 at 12:45pm, an interview was conducted with the AD (Area Director). The AD indicated she would attempt to locate client A's wound care appointment information. The AD indicated the agency nurse was new and had just started her employment. The AD indicated the agency nurse from another area of the state with the REM/Occazio agency was trying to catch up the paperwork for client A. The AD indicated the former nurse had left the agency's employment before 2016. The AD indicated client A was at risk for skin breakdown, had a pressure ulcer open in 6/2015, and no sizes, shapes, and colors of client A's pressure ulcers were developed into a nursing protocol. The AD indicated the nurse sized, shaped, and documented the colors of client A's skin however no documentation was available for review to show that the facility staff documented the sizes, shapes, and colors of client A's skin. On 5/6/16 at 3:15pm, an interview with the AD was conducted. The AD indicated no further information was available for review.		residents that address identified needs. · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns to the Program Coordinator. o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator	

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	3. The facility's reportable and investigative records from 11/1/15 through 4/25/16 were reviewed on 4/25/16 at 1:40pm, and 4/27/16 at 12:20pm. The review did not include a BDDS report regarding missing money for client E. -On 4/26/16 from 6:00am until 8:00am, observation and interview were conducted at the group home. At 7:30am, client E stated he was missing "$30.00 since before Christmas (2015)" and "they never replaced it." Client E stated "three (3) days before I was to leave on vacation my money was locked up in the safe and (I) was to get it. It (my money) was missing." Client E stated the Residential Manager at the time had the only access to his money and then "moved" his (client E's) money to her office in the group home and "locked it up there." At 7:30am, GHS #2 and GHS #4 were present and both indicated client E had reported the allegation of missing money when it was missing in 12/2015. At 7:30am, GHS #4 counted client A, B, C, D, F, and G's finances and client E's finances were kept locked inside the Residential Manager's office. On 4/27/16 at 8:30am, an interview with the Area Director (AD) was conducted.		o Staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts, returning change and receipts). o Resident rights o Vehicle use and safety/supervision precautions during transport. · The Program Coordinator and Program Director will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director have been retrained on IN Mentor's resident finance expectations including tracking of money and what to do in the event of missing money · The Program Coordinator and Program Director will be trained on the accident reporting process including IN Mentor's expectations and reporting BDDS reports. · The Program Coordinator and Program Director will be trained on the staffing expectations for the home. · The Program Coordinator and Program Director will be trained on reporting wound concerns to the	

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	The AD indicated she was unaware of an allegation of missing finances for client E and no BDDS report and investigation were available for review. The AD indicated client E's allegation should have been immediately reported and investigated. On 5/6/16 at 9:15am, the AD provided an additional BDDS report for review. -A 4/27/16 BDDS report for an incident on 4/26/16 at 8:30am, indicated client E "spoke with State Surveyor, [client E] indicated that the money was missing before he went home with his family at Christmas. An exact date or amount of money missing was not provided. When the Program Director (aka Residential Manager) spoke with [client E] on 4/26/16, [client E] indicated that he couldn't remember how much money was missing...." -A 5/2/16 "Summary of Internal Investigation" indicated the 4/2616 BDDS report information. The investigation indicated "While completing the investigation involving [client E], [GHS (Group Home Staff) #2] also reported an additional concern of money missing for [client B]. Amount that was alleged to be missing was unknown. Date the money became missing was also unknown." The		nurse. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director and Program Coordinator will be retrained on the IDT process. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts and communicating the physician recommendations to the team. · The medical charts for the site will be reviewed by the nurse. · A med chart audit will be completed to identify any missing doctor appointments or physician recommendations that need to be followed up on. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Program Coordinator/QIDP/nurse oversight of the skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse)	

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	investigation indicated the following: -Interview with GHS #5 was conducted. GHS #5 stated clients E and H "were the two guys who reported concerns with their money to her. Stated she thought [client E] said it was $30.00 and she thought [client H] was missing a couple of dollars. Stated she did not report the missing money to anyone. When asked why she did not report the missing money, [GHS #5] stated [client E] had said he reported the missing money to [the PD aka Residential Manager]." -Interview with client E was conducted. Client E "stated his missing $30.00 hasn't been replaced yet...Stated the money was missing in December....Stated he was looking for the money before he left for his parents and he couldn't find it...Stated [GHS #1, GHS #2, GHS #3, GHS #4, GHS #5, and the QIDP (Qualified Intellectual Disabilities Professional)] and some of the residents were all aware that his money was missing...Stated [the QIDP] told [client E] he (the QIDP) must have forgotten about it...Stated he was upset over the missing money but believed it would eventually be replaced." -Interview with GHS #6 was conducted. GHS #6 stated she "was aware [client E] had concerns with missing money around Christmas time. Stated she thought it was around $30.00...Stated [client E] had		to ensure it is completed and addressed appropriately. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · In the event that a client develops a pressure sore, the nurse will monitor and/or assess the client on at least a weekly basis until the sore has resolved. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · The Program Director/QIDP will review all ISP's to ensure that they are updated and completed on a yearly basis or more frequently as the needs arise. · The Program Director/QIDP will ensure that there is formal programming in place for all residents that address identified needs. · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Director will monitor to ensure the clients plans	

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	not made a big deal about his missing money since Christmas." -Interview with GHS #3 was conducted. GHS #3 stated "the only time she was aware of money concerns is when [client E] lost his $30.00...Stated she can't remember if [client E] told her specifically he had #30.00 missing or if he told another staff and she heard about it...Stated she reported the missing money to the PC [aka Residential Manager] at the time, believed [former Residential Manager] was the PC at the time. Stated she (GHS #3) reported it to the [name of QIDP]...." -"Conclusion" of the investigation indicated "Evidence supports [client E's] finances do not reflect pawning items for $30.00. Evidence supports a receipt from [name of pawn shop] that [client E] pawned his TV and DVD player for a combined $40.00...Evidence does support that [client E, GHS #4, and GHS #7] reported the missing money of [client E] to [name of QIDP]. Evidence does support that [GHS #3] reported the missing money of [client E] to [name of the Residential Manager]. Evidence supports [name of RM and QIDP] deny knowing about missing money...Evidence does not indicate what happened to the missing money..." and evidence does support that the missing money from the pawned items was "last seen on		and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · Mentor's nurse will be in the home on a weekly basis or more frequently as needed to monitor for concerns and assess residents. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: risk plans, ISP's, BSP's, restrictions in place, programming, and medication review. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. Copies of the staffings will be forwarded to all team members including the Area Director and/or Quality Assurance for review. · Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review. · Oversight of the skin/wound documentation will be completed by the Program Coordinator, QIDP, and nurse. · The QIDP will monitor and review the resident's needs. As the needs arise, formal programming will	

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	12/11/15." The investigation indicated it was unsubstantiated that clients B and H had missing money because the information was not specific to the amounts, dates, and tracking system. 4. The facility's reportable and investigative records from 11/1/15 through 4/25/16 were reviewed on 4/25/16 at 1:40pm, 4/27/16 at 12:20pm, and on 5/6/16 at 9:15am. The review included the following: -A 5/2/16 BDDS (Bureau of Developmental Disabilities Services) report for an incident on 5/2/16 at 6:00pm indicated "While completing an investigation interview with a staff regarding another client at the [name of group home] and a missing money allegation, staff informed this Area Director that he believed that [client B] also had missing money. The amount of the money was not reported by staff as he was uncertain how much was reported missing. The date of the missing money was also unknown, however the other allegation" was reported for 12/14/15 through 12/21/15 and based on staff interview "it is possible that [client B's] missing money allegation occurred around the same time period." On 4/27/16 at 12:45pm, an interview with the Area Director (AD) was		be implemented. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document medical needs, how to report incidents, and understanding of BSP's. · The Quality Improvement Department and the Area Director will monitor incidents as they are reported to ensure that they are reported timely and that all required incidents are reported to BDDS.	

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	conducted. The AD indicated the allegations of missing money for clients B, E, and H were not immediately reported and should have been. The AD indicated client B's guardian allegation was immediately reported but the items approved for the purchase (shoes and jeans) were not completed by the RM who was in charge of the group home during that period of time. The AD indicated the group home had had at least four (4) different Residential Managers and two (2) different QIDPs within the past year. The AD indicated the changes in leadership staff at the group home and staff turnover had made it difficult to determine what had occurred. On 5/6/16 at 3:15pm, the AD indicated no further information was available for review. 5. The facility's reportable and investigative records from 11/1/15 through 4/25/16 were reviewed on 4/25/16 at 1:40pm, and 4/27/16 at 12:20pm. The review did not include a BDDS report regarding an automobile accident and damage to the facility vehicle. On 4/25/16 from 2:55pm until 5:15pm and on 4/26/16 from 6:00am until 8:00am, clients B, C, D, E, F, and G were			

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	15G353	A. BUILDING 00 B. WING	05/06/2016

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	observed at the group home. On 4/25/16 at 3:00pm, clients B, C, D, E, F, and G arrived to the group home on the facility van. On 4/26/16 at 7:55am, clients B, C, D, E, F, and G were leaving on the facility van with facility staff. On 4/26/16 at 7:00am, GHS (Group Home Staff) #4 with clients B, C, E, and F walked in and out of the group home. At 7:00am, GHS #4 indicated the facility van had damage to the left side drivers side fender and stated the fender was held in place with "automotive tape" securing the "damaged fender" until the insurance approves the repairs to the vehicle. GHS #4 indicated a different staff person had wrecked the van on the ice "over a month ago." Clients B, C, E, and F indicated they were on the van when the accident occurred. GHS #4 stated she "thought all the clients" (clients A, B, C, D, E, F, and G) were on the van at the time of the accident. On 4/27/16 at 12:20pm, an interview was conducted with the AD (Area Director). The AD indicated a BDDS report was not filed because there were no injuries to the clients. 6. On 4/27/16 from 2:10pm until 3:13pm, clients B, C, D, E, F, and G were observed at day service site #3. At 3:10pm, GHS #2 pulled the large facility			

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	bus onto the parking lot outside of day services, and clients B, C, D, E, and F were prompted to exit the day service building and load on the large van/bus. GHS #2 remained inside assisting client G to walk through the day service building to leave. From 3:10pm until 3:13pm, clients B, C, D, E, and F sat alone on the large facility van/bus with the keys in the ignition and the vehicle running. At 3:13pm, GHS #2 indicated he was the one staff available for transport today and stated there should "always be two (2)" facility staff on transport. GHS #2 indicated he left the keys in the ignition and the van was running without staff present with the clients. On 4/28/16 at 8:45am, an interview with the AD was conducted. The AD indicated the facility van should not have the keys left in the ignition and should not have the ignition on without a staff present. The AD stated two staff were to "always do transport" for clients B, C, D, E, F, and G from the day services. On 4/28/16 at 8:45am, the facility's undated "Behind the Wheel Company Vehicle Driver Training" did not indicate the staff should not leave the keys in the ignition in the on position and did not indicate the clients should not be without			

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	staff on the facility vehicle. The facility's policy and procedures were reviewed on 4/25/16 at 12:00noon. The facility's 4/2011 Quality and Risk Management policy indicated "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." The 4/2011 Quality and Risk Management Policy indicated failure to provide appropriate supervision, care or training was considered neglect. The 4/2011 Quality and Risk Management Policy indicated, "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. (1.) Investigation findings will be submitted to the AD (Area Director) for review and development of further recommendations as needed within 5 days of the incident." On 4/28/16 at 12:00noon, a record review was conducted of the 10/2005 "Bureau of Developmental Disabilities Services Policy and Guidelines." The BDDS			

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	15G353	A. BUILDING 00 B. WING	05/06/2016

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	policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse or exploitation by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The BDDS policy indicated each allegation of abuse, neglect, and/or mistreatment should be immediately reported. On 4/28/16 at 12:00noon, the 4/2003 "Reportable Incidents to the Bureau of Developmental Disabilities Services" indicated "Reportable incidents area any event characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual." This federal tag relates to complaints #IN00195813 and #IN00198671. 9-3-2(a)			

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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 observation, record review, and interview, for 4 of 4 sampled clients (clients A, B, C, and D) and for 4 additional clients (clients E, F, G, and H), the facility failed to immediately report to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law for the facility's failure to provide nursing oversight and to ensure the facility staff assisted clients A and H to their scheduled physician's appointments, for client A's open pressure skin areas developed in the group home, and for 2 of 2 allegations of missing personal funds (for clients B and E), and to report 1 of 1 motor vehicle accident for clients A, B, C, D, E, F, G, and H. Findings include: 1. The facility's reportable and investigative records from 11/1/15 through 4/25/16 were reviewed on 4/25/16 at 1:40pm, 4/27/16 at 12:20pm, and on 5/6/16 at 9:15am. The review did not indicate a BDDS report that the	W 0153	**W 153 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. **1. What corrective action will be accomplished?** · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns to the Program Coordinator. o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o Staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts, returning change and receipts). o Resident rights	06/05/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G353	A. BUILDING 00 B. WING	05/06/2016

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	facility staff and nursing staff's failure to ensure clients A and H attended their scheduled medical appointments. Client A's record was reviewed on 4/27/16 at 12:55pm. Client A's 1/29/16 ISP (Individual Support Plan) and 2016 Risk Plan indicated client A was at risk for skin integrity problems because of his decreased mobility. Client A's ISP, 11/4/15 Physician's Order, and 4/2016 MAR (Medication Administration Record) indicated client A's diagnoses included, but were not limited to: Cerebral Palsy, Seborrhea Dermatitis, Scoliosis, History of GI Bleed, Iron Deficiency Anemia, Edema, Depression, and Constipation. Client A's records indicated "Adaptive Equipment: Electric and manual Wheel Chairs, soft torso back brace, Vascular knee small/regular ted hose, wrist splint, depends undergarments, Baclofen Pump...rolling toilet seat, and gel cushion for wheel chair." Client A's record did not include dates and times of his scheduled physician's appointments. On 4/26/16 at 8:30am, an interview with the Area Director (AD) was conducted. The AD indicated client A had been hospitalized on 4/18/16 for his dehydration and Baclofen Pump. The AD indicated the agency nurse indicated she		o Vehicle use and safety/supervision precautions during transport. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director have been retrained on IN Mentor's resident finance expectations including tracking of money and what to do in the event of missing money · The Program Coordinator and Program Director will be trained on the accident reporting process including IN Mentor's expectations and reporting BDDS reports · Clients A and H have been discharged from IN Mentor services. · The Program Coordinator and Program Director will be trained on reporting wound concerns to the nurse. · The Program Director will be retrained on the role and expectations of the QIDP. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Training completed with the staff regarding:	

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	checked client A on 4/18/16 and heard bowel sounds before client A left for the hospital. The AD indicated after client A was admitted to the hospital it was a few days later that the diagnosis of impacted bowels was added. The AD indicated the group home had experienced a change of Residential Managers four or five times within the past 6 to 8 month period of time. The AD indicated clients A and H did miss their scheduled appointments and the current Residential Manager (RM) was attempting to recreate who had appointments and when the appointments were scheduled with the current physician's and specialist's doctor's offices. The AD indicated appointments have been missed and assessments for follow up appointments have been late because the facility staff and previous RM's did not document client specific schedules for appointments. The AD stated the nurse "usually provided oversight however during the same time" two different nurses were hired to supervise the group home and one additional nurse with the agency from another area of the state was attempting to oversee the group home when the assigned nurse had left in order to coordinate the nursing care and services for the clients. Confidential Interview (CI) #2 was		o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns to the Program Coordinator. o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o Staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts, returning change and receipts). o Resident rights o Vehicle use and safety/supervision precautions during transport. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on reportable incidents and notifying the administrator. · The Program Coordinator and Program Director have been retrained on IN Mentor's resident finance expectations including tracking of money and what to do in the event of missing money · The Program Coordinator and Program Director will be trained on the accident reporting process including IN Mentor's expectations and reporting BDDS reports. · The Program Coordinator and	

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	conducted. CI #2 stated client A "missed" his physician's appointments and the advocates/guardians were not contacted. CI #2 stated client A "had a Baclofen Pump" to help with his spinal cord fluid, treatment of his spasticity, and Cerebral Palsy. CI #2 stated "how does that run out and no body notices." CI #2 stated client A was out of his medication "over 8 weeks." Then since the pump was out when the group home noticed in 2/2016 the physician decided to evaluate a replacement. CI #2 stated client A was given oral Baclofen, after appointments were missed and/or rescheduled, and "we think" it contributed to his vomiting and stomach problems he was hospitalized with now. CI #2 indicated client A had been in the hospital since 4/18/16 for his vomiting and dehydration. Client H's record was reviewed on 4/27/16 at 12:30pm. Client H's 9/4/15 ISP and 11/23/15 Physician's Order included, but were not limited to the following diagnoses: Chronic Joint Pain, Congestive Heart Failure, Hearing Disability, Severe Rheumatoid Arthritis, and Hypertension. Client H's record did not include his scheduled medical appointments. Confidential Interview (CI) #1 was conducted. CI #1 stated "it was very		Program Director will be trained on reporting wound concerns to the nurse. · The Program Director will be retrained on the role and expectations of the QIDP. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns to the Program Coordinator. o Abuse, neglect and exploitation-what constitutes abuse, report expectations and investigation expectations (competency test provided) o When to contact the Program Coordinator o Staff's role in resident finances (purchasing requested items from guardian/team, obtaining receipts, returning change and receipts). o Resident rights o Vehicle use and safety/supervision precautions during transport. · The Program Coordinator will be trained on when to contact the Program Director. · The Program Coordinator and Program Director will be trained on	

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	difficult to get and give medical information to a staff for [client H]. Call backs after a message was left did not exist." CI #1 indicated client H missed the following physician appointments: -A follow up medical appointment on 3/14/16 was rescheduled. -A 2/24/16 medical appointment, CI #1 stated he was a "no show" for the appointment. -A follow up medical appointment on 1/28/16 was rescheduled. -A 12/7/15 Ears, Nose, and Throat medical appointment client H was a "no show." -A medical appointment on 11/20/15 was rescheduled "because of staffing issues." -A 11/4/15 medical appointment was rescheduled. -A 10/16/15 new patient appointment was kept "however 25 minutes late" with staff to the appointment. -A medical appointment on 9/15/15 was rescheduled and CI #1 stated "was told transportation issues." 2. The facility's reportable and investigative records from 11/1/15 through 4/25/16 were reviewed on 4/25/16 at 1:40pm, 4/27/16 at 12:20pm, and on 5/6/16 at 9:15am. The review did not indicate a report that client A had open pressure ulcer area developed in the group home.		reportable incidents and notifying the administrator. · The Program Coordinator and Program Director have been retrained on IN Mentor's resident finance expectations including tracking of money and what to do in the event of missing money · The Program Coordinator and Program Director will be trained on the accident reporting process including IN Mentor's expectations and reporting BDDS reports. · The Program Coordinator and Program Director will be trained on reporting wound concerns to the nurse. · The Program Director will be retrained on the role and expectations of the QIDP. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document medical needs, how to report incidents, and understanding of BSP's. · The Quality Improvement Department and the Area Director	

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	Client A's record was reviewed on 4/27/16 at 12:55pm. Client A's 1/29/16 ISP (Individual Support Plan) and 2016 Risk Plan indicated client A was at risk for skin integrity problems because of his decreased mobility. Client A's 5/26/15 "Skin Integrity Risk Plan" indicated "the key to keeping the skin intact is keeping it dry and pressure free...repositioning every hour...documenting in therap (a facility computerized record for staff to document each client's information)...." Client A's diagnoses included, but were not limited to: Cerebral Palsy, Scoliosis, and Edema. Client A's 2/12/16 and 4/2016 MAR both indicated client A had problems related to his limited mobility. Client A's record indicated he was seen by the wound clinic in 6/2015, on 6/19/15, and 6/10/15 for a pressure area on his buttock. Client A's record indicated he was checked monthly by the agency nurse regarding his skin and indicated the following signed by the agency nurse: -On 1/15/16 Skin Check "I checked his left hip which has a tendency to be reddened. It is red but not open." -On 11/9/15 Skin Check "due to a fall this morning that he went to the ER for. He has a cut above his right eyebrow 2cm (centimeters) x .5cm with some swelling, he also has a 10cm x 1cm abrasion on his		will monitor incidents as they are reported to ensure that they are reported timely and that all required incidents are reported to BDDS. · New staff hired to work at the site will receive training on reportable incidents, reporting expectations and who to contact. **5. What is the date by which the systemic changes will be completed?** June 5th, 2016	

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	abdomen...checked his left trochanter area (buttocks) I did not note any open area but there is a slightly red shiny 1.5cm x 1.5cm area there with a darker color area below it but all skin is intact at this time." -On 11/4/15 "...assessed left trochanter...at this time skin is intact and no sore noted." -On 6/29/15 "...on 6/19/15 met with [client A] to discuss his appointment at wound care center...has a reddened area but it is not opened at this time...repositioned every hour in the chair and every 2 hours in bed...will purchase new cushion for his wheelchair...." -On 6/11/15 client A "was taken by staff to Urgent Care evening of 6/10/15 for an evaluation of a pressure ulcer. A referral was given for a wound care facility...." -No documentation was available for review from the wound care center. -No documentation regarding the sizes, shapes, and colors of client A's pressure areas were available for review. On 4/27/16 at 12:45pm, an interview was conducted with the AD (Area Director). The AD indicated she would attempt to locate client A's wound care appointment information. The AD indicated the agency nurse was new and had just started her employment. The AD indicated the agency nurse from another			

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	area of the state with the REM/Occazio agency was trying to catch up the paperwork for client A. The AD indicated the former nurse had left the agency's employment before 2016. The AD indicated client A was at risk for skin breakdown, had a pressure ulcer open in 6/2015, and no sizes, shapes, and colors of client A's pressure ulcers were developed into a nursing protocol. The AD indicated the nurse sized, shaped, and documented the colors of client A's skin however no documentation was available for review to show that the facility staff documented the sizes, shapes, and colors of client A's skin. On 5/6/16 at 3:15pm, an interview with the AD was conducted. The AD indicated no further information was available for review. 3. The facility's reportable and investigative records from 11/1/15 through 4/25/16 were reviewed on 4/25/16 at 1:40pm, and 4/27/16 at 12:20pm. The review did not include a BDDS report regarding missing money for client E. -On 4/26/16 from 6:00am until 8:00am, observation and interview were conducted at the group home. At 7:30am, client E stated he was missing			

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	"$30.00 since before Christmas (2015)" and "they never replaced it." Client E stated "three (3) days before I was to leave on vacation my money was locked up in the safe and (I) was to get it. It (my money) was missing." Client E stated the Residential Manager at the time had the only access to his money and then "moved" his (client E's) money to her office in the group home and "locked it up there." At 7:30am, GHS #2 and GHS #4 were present and both indicated client E had reported the allegation of missing money when it was missing in 12/2015. At 7:30am, GHS #4 counted client A, B, C, D, F, and G's finances and client E's finances were kept locked inside the Residential Manager's office. On 4/27/16 at 8:30am, an interview with the Area Director (AD) was conducted. The AD indicated she was unaware of an allegation of missing finances for client E and no BDDS report and investigation were available for review. The AD indicated client E's allegation should have been immediately reported and investigated. On 5/6/16 at 9:15am, the AD provided an additional BDDS report for review. -A 4/27/16 BDDS report for an incident on 4/26/16 at 8:30am, indicated client E "spoke with State Surveyor, [client E]			

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	indicated that the money was missing before he went home with his family at Christmas. An exact date or amount of money missing was not provided. When the Program Director (aka Residential Manager) spoke with [client E] on 4/26/16, [client E] indicated that he couldn't remember how much money was missing...." -A 5/2/16 "Summary of Internal Investigation" indicated the 4/2616 BDDS report information. The investigation indicated "While completing the investigation involving [client E], [GHS (Group Home Staff) #2] also reported an additional concern of money missing for [client B]. Amount that was alleged to be missing was unknown. Date the money became missing was also unknown." The investigation indicated the following: -Interview with GHS #5 was conducted. GHS #5 stated clients E and H "were the two guys who reported concerns with their money to her. Stated she thought [client E] said it was $30.00 and she thought [client H] was missing a couple of dollars. Stated she did not report the missing money to anyone. When asked why she did not report the missing money, [GHS #5] stated [client E] had said he reported the missing money to [the PD aka Residential Manager]."			

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	-Interview with client E was conducted. Client E "stated his missing $30.00 hasn't been replaced yet...Stated the money was missing in December....Stated he was looking for the money before he left for his parents and he couldn't find it...Stated [GHS #1, GHS #2, GHS #3, GHS #4, GHS #5, and the QIDP (Qualified Intellectual Disabilities Professional)] and some of the residents were all aware that his money was missing...Stated [the QIDP] told [client E] he (the QIDP) must have forgotten about it...Stated he was upset over the missing money but believed it would eventually be replaced." -Interview with GHS #6 was conducted. GHS #6 stated she "was aware [client E] had concerns with missing money around Christmas time. Stated she thought it was around $30.00...Stated [client E] had not made a big deal about his missing money since Christmas." -Interview with GHS #3 was conducted. GHS #3 stated "the only time she was aware of money concerns is when [client E] lost his $30.00...Stated she can't remember if [client E] told her specifically he had #30.00 missing or if he told another staff and she heard about it...Stated she reported the missing money to the PC [aka Residential Manager] at the time, believed [former Residential Manager] was the PC at the time. Stated			

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	she (GHS #3) reported it to the [name of QIDP]...." -"Conclusion" of the investigation indicated "Evidence supports [client E's] finances do not reflect pawning items for $30.00. Evidence supports a receipt from [name of pawn shop] that [client E] pawned his TV and DVD player for a combined $40.00...Evidence does support that [client E, GHS #4, and GHS #7] reported the missing money of [client E] to [name of QIDP]. Evidence does support that [GHS #3] reported the missing money of [client E] to [name of the Residential Manager]. Evidence supports [name of RM and QIDP] deny knowing about missing money...Evidence does not indicate what happened to the missing money..." and evidence does support that the missing money from the pawned items was "last seen on 12/11/15." The investigation indicated it was unsubstantiated that clients B and H had missing money because the information was not specific to the amounts, dates, and tracking system. 4. The facility's reportable and investigative records from 11/1/15 through 4/25/16 were reviewed on 4/25/16 at 1:40pm, 4/27/16 at 12:20pm, and on 5/6/16 at 9:15am. The review included the following BDDS report: -A 5/2/16 BDDS (Bureau of			

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	Developmental Disabilities Services) report for an incident on 5/2/16 at 6:00pm indicated "While completing an investigation interview with a staff regarding another client at the [name of group home] and a missing money allegation, staff informed this Area Director that he believed that [client B] also had missing money. The amount of the money was not reported by staff as he was uncertain how much was reported missing. The date of the missing money was also unknown, however the other allegation" was reported for 12/14/15 through 12/21/15 and based on staff interview "it is possible that [client B's] missing money allegation occurred around the same time period." On 4/27/16 at 12:45pm, an interview with the Area Director (AD) was conducted. The AD indicated the allegations of missing money for clients B, E, and H were not immediately reported and should have been. The AD indicated client B's guardian allegation was immediately reported but the items approved for the purchase (shoes and jeans) were not completed by the RM who was in charge of the group home during that period of time. The AD indicated the group home had had at least four (4) different Residential Managers and two (2) different QIDPs within the			

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	past year. The AD indicated the changes in leadership staff at the group home and staff turnover had made it difficult to determine what had occurred. On 5/6/16 at 3:15pm, the AD indicated no further information was available for review. 5. The facility's reportable and investigative records from 11/1/15 through 4/25/16 were reviewed on 4/25/16 at 1:40pm, and 4/27/16 at 12:20pm. The review did not include a BDDS report regarding an automobile accident and damage to the facility vehicle. On 4/25/16 from 2:55pm until 5:15pm and on 4/26/16 from 6:00am until 8:00am, clients B, C, D, E, F, and G were observed at the group home. On 4/25/16 at 3:00pm, clients B, C, D, E, F, and G arrived to the group home on the facility van. On 4/26/16 at 7:55am, clients B, C, D, E, F, and G were leaving on the facility van with facility staff. On 4/26/16 at 7:00am, GHS (Group Home Staff) #4 with clients B, C, E, and F walked in and out of the group home. At 7:00am, GHS #4 indicated the facility van had damage to the left side drivers side fender and stated the fender was held in place with "automotive tape" securing			

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	15G353	A. BUILDING 00 B. WING	05/06/2016

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	the "damaged fender" until the insurance approves the repairs to the vehicle. GHS #4 indicated a different staff person had wrecked the van on the ice "over a month ago." Clients B, C, E, and F indicated they were on the van when the accident occurred. GHS #4 stated she "thought all the clients" (clients A, B, C, D, E, F, and G) were on the van at the time of the accident. On 4/27/16 at 12:20pm, an interview was conducted with the AD (Area Director). The AD indicated a BDDS report was not filed because there were no injuries to the clients. This federal tag relates to complaints #IN00195813 and #IN00198671. 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, interview, and record review, for 1 of 7 clients living in the group home (client G), the facility	W 0249	**W 249 Program Implementation** As soon as the interdisciplinary team has formulated a client's individual program plan, each client must	06/05/2016

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	failed to ensure client G's BSP (Behavior Support Plan) was implemented to secure locked sharps when not in direct staff supervision for client G. Findings include: Observations and interviews were conducted at the group home on 4/25/16 from 2:55pm until 5:15pm and on 4/26/16 from 6:00am until 8:00am. During both the observation periods client G retrieved items from the kitchen cabinets and drawers without GHS (Group Home Staff) #1, #2, #3, #4, #5, and the Residential Manager (RM) being present. On 4/25/16 at 3:00pm, inside the kitchen drawer between the stove and the sink were three (3) metal probe thermometers with pointed ends, two (2) metal can openers with pointed edges, and one (1) potato peeler with two metal razor edges were observed with GHS #2. During both observation periods the unsecured metal sharps were kept inside the drawer. On 4/26/16 at 6:am, GHS #3 indicated sharp objects were kept locked inside the medication room. GHS #3 indicated the 3 metal probes, 2 metal can openers, and 1 metal potato peeler remained in the unsecured kitchen drawer. GHS #3 showed the locked box inside the		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. **1. What corrective action will be accomplished?** · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o Behavior plan and restricted items such as sharps being locked for Client G · The Behavior Clinician will complete monthly observations or more frequent based on the client's behavioral support needs to ensure staff is implementing the behavior plan appropriately and that the plan is still effective. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice.	

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	medication room containing knives, screw drivers, scissors, and blades. GHS #3 indicated the group home was to have kept sharp objects secured because of client G's behaviors and threats with knives. On 4/26/16 at 7:30am, GHS #1 indicated sharps were kept locked inside the medication room because of client behaviors. Client G's record was reviewed on 4/28/16 at 10:00am. Client G's 12/4/15 ISP (Individual Support Plan) indicated client G "has indicated on numerous occasions that he can make a weapon to harm himself with just about any materials provided to him. Most of his threats to cut himself though center around him using knives or pop cans. This has forced staff to lock all of the sharps and pop cans within the home." Client G's ISP indicated client G "can be very intimidating toward others" and included threats with a gun and/or weapon. Client G's 11/21/15 BSP (Behavior Support Plan) indicated the need for locked sharps inside the group home and targeted behaviors of physical aggression, verbal aggression, self injurious behavior, and intimidation. On 4/27/16 at 12:45pm, an interview		· The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o Behavior plan and restricted items such as sharps being locked for Client G. · The Behavior Clinician will complete monthly observations or more frequent based on the client's behavioral support needs to ensure staff is implementing the behavior plan appropriately and that the plan is still effective. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met.	

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	with the Area Director (AD) was conducted. The AD stated facility staff should have ensured that "all" sharps were kept secured and locked when not directly supervised by the facility staff. The AD indicated the unsecured sharps should not have been left unsecured in the kitchen drawers/cabinets. The AD indicated client G had the identified need for locked sharps to ensure their safety. On 5/6/16 at 3:15pm, the AD indicated no further information was available for review. 9-3-4(a)		· The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o Behavior plan and restricted items such as sharps being locked for Client G. · The Behavior Clinician will complete monthly observations or more frequent based on the client's behavioral support needs to ensure staff is implementing the behavior plan appropriately and that the plan is still effective. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · . **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Director will monitor to ensure the clients plans and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · The Behavior Clinician will complete monthly observations or more frequent based on the client's	

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			behavioral support needs to ensure staff is implementing the behavior plan appropriately and that the plan is still effective. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's diets, risk plans, ISP's, BSP's, programming, and medication review. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. The notes from this meeting will be shared with the Area Director and/or Quality Assurance for their review. · Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document medical needs, how to report incidents, and understanding	

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			of BSP's. **5. What is the date by which the systemic changes will be completed?** June 5th, 2016	
W 0318 Bldg. 00	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C, and D) and 4 additional clients (clients E, F, G, and H), the facility failed to meet the Condition of Participation: Health Care Services. The facility failed to ensure nursing services met the health care needs of clients A, B, C, D, E, F, G, and H. The facility failed to ensure nursing services assessed and monitored clients A and H's attendance to medical appointments, client A's pressure ulcer area, client D's development of a pain protocol plan, clients A and D's laboratory testing, tuberculin skin testing, medication administration errors, and medication and medication key security. Findings include: Please refer to W331. The facility's nursing staff failed to ensure oversight of staff to ensure clients A and H's medical	W 0318	**W 318 Health Care Services** **The facility must ensure that specific health care services requirements are met.** **1. What corrective action will be accomplished?** · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms)- training completed by the nurse to ensure compliance. o Reporting skin/wound concerns to the Program Coordinator. o Client D's risk plan for reporting pain. This training will be completed	06/05/2016

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	appointments were completed. The facility's nursing staff failed to ensure the development of a protocol for client's A open skin pressure wound and to ensure the pressure area was staged, measured, and the appearance documented by the facility staff and the agency nurse. The facility's nursing staff failed to ensure the development of a pain protocol for client D's pain. The facility's nursing staff failed to ensure clients A and D's PSA (Prostate-Specific Antigen to determine protein produced by the cells of the prostate gland) tests were completed for 2 of 3 sampled clients (clients A and D). Please refer to W327. The facility failed to complete clients A, B, and C's Mantoux (tuberculin skin test) and/or screening in millimeters (mm) for 3 of 4 sampled clients (clients A, B, and C). Please refer to W368. The facility failed to ensure clients A, B, C, D, E, F, G, and H's medications were administered according to physician's orders for 7 of 7 clients (clients A, B, C, D, E, F, and G) and 1 additional client (client H). Please refer to W382. The facility failed to ensure client A, B, C, D, E, F, and G's medications were kept secured when not being administered for 4 of 4 clients (clients A, B, C, and D) and 3 additional		by the nurse to ensure understanding. o Administering PRN medications and documenting follow up o Med administration expectations o Notifying the Program Coordinator when medications are getting low or are no longer available in the home o Expectations for securing medication (med cabinet and keys) · The Program Coordinator and Program Director/QIDP will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. This training will be completed by the nurse. · The Program Director/QIDP will be retrained on how to approve the MAR's and the expectations for configuring the MAR's. This training will be completed by the nurse. · The nurse will monitor the MAR approve for the next three months to ensure accuracy. · The nurse will review the monthly physician orders generated from the pharmacy to ensure accuracy. These will be compared to the MAR's in Mentor's electronic system. · The nurse will communicate any discrepancies and submit rewrites to the pharmacy. · The Program Director/QIDP, Program Coordinator and Nurse will be trained on how to complete med cabinet checks. This training will be completed by Mentor's nurse.	

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	clients (clients E, F, and G). Please refer to W383. The facility failed to secure the medication cart keys for 4 of 4 sampled clients (A, B, C, and D) and 3 additional clients (clients E, F, and G) who resided in the home. This federal tag relates to complaints #IN00195813 and #IN00198671. 9-3-6(a)		· Med cabinet checks will be completed by the Program Coordinator weekly. Results of the checks will be forwarded to the nurse to ensure that the needs for the residents are being addressed. · A med cabinet audit will be completed to ensure that the med labels match the MAR and that all medication per physician orders are available in the home. This was completed by the nurse on 6-2-16. · Staff who are responsible for a medication error will be suspended from passing meds until a med practicum can be completed. In addition they will received a written warning for their first error. Staff responsible for a second medication error will be suspended from passing meds, receive a final warning, attend Core A/B again and then must successfully complete a med practicum. Staff responsible for a third medication error will be terminated from employment. · Clients A and H have been discharged from IN Mentor services. · The Program Coordinator and Program Director/QIDP will be trained on reporting wound concerns to the nurse. This training will be completed by the nurse. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. This training was completed by Michelle Hayes, RN with IN Mentor on 5-16-16. · The nurse will review the skin wound documentation submitted by	

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			the staff on a weekly basis to ensure accuracy. Any observation of skin integrity concerns will be communicated to the nurse per the client skin/wound protocol. · A risk plan/protocol for reporting pain for Client D will be implemented. The nurse has written this protocol. · Client D will complete a PSA screening. · Client B and C will have TB tests administered. · The medication keys will be kept on staff during their shift instead of hanging on the wall. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director and Program Coordinator will be retrained on the IDT process. · The Program Coordinator and Program Director/QIDP will be retrained on the expectations for the medical charts and communicating the physician recommendations to the team. The nurse completed this training on 6-2-16. · The medical charts for the site will be reviewed by the nurse and/or Area Director. This was completed on 6-3-16. · A med chart audit will be completed to identify any missing doctor appointments or physician recommendations that need to be followed up on. This was completed by the nurse and/or Area Director on 6-3-16. · The IDT will complete	

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			monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Program Coordinator/QIDP/nurse oversight of the MAR's, intake/elimination and skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. This training will be completed by the Mentor nurse. · In the event that a client develops a pressure sore, the nurse will monitor and/or assess the client on at least a weekly basis until the sore has resolved. **2.** How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the same deficient practice. · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do	

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			home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms)- training completed by the nurse to ensure compliance. o Reporting skin/wound concerns to the Program Coordinator. o Client D's risk plan for reporting pain. This training will be completed by the nurse to ensure understanding. o Administering PRN medications and documenting follow up o Med administration expectations o Notifying the Program Coordinator when medications are getting low or are no longer available in the home o Expectations for securing medication (med cabinet and keys) · The Program Coordinator and Program Director/QIDP will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. This training will be completed by the nurse. · The Program Director/QIDP will be retrained on how to approve the MAR's and the expectations for configuring the MAR's. This training will be completed by the nurse.	

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			· The nurse will monitor the MAR approve for the next three months to ensure accuracy. · The nurse will review the monthly physician orders generated from the pharmacy to ensure accuracy. These will be compared to the MAR's in Mentor's electronic system. · The nurse will communicate any discrepancies and submit rewrites to the pharmacy. · The Program Director/QIDP, Program Coordinator and Nurse will be trained on how to complete med cabinet checks. This training will be completed by Mentor's nurse. · Med cabinet checks will be completed by the Program Coordinator weekly. Results of the checks will be forwarded to the nurse to ensure that the needs for the residents are being addressed. · A med cabinet audit will be completed to ensure that the med labels match the MAR and that all medication per physician orders are available in the home. This was completed by the nurse on 6-2-16. · Staff who are responsible for a medication error will be suspended from passing meds until a med practicum can be completed. In addition they will received a written warning for their first error. Staff responsible for a second medication error will be suspended from passing meds, receive a final warning, attend Core A/B again and then must successfully complete a med practicum. Staff responsible for a	

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			third medication error will be terminated from employment. · The Program Coordinator and Program Director/QIDP will be trained on reporting wound concerns to the nurse. This training will be completed by the nurse. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. This training was completed by Michelle Hayes, RN with IN Mentor on 5-16-16. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. Any observation of skin integrity concerns will be communicated to the nurse per the client skin/wound protocol. · The medication keys will be kept on staff during their shift instead of hanging on the wall. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Director and Program Coordinator will be retrained on the IDT process. · The Program Coordinator and Program Director/QIDP will be retrained on the expectations for the medical charts and communicating the physician recommendations to the team. The nurse completed this training on 6-2-16. · The medical charts for the site will be reviewed by the nurse and/or Area Director. This was completed on 6-3-16. · A med chart audit will be	

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	15G353	A. BUILDING 00 B. WING	05/06/2016

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			completed to identify any missing doctor appointments or physician recommendations that need to be followed up on. This was completed by the nurse and/or Area Director on 6-3-16. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Program Coordinator/QIDP/nurse oversight of the MAR's, intake/elimination and skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. This training will be completed by the Mentor nurse. · In the event that a client develops a pressure sore, the nurse will monitor and/or assess the client on at least a weekly basis until the sore has resolved. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · All resident risk plans will be reviewed by the nurse. Revisions will	

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			be implemented as necessary. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. **3.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms)- training completed by the nurse to ensure compliance. o Reporting skin/wound concerns to the Program Coordinator. o Client D's risk plan for reporting pain. This training will be completed by the nurse to ensure understanding. o Administering PRN medications and documenting follow up o Med administration expectations o Notifying the Program Coordinator when medications are getting low or are no longer available in the home	

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			o Expectations for securing medication (med cabinet and keys) · The Program Coordinator and Program Director/QIDP will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. This training will be completed by the nurse. · The Program Director/QIDP will be retrained on how to approve the MAR's and the expectations for configuring the MAR's. This training will be completed by the nurse. · The nurse will monitor the MAR approve for the next three months to ensure accuracy. · The nurse will review the monthly physician orders generated from the pharmacy to ensure accuracy. These will be compared to the MAR's in Mentor's electronic system. · The nurse will communicate any discrepancies and submit rewrites to the pharmacy. · The Program Director/QIDP, Program Coordinator and Nurse will be trained on how to complete med cabinet checks. This training will be completed by Mentor's nurse. · Med cabinet checks will be completed by the Program Coordinator weekly. Results of the checks will be forwarded to the nurse to ensure that the needs for the residents are being addressed. · A med cabinet audit will be completed to ensure that the med	

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			labels match the MAR and that all medication per physician orders are available in the home. This was completed by the nurse on 6-2-16. · Staff who are responsible for a medication error will be suspended from passing meds until a med practicum can be completed. In addition they will received a written warning for their first error. Staff responsible for a second medication error will be suspended from passing meds, receive a final warning, attend Core A/B again and then must successfully complete a med practicum. Staff responsible for a third medication error will be terminated from employment. · The Program Coordinator and Program Director/QIDP will be trained on reporting wound concerns to the nurse. This training will be completed by the nurse. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. This training was completed by Michelle Hayes, RN with IN Mentor on 5-16-16. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. Any observation of skin integrity concerns will be communicated to the nurse per the client skin/wound protocol. · The medication keys will be kept on staff during their shift instead of hanging on the wall. · The Program Director will be retrained on the role and expectations	

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			of the QIDP. · The Program Director and Program Coordinator will be retrained on the IDT process. · The Program Coordinator and Program Director/QIDP will be retrained on the expectations for the medical charts and communicating the physician recommendations to the team. The nurse completed this training on 6-2-16. · The medical charts for the site will be reviewed by the nurse and/or Area Director. This was completed on 6-3-16. · A med chart audit will be completed to identify any missing doctor appointments or physician recommendations that need to be followed up on. This was completed by the nurse and/or Area Director on 6-3-16. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Program Coordinator/QIDP/nurse oversight of the MAR's, intake/elimination and skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately. · The nurse will be trained on how to follow up with physician recommendations to ensure they are	

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			implemented and/or addressed by the IDT. This training will be completed by the Mentor nurse. · In the event that a client develops a pressure sore, the nurse will monitor and/or assess the client on at least a weekly basis until the sore has resolved. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. **4.** How will the corrective action be monitored to ensure the deficient practice will not recur? · The Program Director/QIDP will monitor to ensure the clients plans and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · Mentor's nurse will be in the home on a weekly basis or more frequently as needed to monitor for concerns and assess residents.	
W 0327 Bldg. 00	483.460(a)(3)(iv) PHYSICIAN SERVICES The facility must provide or obtain annual			

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	physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Based on interview and record review, for 3 of 4 sampled clients (clients A, B, and C), the facility failed to complete clients A, B, and C's Mantoux (tuberculin skin test) and/or screening in millimeters (mm). Findings include: Client A's record was reviewed on 4/27/16 at 12:55pm. Client A's record indicated he was admitted to the facility on 3/30/1999. Client A's 2/12/16, 12/10/15, 11/13/15, 8/7/15, 6/19/15, and 4/21/15 physician's visits did not include a Mantoux skin test which was read as millimeters. Client B's record was reviewed on 4/27/16 at 12:45pm, and on 4/28/16 at 9:10am. Client B's 11/4/15, 10/14/15, 7/21/15, and 4/21/15 physician's visits did not include a Mantoux skin test which was read as millimeters. Client C's record was reviewed on 4/27/16 at 1:00pm and on 4/28/16 at 8:40am. Client C's 2/12/16, 11/3/15,	W 0327	**W 327 Physician Services** The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. **1. What corrective action will be accomplished?** · The Program Coordinator and Program Director will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. · Client B and C will have TB tests administered. · The medical charts for the site will be reviewed by the nurse. · A med chart audit will be completed to identify any missing doctor appointments or physician recommendations that need to be followed up on. **2. How will we identify other**	06/05/2016

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	8/7/15, and 4/21/15 physician's visits did not include a Mantoux skin test which was read as millimeters. On 4/27/16 at 12:45pm, an interview with the Area Director (AD) was conducted. The AD indicated clients living in the group home should receive a yearly Mantoux/Tuberculin skin test and/or a tuberculosis screening read in millimeters. The AD indicated clients A, B, and C's Mantoux skin tests were not available for review. On 5/6/16 at 3:15pm, the AD indicated no further information was available for review. 9-3-6(a)		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The Program Coordinator and Program Director will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. · The medical charts for the site will be reviewed by the nurse. · A med chart audit will be completed to identify any missing doctor appointments or physician recommendations that need to be followed up on. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · TB tests will be obtained for all clients who are past due. · TB tests will be obtained yearly for all clients. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The Program Coordinator and	

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			Program Director will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. · The medical charts for the site will be reviewed by the nurse. · A med chart audit will be completed to identify any missing doctor appointments or physician recommendations that need to be followed up on. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · TB tests will be obtained for all clients who are past due. · TB tests will be obtained yearly for all clients. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. Copies of the staffings will be forwarded to all team members including the Area Director and/or Quality Assurance	

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			for review. · The Program Coordinator will turn in appointment tracking sheets to the nurse biweekly for review. · The Program Coordinator will submit scan in all physician notes into Therap (electronic documentation system) for the team to be able to review. The original notes will be forwarded to the nurse to be filed in the client medical chart. **5. What is the date by which the systemic changes will be completed?** June 5th, 2016	
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 3 of 8 clients (clients A, D, and H), the facility's nursing staff failed to ensure oversight of staff to ensure clients A and H's medical appointments were completed. The facility's nursing staff failed to ensure the development of a protocol for client A's open pressure wound and to ensure the pressure area was staged, measured, and the appearance documented by the facility staff and the agency nurse.	W 0331	**W 331 Nursing Services** The facility must provide clients with nursing services in accordance with their needs. **1. What corrective action will be accomplished?** · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns to the Program Coordinator. o Client D's risk plan for reporting pain.	06/05/2016

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	The facility's nursing staff failed to ensure the development of a pain protocol for client D's pain. The facility's nursing staff failed to ensure clients A and D's PSA (Prostate-Specific Antigen to determine protein produced by the cells of the prostate gland) tests were completed. Findings include: 1. The facility's reportable and investigative records from 11/1/15 through 4/25/16 were reviewed on 4/25/16 at 1:40pm, 4/27/16 at 12:20pm, and on 5/6/16 at 9:15am. The review did not indicate the facility staff and nursing staff's failure to ensure clients A and H attended their scheduled medical appointments. Client A's record was reviewed on 4/27/16 at 12:55pm. Client A's 1/29/16 ISP (Individual Support Plan) and 2016 Risk Plan indicated client A was at risk for skin integrity problems because of his decreased mobility. Client A's ISP, 11/4/15 Physician's Order, and 4/2016 MAR (Medication Administration Record) indicated client A's diagnoses included, but were not limited to: Cerebral Palsy, Seborrhea Dermatitis, Scoliosis, History of GI Bleed, Iron		· The Program Coordinator and Program Director will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. · Clients A and H have been discharged from IN Mentor services. · The Program Coordinator and Program Director will be trained on reporting wound concerns to the nurse. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. · A risk plan/protocol for reporting pain for Client D will be implemented. · Client D will complete a PSA screening. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts and communicating the physician recommendations to the team. · The medical charts for the site will be reviewed by the nurse. · A med chart audit will be completed to identify any missing doctor appointments or physician	

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	Deficiency Anemia, Edema, Depression, and Constipation. Client A's records indicated "Adaptive Equipment: Electric and manual Wheel Chairs, soft torso back brace, Vascular knee small/regular ted hose, wrist splint, depends undergarments, Baclofen Pump...rolling toilet seat, and gel cushion for wheel chair." Client A's record did not include dates and times of his scheduled physician's appointments. On 4/26/16 at 8:30am, an interview with the Area Director (AD) was conducted. The AD indicated client A had been hospitalized on 4/18/16 for his dehydration and Baclofen Pump. The AD indicated the agency nurse indicated she checked client A on 4/18/16 and heard bowel sounds before client A left for the hospital. The AD indicated after client A was admitted to the hospital it was a few days later that the diagnosis of impacted bowels was added. The AD indicated the group home had experienced a change of Residential Managers four or five times within the past 6 to 8 month period of time. The AD indicated clients A and H did miss their scheduled appointments and the current Residential Manager (RM) was attempting to recreate who had appointments and when the appointments were scheduled with the current physician's and specialist's doctor's		recommendations that need to be followed up on. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Program Coordinator/QIDP/nurse oversight of the skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and addressed appropriately. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · In the event that a client develops a pressure sore, the nurse will monitor and/or assess the client on at least a weekly basis until the sore has resolved. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the	

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	offices. The AD indicated appointments have been missed and assessments for follow up appointments have been late because the facility staff and previous RM's did not document client specific schedules for appointments. The AD stated the nurse "usually provided oversight however during the same time" two different nurses were hired to supervise the group home and one additional nurse with the agency from another area of the state was attempting to oversee the group home when the assigned nurse had left in order to coordinate the nursing care and services for the clients. Confidential Interview (CI) #2 was conducted. CI #2 stated client A "missed" his physician's appointments and the advocates/guardians were not contacted. CI #2 stated client A "had a Baclofen Pump" to help with his spinal cord fluid, treatment of his spasticity, and Cerebral Palsy. CI #2 stated "how does that run out and no body notices?" CI #2 stated client A was out of his medication "over 8 weeks." Then since the pump was out when the group home noticed in 2/2016 the physician decided to evaluate a replacement. CI #2 stated client A was given oral Baclofen, after appointments were missed and/or rescheduled, and "we think" it contributed to his vomiting and		wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns to the Program Coordinator. o Client D's risk plan for reporting pain. · The Program Coordinator and Program Director will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator and Program Director will be trained on reporting wound concerns to the nurse. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Coordinator and Program Director will be retrained on the expectations for the medical charts and communicating the physician recommendations to the team. · The medical charts for the site will be reviewed by the nurse. · A med chart audit will be completed to identify any missing doctor appointments or physician recommendations that need to be	

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	stomach problems he was hospitalized with now. CI #2 indicated client A had been in the hospital since 4/18/16 for his vomiting and dehydration. Client H's record was reviewed on 4/27/16 at 12:30pm. Client H's 9/4/15 ISP and 11/23/15 Physician's Order included, but were not limited to the following diagnoses: Chronic Joint Pain, Congestive Heart Failure, Hearing Disability, Severe Rheumatoid Arthritis, and Hypertension. Client H's record did not include his scheduled medical appointments. Confidential Interview (CI) #1 was conducted. CI #1 stated "it was very difficult to get and give medical information to a staff for [client H]. Call backs after a message was left did not exist." CI #1 indicated client H missed the following physician appointments: -A follow up medical appointment on 3/14/16 was rescheduled. -A 2/24/16 medical appointment, CI #1 stated he was a "no show" for the appointment. -A follow up medical appointment on 1/28/16 was rescheduled. -A 12/7/15 Ears, Nose, and Throat medical appointment client H was a "no show." -A medical appointment on 11/20/15 was		followed up on. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Program Coordinator/QIDP/nurse oversight of the skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and addressed appropriately. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · In the event that a client develops a pressure sore, the nurse will monitor and/or assess the client on at least a weekly basis until the sore has resolved. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize. · All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. **3. What measures will be put**	

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	15G353	A. BUILDING 00 B. WING	05/06/2016

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	rescheduled "because of staffing issues." -A 11/4/15 medical appointment was rescheduled. -A 10/16/15 new patient appointment was kept "however 25 minutes late" with staff to the appointment. -A medical appointment on 9/15/15 was rescheduled "was told transportation issues." 2. The facility's reportable and investigative records from 11/1/15 through 4/25/16 were reviewed on 4/25/16 at 1:40pm, 4/27/16 at 12:20pm, and on 5/6/16 at 9:15am. The review did not indicate client A had open pressure ulcer areas. Client A's record was reviewed on 4/27/16 at 12:55pm. Client A's 1/29/16 ISP (Individual Support Plan) and 2016 Risk Plan indicated client A was at risk for skin integrity problems because of his decreased mobility. Client A's 5/26/15 "Skin Integrity Risk Plan" indicated "the key to keeping the skin intact is keeping it dry and pressure free...repositioning every hour...documenting in therap (a facility computerized record for staff to document each client's information)...." Client A's diagnoses included, but were not limited to: Cerebral Palsy, Scoliosis, and Edema. Client A's 2/12/16 and 4/2016 MAR both indicated client A had		**into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Training completed with the staff regarding: o How to document skin/wound findings including competency based training (documentation of the wound, when to notify the nurse, descriptive terms) o Reporting skin/wound concerns to the Program Coordinator. o Client D's risk plan for reporting pain. · The Program Coordinator and Program Director will be retrained on the appointment process expectations, yearly appointment expectations, following physician recommendations and communication expectations with the nurse. · The Program Coordinator and Program Director will be trained on reporting wound concerns to the nurse. · The nurse will be trained on how to stage skin sores, measure and to document their appearance in their nursing notes. · The nurse will review the skin wound documentation submitted by the staff on a weekly basis to ensure accuracy. · The Program Director will be retrained on the role and expectations of the QIDP. · The Program Coordinator and Program Director will be retrained on the expectations for the medical	

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	problems related to his limited mobility. Client A's record indicated he was seen by the wound clinic in 6/2015, on 6/19/15, and 6/10/15 for a pressure area on his buttock. Client A's record indicated he was checked monthly by the agency nurse regarding his skin and indicated the following signed by the agency nurse: -On 1/15/16 Skin Check "I checked his left hip which has a tendency to be reddened. It is red but not open." -On 11/9/15 Skin Check "due to a fall this morning that he went to the ER for. He has a cut above his right eyebrow 2cm (centimeters) x .5cm with some swelling, he also has a 10cm x 1cm abrasion on his abdomen...checked his left trochanter area (buttocks) I did not note any open area but there is a slightly red shiny 1.5cm x 1.5cm area there with a darker color area below it but all skin is intact at this time." -On 11/4/15 "...assessed left trochanter...at this time skin is intact and no sore noted." -On 6/29/15 "...on 6/19/15 met with [client A] to discuss his appointment at wound care center...has a reddened area but it is not opened at this time...repositioned every hour in the chair and every 2 hours in bed...will purchase new cushion for his wheelchair...." -On 6/11/15 client A "was taken by staff		charts and communicating the physician recommendations to the team. · The medical charts for the site will be reviewed by the nurse. · A med chart audit will be completed to identify any missing doctor appointments or physician recommendations that need to be followed up on. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. · Program Coordinator/QIDP/nurse oversight of the skin/wound documentation (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and addressed appropriately. · The nurse will be trained on how to follow up with physician recommendations to ensure they are implemented and/or addressed by the IDT. · In the event that a client develops a pressure sore, the nurse will monitor and/or assess the client on at least a weekly basis until the sore has resolved. · The IDT will continue to monitor the needs of all of the clients. The IDT will convene to address and monitor the health care needs of the residents until they improve and/or stabilize.	

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	to Urgent Care evening of 6/10/15 for an evaluation of a pressure ulcer. A referral was given for a wound care facility...." -No documentation was available for review from the wound care center. -No documentation regarding the sizes, shapes, and colors of client A's pressure areas were available for review. On 4/27/16 at 12:45pm, an interview was conducted with the AD (Area Director). The AD indicated she would attempt to locate client A's wound care appointment information. The AD indicated the agency nurse was new and had just started her employment. The AD indicated the agency nurse from another area of the state with the REM/Occazio agency was trying to catch up the paperwork for client A. The AD indicated the former nurse had left the agency's employment before 2016. The AD indicated client A was at risk for skin breakdown, had a pressure ulcer open in 6/2015, and no sizes, shapes, and colors of client A's were developed into a nursing protocol. The AD indicated the nurse sized, shaped, and documented the colors of client A's skin however no documentation was available for review to show that the facility staff documented the sizes, shapes, and colors of client A's skin.		· All resident risk plans will be reviewed by the nurse. Revisions will be implemented as necessary. · The nurse will monitor staff documentation at a minimum of weekly and communicate with the necessary team members as needed. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Director will monitor to ensure the clients plans and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · Mentor's nurse will be in the home on a weekly basis or more frequently as needed to monitor for concerns and assess residents. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: risk plans, ISP's, BSP's, restrictions in place, programming, and medication review. · The IDT will complete monthly staffings to ensure that the team discusses the needs of the residents in the following areas: home, behavior, IDT's needed, family involvement, medical, workshop/day services, financial and adaptive equipment. Copies of the staffings will be forwarded to all team members including the Area	

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	On 5/6/16 at 3:15pm, an interview with the AD was conducted. The AD indicated no further information was available for review. 3. On 4/25/16 from 2:55pm until 5:15pm and on 4/26/16 from 6:00am until 8:00am, observation and interviews were conducted at the group home. During both observation periods client D used a walker to walk throughout the group home. On 4/25/16 at 3:55pm, client D told GHS (Group Home Staff) #2 that his legs hurt and indicated that he was in pain in his legs. GHS #2 administered two (2) tablets of "Acetaminophen 325mg tid (3 times daily)" for Arthritis. Client D took the medication with water. GHS #2 did not have client D rate his pain on a pain scale and did not collect information regarding client D's pain. At 4:00pm, Client D's 4/2016 MAR (Medication Administration Record) was reviewed and indicated "Acetaminophen 325mg tid (3 times daily) for Arthritis. Take 2 tablets (or 650mg (milligrams)) by mouth every 4 hours as needed for pain." At 4:00pm, GHS #2 indicated client D did not have a pain protocol available to refer to. Client D's record was reviewed on 4/28/16 at 9:35am. Client D's 2/23/16 ISP and 2016 Risk Plans indicated "Risk		Director and/or Quality Assurance for review. · Oversight of the skin/wound documentation will be completed by the Program Coordinator, QIDP, and nurse. · Quarterly Health and Safety assessments will be completed by the Program Coordinator and/or the Program Director and forwarded to the Quality Improvement department. These assessments include a review of the environmental needs for the home, review of risk plans, ISP, BSP and client specific training for the residents. The assessment also includes an interview of staff to ensure they know how to properly document medical needs, how to report incidents, and understanding of BSP's. · The Program Coordinator will turn in appointment tracking sheets to the nurse biweekly for review. · The Program Coordinator will submit scan in all physician notes into Therap (electronic documentation system) for the team to be able to review. The original notes will be forwarded to the nurse to be filed in the client medical chart. **5. What is the date by which the systemic changes will be completed?** June 5th, 2016	

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	plan for clubfoot...5/26/15 Clubfoot describes a range of foot abnormalities usually present at birth...The tissues connecting the muscles to the bone are shorter than usual...refer to the sharp angle to the ankle, like the head of a golf club...." Client D's ISP indicated Adaptive Equipment "walker, built up shoe right foot, and leg braces." Client D's diagnoses included, but were not limited to: Kyphosis, Arthritis, Cerebral Palsy, right leg, and Spastic both lower extremities. On 4/27/16 at 12:45pm, an interview was conducted with the AD (Area Director). The AD indicated she would attempt to locate client D's pain protocol. On 5/6/16 at 3:15pm, an interview with the AD was conducted. The AD indicated no further information was available for review. 4. Client A's record was reviewed on 4/27/16 at 12:55pm. Client A's 1/29/16 ISP (Individual Support Plan) and 2016 Risk Plan indicated client A was over the age of 50 years. Client A's diagnoses included, but were not limited to: Cerebral Palsy, Scoliosis, and Edema. Client A's 4/2016 MAR and 2/2016 Physician Order both indicated a recommendation for a yearly PSA			

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	(Prostate-Specific Antigen to determine protein produced by the cells of the prostate gland) test and no PSA was available for review. Client D's record was reviewed on 4/28/16 at 9:35am. Client D's record indicated he was over the age of 50 years. Client D's diagnoses included, but were not limited to: Kyphosis, Arthritis, Cerebral Palsy, right leg, and Spastic both lower extremities. Client D's 11/4/15 Physician's Order and 4/2016 MAR both indicated a recommendation for a yearly PSA (Prostate-Specific Antigen to determine protein produced by the cells of the prostate gland) test to "begin date 8/12/1998" and no PSA was available for review. On 4/27/16 at 12:45pm, an interview was conducted with the AD (Area Director). The AD indicated she would attempt to locate clients A and D's current PSA testing. On 5/6/16 at 3:15pm, an interview with the AD was conducted. The AD indicated no further information was available for review. This federal tag relates to complaints #IN00195813 and #IN00198671.			

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	9-3-6(a)			
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 7 of 7 clients (clients A, B, C, D, E, F, and G) and 1 additional client (client H), the facility failed to ensure clients A, B, C, D, E, F, G, and H's medications were administered according to physician's orders. Findings include: The facility's reportable and investigative records from 11/1/15 through 4/25/16 were reviewed on 4/25/16 at 1:40pm, 4/27/16 at 12:20pm, and on 5/6/16 at 9:15am. The review included the following: -A 5/3/16 BDDS (Bureau of Developmental Disabilities Services) report for an incident on 5/1/16 at 8:00am indicated "MARS (Medication Administration Records) was not configured for the 1st (of the month) and staff passed meds (medications) and didn't give all the meds" for clients B, D, and E. The report did not indicate which medications were omitted by the facility	W 0368	**W 368 Drug Administration** The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. **1. What corrective action will be accomplished?** · Training completed with the staff regarding: o Med administration expectations o Notifying the Program Coordinator when medications are getting low or are no longer available in the home · The Program Director will be retrained on how to configure the MAR's and the expectations for configuring the MAR's. · The Program Director, Program Coordinator and Nurse will be trained on how to complete med cabinet checks. · Med cabinet checks will be completed by the Program Director weekly. Results of the checks will be forwarded to the nurse. · A med cabinet audit will be completed to ensure that the med labels match the MAR and that all medication per physician orders are available in the home.	06/05/2016

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	staff. -A 1/30/16 BDDS report for an incident on 1/29/16 at 10:30pm "Staff reported [client B] did not get his morning 7am medications Lisinopril for B/P (Blood Pressure), Vitamin E a nutritional supplement, Invega for behavior, and Lexapro for behavior." The report indicated the medications were "returned and given and later discovered that [client B] received them at 7am, so his dosage was doubled." The investigation indicated client B's 1/29/16 medications were not dispensed from client B's 1/29/16 medication cards "instead" client B's medications from his "2/1/16 7:00am" medication cards were administered in error. -An 11/17/15 BDDS report for an incident on 11/14/15 at 8:00pm indicated a Group Home Staff "gave [client E's] 8pm medications to one of the clients and [name of GHS] does not remember who. [Client E's] 8pm meds. are as follows: Abilify, Lipitor, and Metaformin (sic)." The report indicated staff took vitals and "watched for symptoms that night for all clients" (clients A, B, C, D, E, F, G, and H). On 4/27/16 at 12:45pm, an interview with the Area Director (AD) was		· Staff who are responsible for a medication error will be suspended from passing meds until a med practicum can be completed. In addition they will received a written warning for their first error. Staff responsible for a second medication error will be suspended from passing meds, receive a final warning, attend Core A/B again and then must successfully complete a med practicum. Staff responsible for a third medication error will be terminated from employment. · Program Coordinator/QIDP/nurse oversight of the MAR's (daily basis Program Coordinator) and when in the home (QIDP and nurse) to ensure it is completed and holes are addressed appropriately. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · Training completed with the staff regarding: o Med administration expectations o Notifying the Program Coordinator when medications are getting low or are no longer available in the home · The Program Director will be retrained on how to configure the MAR's and the expectations for configuring the MAR's.	

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	conducted. The AD indicated staff should ensure client A, B, C, D, E, F, G, and H's physician's orders were followed. The AD indicated the facility followed the Core A/Core B training for medication administration and the facility's policy and procedure for medication administration. On 4/27/16 at 12:45pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be administered according to physician's orders. On 5/6/16 at 3:15pm, the AD indicated no further information was available for review. 9-3-6(a)		· The Program Director, Program Coordinator and Nurse will be trained on how to complete med cabinet checks. · Med cabinet checks will be completed by the Program Director weekly. Results of the checks will be forwarded to the nurse. · A med cabinet audit will be completed to ensure that the med labels match the MAR and that all medication per physician orders are available in the home. · Staff who are responsible for a medication error will be suspended from passing meds until a med practicum can be completed. In addition they will received a written warning for their first error. Staff responsible for a second medication error will be suspended from passing meds, receive a final warning, attend Core A/B again and then must successfully complete a med practicum. Staff responsible for a third medication error will be terminated from employment. · Medication practicums will be completed with a random staff in the home at least monthly. Results of this practicum will be forwarded to the nurse for review. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Training completed with the staff regarding: o Med administration expectations	

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			o Notifying the Program Coordinator when medications are getting low or are no longer available in the home · The Program Director will be retrained on how to configure the MAR's and the expectations for configuring the MAR's. · The Program Director, Program Coordinator and Nurse will be trained on how to complete med cabinet checks. · Med cabinet checks will be completed by the Program Director weekly. Results of the checks will be forwarded to the nurse. · A med cabinet audit will be completed to ensure that the med labels match the MAR and that all medication per physician orders are available in the home. · Staff who are responsible for a medication error will be suspended from passing meds until a med practicum can be completed. In addition they will received a written warning for their first error. Staff responsible for a second medication error will be suspended from passing meds, receive a final warning, attend Core A/B again and then must successfully complete a med practicum. Staff responsible for a third medication error will be terminated from employment. · Medication practicums will be completed with a random staff in the home at least monthly. Results of this practicum will be forwarded to the nurse for review.	

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			4. How will the corrective action be monitored to ensure the deficient practice will not recur? · Mentor's nurse will be in the home on a weekly basis or more frequently as needed to monitor for concerns and assess residents. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: risk plans, ISP's, BSP's, restrictions in place, programming, and medication review. · Oversight of the MARdocumentation will be completed by the Program Coordinator, QIDP, and nurse. · Medication practicums completed with the staff will be forwarded to the nurse for review. **5. What is the date by which the systemic changes will be completed?** June 5th, 2016	
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, record review, and interview, for 4 of 4 clients (clients A, B, C, and D) and 3 additional clients (clients E, F, and G), the facility failed to ensure client A, B, C, D, E, F, and G's medications were kept secured when not being administered.	W 0382	**W 382 Drug Storage and Recordkeeping** The facility must keep all drugs and biologicals locked except when being prepared for administration. **1. What corrective action will be accomplished?**	06/05/2016

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	Findings include: Observations and interviews were conducted at the group home on 4/26/16 from 6:00am until 8:00am. During the observation period clients B, C, D, E, F, and G were observed at the group home. Client A had been admitted to the local hospital. During the observation period clients B, C, D, E, F, and G were observed to walk and access rooms throughout the group home. During the observation period from 6:20am until 7:45am, the medication cabinet located inside the unsecured medication/activity room was left unlocked. On 4/26/16 at 7:45am, GHS (Group Home Staff) #1 stated the medication cabinet was unlocked when she started the medication administration at 6:20am and the cabinet was "not locked" until 7:45am. GHS #1 stated "staff do shut the door" and the medication/activity room door was not "kept" locked. On 4/27/16 at 12:45pm, an interview with the Area Director (AD) was conducted. The AD indicated the medication cabinet should be kept locked. The AD indicated clients A, B, C, D, E, F, and G's medications were kept inside the cabinet. The AD indicated the facility followed Core A/Core B Living		· The Program Coordinator will do home observations weekly to ensure staff are ensuring the medications are locked. · The Program Director will do home observations bi-weekly to ensure staff are ensuring the medications are locked. · Training completed with the staff regarding: o Expectations for securing medication (med cabinet and keys) **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The Program Coordinator will do home observations weekly to ensure staff are ensuring the medications are locked. · The Program Director will do home observations bi-weekly to ensure staff are ensuring the medications are locked. · Training completed with the staff regarding: o Expectations for securing medication (med cabinet and keys) **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The Program Coordinator will do home observations weekly to	

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	15G353	A. BUILDING 00 B. WING	05/06/2016

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	in the Community for medication administration and medication security. The AD indicated clients A, B, C, D, E, F, and G had access to the unsecured medications inside the unlocked cabinet. On 4/27/16 at 12:45pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be kept secured when not being administered. 9-3-6(a)		ensure staff are ensuring the medications are locked. · The Program Director will do home observations bi-weekly to ensure staff are ensuring the medications are locked. · Training completed with the staff regarding: o Expectations for securing medication (med cabinet and keys) **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Coordinator will do home observations weekly to ensure staff are ensuring the medications are locked. · The Program Director will do home observations bi-weekly to ensure staff are ensuring the medications are locked. · Mentor's nurse will be in the home on a weekly basis or more frequently as needed to monitor for concerns and assess residents. While in the home she will check to ensure the medications are locked. · Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review. **5. What is the date by which the systemic changes will be completed?** June 5th, 2016	
W 0383 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access			

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	to the keys to the drug storage area. Based on observation, record review, and interview, the facility failed to secure the medication cart keys for 4 of 4 sampled clients (A, B, C, and D) and 3 additional clients (clients E, F, and G) who resided in the home. Findings include: Observations and interviews were conducted at the group home on 4/25/16 from 2:55pm until 5:15pm and on 4/26/16 from 6:00am until 8:00am. During both observation periods clients B, C, D, E, F, and G were observed at the group home. Client A had been admitted at the local hospital. During both observation periods clients B, C, D, E, F, and G were observed to walk and access rooms throughout the group home. During the observation periods the medication keys for the medication cabinet were left unsecured at waist height hanging on the bulletin board inside the unsecured and open doorway to the medication/activity room. On 4/26/16 at 7:45am, GHS (Group Home Staff) #1 stated the medication cabinet keys were "always" kept hanging unsecured on the bulletin board. GHS #1 indicated the bulletin board was not secured. GHS #1 stated "staff do shut the door" and the medication/activity room	W 0383	**W 383 Drug Storage and Recordkeeping** Only authorized persons may have access to the keys to the drug storage area. **1. What corrective action will be accomplished?** · The Program Coordinator will do home observations weekly to ensure staff are ensuring the keys are secured. · The Program Director will do home observations bi-weekly to ensure staff are ensuring the keys are secured. · Training completed with the staff regarding: o Expectations for securing medication (med cabinet and keys) · The medication keys will be kept on staff during their shift instead of hanging on the wall. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The Program Coordinator will do home observations weekly to ensure staff are the keys are secured. · The Program Director will do home observations bi-weekly to ensure staff are ensuring the keys are secured. · Training completed with the	06/05/2016

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	door was not "kept" locked. On 4/27/16 at 12:45pm, an interview with the Area Director (AD) was conducted. The AD indicated medication cabinet keys for clients A, B, C, D, E, F, and G's medication cabinet should be kept secured by the facility staff. The AD indicated the facility followed Core A/Core B Living in the Community for medication administration and medication key security. The AD indicated clients A, B, C, D, E, F, and G had access to the unsecured medication cabinet keys which were left hanging on the bulletin board. On 4/27/16 at 12:45pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of Administering Medication" indicated medication cabinet keys should be kept secure. 9-3-6(a)		staff regarding: o Expectations for securing medication (med cabinet and keys) · The medication keys will be kept on staff during their shift instead of hanging on the wall. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The Program Coordinator will do home observations weekly to ensure staff are the keys are secured. · The Program Director will do home observations bi-weekly to ensure staff are ensuring the keys are secured. · Training completed with the staff regarding: o Expectations for securing medication (med cabinet and keys) · The medication keys will be kept on staff during their shift instead of hanging on the wall. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Coordinator will do home observations weekly to ensure staff are ensuring the keys are secured. · The Program Director will do home observations bi-weekly to ensure staff are ensuring the keys are secured. · Mentor's nurse will be in the home on a weekly basis or more frequently as needed to monitor for	

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			concerns and assess residents. While in the home, she will check to ensure that the keys are properly secured. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: risk plans, ISP's, BSP's, restrictions in place, programming, and medication review. · Monthly supervisory visit check sheets to be completed by the QIDP. These will be forwarded to the Area Director for review. **5. What is the date by which the systemic changes will be completed?** June 5th, 2016	
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, for 4 of 4 sampled clients (clients A, B, C, and D), the facility failed to ensure client A's wheelchair was in good repair, to ensure clients B, C, and D wore their prescribed eye glasses, and to ensure client D's walker was in good repair.	W 0436	**W 436 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.**	06/05/2016

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	Findings include: 1. On 4/25/16 from 2:55pm until 5:15pm and on 4/26/16 from 6:00am until 8:00am, observation and interviews were conducted at the group home. During both observation periods client A was not present in the group home and had been admitted at the local hospital. On 4/26/16 at 7:00am, GHS (Group Home Staff) #4 showed client A's wheelchair (w/c) stored on the larger facility bus. GHS #4 stated client A's w/c "was dirty," the two arm rest coverings were worn, the seatbelt on the w/c was not functional and was broken, and the back rest covering was worn. GHS #4 indicated client A's w/c was in need of repairs and the agency had been working on getting the repairs completed or a new w/c for client A since 2015. The facility's reportable and investigative records from 11/1/15 through 4/25/16 were reviewed on 4/25/16 at 1:40pm, 4/27/16 at 12:20pm, and on 5/6/16 at 9:15am. The review included the following for client A. -A 11/9/15 BDDS (Bureau of Developmental Disabilities Services) report for an incident on 11/9/15 at 10:00am indicated client A "was placed in his wheel chair. As staff started to buckle the safety belt. [Client A] started		**1. What corrective action will be accomplished?** · Client A has been discharged from IN Mentor's services. · Client B, C and D will have formal programming implemented for them to wear their glasses. · Client B, C and D will have formal programming implemented for them to learn how to properly store their glasses. · Client B's glasses will be found or a new pair will be obtained according to his prescription. · Client D has obtained a new walker. · The Program Coordinator will complete weekly adaptive equipment checks to ensure adaptive equipment is in good working order. These adaptive equipment checks will be forwarded to the Program Director/QIDP for review and to ensure concerns are addressed timely. · The reasons to contact the Program Coordinator and Program Director/QIDP have been updated to include reporting adaptive equipment concerns. · Staff training regarding: o Encouraging the use of adaptive equipment by the residents including wearing glasses. o Reporting concerns with adaptive equipment o Checking and cleaning adaptive equipment such as walkers and wheelchairs nightly. **2.** How will we identify other	

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	to shake as he does often. [Client A] fell to his right side out of the chair to the floor." The report indicated client A was seen at the ER (Emergency Room), and the physician "had to glue his cut closed above his right eye." The report indicated "staff will be retrained on gait belt and transferring." Client A's record was reviewed on 4/27/16 at 12:55pm. Client A's 1/29/16 ISP (Individual Support Plan) and 2016 Risk Plan indicated he used a wheelchair for his mobility. Client A's 3/3/16 wheel chair evaluation indicated a new electric wheel chair was recommended on 8/10/15. Client A's 1/22/16 IDT (Interdisciplinary Team) meeting indicated client A needed a new wheel chair. Client A's diagnoses included, but were not limited to: Cerebral Palsy, Scoliosis, and Edema. Client A's record indicated he used a wheel chair for his independent mobility. Client A's 2016 "Fall Risk" plan was reviewed 5/26/15. The Fall risk plan indicated "staff are to ensure that any adaptive devices are in good repair, broken equipment should be reported to the [Residential Manager] immediately...." On 4/27/16 at 12:45pm, an interview was conducted with the AD (Area Director). The AD indicated it was not known how		residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the same deficient practice. · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director/QIDP will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Coordinator will complete weekly adaptive equipment checks to ensure adaptive equipment is in good working order. These adaptive equipment checks will be forwarded to the Program Director/QIDP for review and to ensure concerns are addressed timely. · The reasons to contact the Program Coordinator and Program Director/QIDP have been updated to include reporting adaptive equipment concerns. · Training completed with the staff regarding: o Encouraging the use of adaptive equipment by the residents including wearing glasses. o Reporting concerns with adaptive equipment o Checking and cleaning adaptive equipment such as walkers and wheelchairs nightly.	

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	long client A's seat belt had been broken. The AD indicated the Residential Manager had attempted to order a new seat belt for the w/c and the replacement did not fit in 11/2015. The AD indicated the staff should have used a gait belt while transferring client A. The AD indicated client A was at risk for falls before the incident occurred. 2. On 4/25/16 from 2:55pm until 5:15pm and on 4/26/16 from 6:00am until 8:00am, observation and interviews were conducted at the group home. During both observation periods clients B, C, and D did not wear their prescribed eye glasses. During both observation periods clients B, C, and D completed medication administration, shaved, dressed, bathed, cooked in the kitchen, watched television, walked throughout the group home, and did not wear their eye glasses. On 4/25/16 at 4:25pm, client C showed his bedroom. Client C picked up a pile of dirty clothing from the floor, his prescribed eye glasses were underneath the clothing, and they bounced on the floor when client C shifted the dirty clothing in his arms. Client C indicated he wore prescribed eye glasses to see. On 4/26/16 at 7:45am, client B indicated he wore prescribed eye glasses to see and stated he "didn't know" how long his glasses had been "gone." Client B		**3.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director/QIDP will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Coordinator will complete weekly adaptive equipment checks to ensure adaptive equipment is in good working order. These adaptive equipment checks will be forwarded to the Program Director/QIDP for review and to ensure concerns are addressed timely. · The reasons to contact the Program Coordinator and Program Director/QIDP have been updated to include reporting adaptive equipment concerns. · Training completed with the staff regarding: o Encouraging the use of adaptive equipment by the residents including wearing glasses. o Reporting concerns with adaptive equipment o Checking and cleaning adaptive equipment such as walkers and wheelchairs nightly. **4.** How will the corrective action	

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	indicated he had not had his prescribed eye glasses for "several" months. During both observation periods clients B, C, and D were not encouraged to wear their prescribed eye glasses. Client B's record was reviewed on 4/27/16 at 12:45pm and on 4/28/16 at 9:10am. Client B's 4/26/16 ISP (Individual Support Plan) and 7/21/15 vision evaluation both indicated client B wore prescribed eye glasses to see. Client B's ISP indicated a goal/objective for him to take care of his eye glasses. Client C's record was reviewed on 4/27/16 at 1:00pm and on 4/28/16 at 8:40am. Client C's 9/11/15 ISP and 4/24/14 vision evaluation both indicated client C wore prescribed eye glasses to see. Client C's ISP indicated a goal/objective for him to wear his prescribed eye glasses. Client D's record was reviewed on 4/28/16 at 9:35am. Client D's 2/23/16 ISP and 5/16/14 vision evaluation both indicated client D wore prescribed eye glasses to see. Client D's ISP indicated a goal/objective to wear his prescribed eye glasses. On 4/27/16 at 12:45pm, an interview was conducted with the AD (Area Director).		be monitored to ensure the deficient practice will not recur? · The Program Director/QIDP will monitor to ensure the clients plans and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · Mentor's nurse will be in the home on a regular basis or more frequently as needed to monitor for concerns and assess residents. When she is in the home she will check the adaptive equipment to be sure it is in good working order. These adaptive equipment checks will be forwarded to the Program Director/QIDP for review and to ensure concerns are addressed timely. · The reasons to contact the Program Coordinator and Program Director/QIDP have been updated to include reporting adaptive equipment concerns. · New staff hired to work at the site will receive client specific training for each individual prior to working a shift. This training includes items such as: client's adaptive equipment needs, risk plans, ISP's, programming, and medication review. **5.** What is the date by which the systemic changes will be completed? June 5th, 2016	

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	The AD indicated clients B, C, and D wore prescribed eye glasses to see. The AD indicated the facility staff should have encouraged clients B, C, and D to wear their prescribed eye glasses during formal and informal opportunities. 3. On 4/25/16 from 2:55pm until 5:15pm and on 4/26/16 from 6:00am until 8:00am, observation and interviews were conducted at the group home. During both observation periods client D used a walker to walk throughout the group home and the right side hand grip of client D's walker moved back and forth as the walker moved. On 4/25/16 at 3:55pm, client D and GHS (Group Home Staff) #2 both indicated client D's right side hand grip which should have locked into place was broken and the right side of client D's walker was not secure. GHS #2 stated client D's walker had been broken "like that" for "over three (3) months." Client D's record was reviewed on 4/28/16 at 9:35am. Client D's 2/23/16 ISP and 2016 Risk Plans indicated "Risk plan for clubfoot...5/26/15 Clubfoot describes a range of foot abnormalities usually present at birth...The tissues connecting the muscles to the bone are shorter than usual...refer to the sharp angle to the ankle, like the head of a golf			

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	club...." Client D's ISP indicated Adaptive Equipment "walker, built up shoe right foot, and leg braces." On 4/27/16 at 12:45pm, an interview was conducted with the AD (Area Director). The AD indicated it was not known how long client D's walker had been broken. The AD indicated she was not aware the walker was broken. This federal tag relates to complaint #IN00198671. 9-3-7(a)			
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, for 4 of 4 sampled clients (clients A, B, C, and D) and 3 additional clients (clients E, F, and G), the facility failed to ensure an evacuation drill was conducted quarterly for the each shift of personnel every 90 days for the overnight shift (12:00midnight until 8:00am) 6/20/15 through 4/25/16, for the day shift (6am until 2pm) from 4/30/15 through 4/25/16, and for the evening shift (2:00pm until 12:00midnight) from 8/18/15 until 1/12/16.	W 0440	**W 440 Evacuation Drills** The facility must hold at least quarterly drills for each shift of personnel. **1. What corrective action will be accomplished?** · A schedule identifying when each emergency drill should be ran has been implemented. · The Program Coordinator will receive training on the emergency drill tracking. · The importance of ensuring emergency drills are ran each month for the appropriate time period will be completed at the staff meeting.	06/05/2016

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	Findings include: The facility's evacuation drills were reviewed on 4/25/16 at 2:55pm and on 4/27/16 at 12:00noon. The review indicated the facility had failed to conduct evacuation drills for clients A, B, C, D, E, F, and G for the following: -After an emergency drill on 6/20/15 at 2am and before 4/25/16 at 2:55pm, for the overnight shift of personnel. -After an emergency drill on 4/30/15 at 8:45am and before 4/25/16 at 2:55pm, for the day shift of personnel. -After an emergency drill on 8/18/15 at 7:16pm and before 1/12/16 at 7:30pm, for the evening shift personnel. An interview with the Residential Manager (RM) was conducted on 4/27/16 at 12:00noon. The RM indicated the overnight shift of personnel was from 12:00midnight until 8:00am, the day shift of personnel was from 6:00am until 2:00pm, and the evening shift of personnel was from 2:00pm until 12:00 midnight. The RM indicated no further emergency drills had been located. On 4/27/16 at 12:00noon, an interview with the AD (Area Director) was conducted. The AD indicated she was unable to locate any further evacuation		· A drill for the overnight, day and evening shift personnel will be completed. · The Program Director will monitor the emergency drills monthly. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · A schedule identifying when each emergency drill should be ran has been implemented. · The Program Coordinator will receive training on the emergency drill tracking. · The importance of ensuring emergency drills are ran each month for the appropriate time period will be completed at the staff meeting. · A drill for the overnight, day and evening shift personnel will be completed. · The Program Director will monitor the emergency drills monthly. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · A schedule identifying when each emergency drill should be ran has been implemented. · The Program Coordinator will	

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	15G353	A. BUILDING 00 B. WING	05/06/2016

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	drills for the overnight, day, and evening shifts of personnel for clients A, B, C, D, E, F, and G. 9-3-7(a)		receive training on the emergency drill tracking. · The importance of ensuring emergency drills are ran each month for the appropriate time period will be completed at the staff meeting. · A drill for the overnight, day and evening shift personnel will be completed. · The Program Director will monitor the emergency drills monthly. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Coordinator will monitor staff daily when they are in the home. · The Program Director will monitor on a regular basis when they are in the home and during monthly supervisory visits. · The Area Directors will monitor as they complete their audits. · The Quality Assurance Specialist will monitor as they complete their audits. **5. What is the date by which the systemic changes will be completed?** June 5th, 2016	
W 0475 Bldg. 00	483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils. Based on observation and interview, for 3 of 4 sampled clients (clients B, C, and D)	W 0475	**W 475 Meal Services** Food must be served with	06/05/2016

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	and 3 additional clients (clients E, F, and G), the facility failed to teach and encourage a full set of standard utensils available for use during dining opportunities. Findings include: On 4/25/16 from 2:55pm until 5:15pm, clients B, C, D, E, F, and G were observed at the group home. Client A had been admitted at the local hospital. During the observation period clients B, C, D, E, F, and G were provided a spoon and a fork to eat with and no knives were offered by the facility staff during dining. During the observation period clients B, C, D, E, F, and G served themselves and consumed pieces of baked chicken, peach slices, and peas and corn. On 4/27/16 at 1:15pm, an interview with the AD (Area Director) was conducted. The AD indicated clients B, C, D, E, F, and G should use a full set of utensils at the group home during dining opportunities. 9-3-8(a)		appropriate utensils. **1. What corrective action will be accomplished?** · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o Ensuring all appropriate tableware settings are out for meals. · Formal programming will be implemented for Clients B-G regarding setting the table and using appropriate utensils during meals. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met.	

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			· Training completed with the staff regarding: o Ensuring all appropriate tableware settings are out for meals. · Formal programming will be implemented for Clients B-G regarding setting the table and using appropriate utensils during meals. · The Program Director/QIDP will ensure that there is formal programming in place for all residents that address identified needs. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The Program Coordinator will do home observations weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · The Program Director will do home observations bi-weekly to ensure staff are implementing the plans of clients and the client's needs are being met. · Training completed with the staff regarding: o Ensuring all appropriate tableware settings are out for meals. · Formal programming will be implemented for Clients B-G regarding setting the table and using appropriate utensils during meals. · The Program Director/QIDP will ensure that there is formal programming in place for all residents that address identified	

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			needs. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Director will monitor to ensure the clients plans and needs are being met during their bi-weekly observations. · The Program Coordinator will monitor to ensure the clients plans and needs are being met during their weekly observations. · The QIDP will monitor and review the resident's needs. As the needs arise, formal programming will be implemented. **5. What is the date by which the systemic changes will be completed?** June 5th, 2016	