

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G432	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/08/2013
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3606 HIGHWOODS DR N INDIANAPOLIS, IN 46222
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: April 30, May 1, 2, 6, 7 and 8, 2013.</p> <p>Facility Number: 000946 Provider Number: 15G432 AIMS Number: 100244570</p> <p>Surveyor: Claudia Ramirez, RN</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/15/13 by Ruth Shackelford, QIDP.</p>	W000000		

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

TITLE

(X6) DATE

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

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W000149	<p>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.</p> <p>Based on record review and interview for 1 of 11 BDDS (Bureau of Developmental Disabilities Services) reports, the facility neglected to implement the facility's policy and procedure and neglected to provide adequate supervision for 8 of 8 clients living in the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8).</p> <p>Findings include:</p> <p>On 04/30/13 at 11:43 AM the facility's BDDS Reports and investigations were reviewed from 04/01/12 through 04/29/13 and indicated the following:</p> <p>03/31/13: Reports on clients #1, #2, #3, #4, #5, #6, #7 and #8 submitted to BDDS for an incident dated 03/31/13 at 5:20 AM indicated, "The House Manager, [name], went to the group home at 5:20 AM on 3/31/13 and found the overnight staff, [name], sleeping on the floor. It appeared that she had made a bed on the floor. In addition, she also had an unidentified female in the bed with her. Upon leaving she collected her own personal laundry from the washing machine/dryer that she was doing in the group home. The House</p>	W000149	<p>W149 Indiana MENTOR Quality Assurance Staff completed a thorough investigation. The staff was terminated. All remaining staff were client specifically retrained, including maintaining staffing levels at all times. Ongoing, the Home Manager and/or Program Director will continue to complete random pop up visits to ensure that all staffing levels are appropriate and maintained. Completion Date: June 7, 2013 Responsible Party: Home Manager and Program Director</p>	06/07/2013	

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	<p>Manager notified her PD (Program Director) and immediately suspended the staff member."</p> <p>The BDDS Follow-up Report dated 04/03/13 indicated, "...The staff that the allegation was made against was suspended at the time she was found sleep (sic). The staff resigned and refused to answer questions concerning this incident. The facts gathered supported the allegation made against the staff sleeping while on the job. The home manager will continue to do her random checks on the home to ensure the safety of the clients."</p> <p>The Summary of Internal Investigation Report dated 04/04/13 indicated, "Date of Incident: 3/31/13. Client Names: (clients #1, #2, #3, #4, #5, #6, #7 and #8). The Home Manager, [name], found [staff name] sleeping on the floor of the group home at 5:20 AM on 03/31/13. [House Manager] suspended [staff] immediately...All clients listed above require 24 hour supervision. All clients listed above were sleeping at the time of the incident. Factual Findings: Interview with [Program Director (PD)] on 4/01/13: Noticed someone sleeping in [staff's] car parked in the driveway of the group home at 7:20 AM on 3/29/13. The person was wrapped in a blanket, had a pillow, and appeared to be sound asleep. The person</p>			

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	<p>did not know [PD] was outside the car. [Staff] was leaving her shift in 10 minutes so he did not attempt to wake the person up and did not say anything to [staff]. Informed [House Manager] he felt uneasy about what he saw and requested she complete a (sic) unannounced visit. Interview with [House Manager] on 04/01/13: Stopped at the group home at 5:20 AM on 03/31/13 after [PD] requested she make an unannounced visit during [staff's] shift. When she let herself into the home with her key she noted most of the lights were out and no one responded to her entry into the home. When she entered the living room area she observed [staff] and an unknown female sleeping on the floor on a bedroll with their own pillows and blankets. Turned on the over head lights in an attempt to awaken them, but that was unsuccessful. All clients were checked and they were all safe and sleeping. After 5 minutes they still had not awakened. Noted they had personal laundry in the washer and dryer so she bagged their clothing up for them and went to return to the living room to awaken them As she was approaching the living room [staff] rounded the corner. [HM] informed her (staff) she needed to gather her personal belongings, clock out because she was suspended. [Staff's] friend awakened at this time and assisted her in gathering</p>						

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	<p>their belongings. [Staff] stated, 'I'm sorry' before leaving.</p> <p>Interview with [staff] on 4/02/13.</p> <p>Refused to come in to discuss the incident stating she had called yesterday and 'quit'...Conclusion: Evidence supports neglect of supervision."</p> <p>Client #1's record was reviewed on 05/01/13 at 11:40 AM. Client #1's ISP (Individual Support Plan) was dated 12/06/12 and indicated client #1 required 24 hour supervision.</p> <p>Client #2's record was reviewed on 05/01/13 at 3:17 PM. Client #2's ISP was dated 12/27/12 and indicated client #2 required 24 hour supervision.</p> <p>Client #3's record was reviewed on 05/02/13 at 10:55 AM. Client #3's ISP was dated 10/18/12 and indicated client #3 required 24 hour supervision.</p> <p>Client #4's record was reviewed on 05/02/13 at 12:05 PM. Client #4's ISP was dated 05/20/12 and indicated client #4 required 24 hour supervision.</p> <p>On 04/30/13 at 1:30 PM, a review of the facility's 04/2011 Policy of Quality and Risk Management indicated, "Indiana MENTOR promotes a high quality of service and seeks to protect individuals</p>						

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	<p>receiving Indiana MENTOR services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluation and reducing risk to which individuals are exposed. Indiana MENTOR follows the BDDS Incident Reporting policy as outlined in the Provider Standards. An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS: 1. Alleged, suspected, or actual abuse, neglect, or exploitation of an individual...iii. Cause the individual to experience emotional distress...e. Failure to provide appropriate supervision, care or training...Indiana MENTOR is committed to ensuring the individuals we serve are provided with a safe and quality living environment...."</p> <p>On 05/07/13 at 1:30 PM an interview was conducted with the Area Director (AD). The AD indicated staff failed to follow the policy/procedure as they failed to provide appropriate supervision of the clients and the clients were unsupervised for an unknown period of time. The AD indicated clients #1, #2, #3, #4, #5, #6, #7 and #8 required 24 hour supervision and staff should not have been sleeping on duty. She indicated the clients should not have been unsupervised as their needs</p>				

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	required staff supervision at all times. 9-3-2(a)			

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#3 and #4), the QIDP (Qualified Intellectual Disabilities Professional) failed to monitor clients' programs by not updating the clients' Behavior Support Plans (BSP) to include the current dosages of the medications in the plans.</p> <p>Findings include:</p> <p>1. Client #3's record was reviewed on 05/02/13 at 10:55 AM. Client #3's May 2013 physician's orders indicated he was taking a total of: Haldol (antipsychotic) 10 mg (milligrams) daily and Lorazepam (antianxiety) 3 mg daily.</p> <p>Client #3's 11/30/12 BSP indicated client #3 was taking only 5 mg of Haldol and 1 mg of Lorazepam. The BSP did not indicate the medications had been increased due to the symptoms nor did the plan have a range for the medications which included the current doses.</p> <p>On 05/07/13 at 1:30 PM an interview with the Area Director (AD) was</p>	W000159	<p>The Behavior Consultant will complete an addendum to clients3's Behavior Support Plan to include the use of his psychotropic medications. The Behavior Consultant will complete an addendum to clients4's Behavior Support Plan to include the use of his psychotropic medications. Ongoing, the Behavior Consultant will include the current dose of all psychotropic medications in all client Behavior Support Plans. The Interdisciplinary Team, Area Director, and/or Human Rights Committee will review each Behavior Support Plan to ensure it includes the use of current psychotropic medications, when needed/available. Completion Date: June 7, 2013 Responsible Party: Home Manager and Program Director</p>	06/07/2013	

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	<p>conducted. The AD indicated client #3's BSP did not contain the current dosages of the medications.</p> <p>2. Client #4's record was reviewed on 05/02/13 at 12:05 PM. Client #4's May 2013 physician's orders indicated he was taking a total of 4 mg of Risperidone (antipsychotic) daily.</p> <p>Client #4's 05/09/12 BSP indicated client #4 was taking only 3 mg of Risperidone daily. The BSP did not indicate the medications had been increased due to the behaviors or did the plan have a range for the medications which included the current doses.</p> <p>On 05/07/13 at 1:30 PM an interview with the AD was conducted. The AD indicated client #4's BSP did not contain the current dosages of the medication.</p> <p>9-3-3(a)</p>			

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W000209	<p>483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.</p> <p>Based on record review and interview, the facility failed to ensure actions were taken to obtain the participation of the guardian (GU) in the Interdisciplinary Team process for 3 of 4 sampled clients (clients #1, #2 and #4).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 05/01/13 at 11:40 AM. Client #1's ISP (Individual Support Plan) was dated 12/06/12 and indicated client #1 has a GU. Client #1's ISP was not signed by the GU to indicate her input or agreement with the ISP.</p> <p>Client #2's record was reviewed on 05/01/13 at 3:17 PM. Client #2's ISP was dated 12/27/12 and indicated client #2 has a GU who is his mother. Client #2's ISP was not signed by the GU to indicate her input or agreement with the ISP.</p> <p>Client #4's record was reviewed on 05/02/13 at 12:05 PM. Client #4's ISP was dated 05/20/12 and indicated client #4 has a GU who is his mother. Client</p>	W000209	<p>W209 The Program Director will initiate an IDT meeting to ensure that client #1's records are reviewed and signed off on by the guardian/HCR. The Program Director will initiate an IDT meeting to ensure that client #2's records are reviewed and signed off on by the guardian/HCR. The Program Director will initiate an IDT meeting to ensure that client #4's records are reviewed and signed off on by the guardian/HCR. The Program Director will be retrained to ensure that meetings are held and team signatures are obtained to ensure that the team is in agreement with the Individualized Support Plan as it is written. Ongoing, the Area Director will complete random audits to ensure that the Program Director is seeking team approval , via documented signatures on all ISPs. Completion Date: April 15,2012 Responsible Party: Program Director and Program Nurse</p>	06/07/2013

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	<p>#4's ISP was not signed by the guardian to indicate her input or agreement with the ISP.</p> <p>On 05/07/13 at 1:30 PM an interview with the Area Director (AD) was conducted. The AD indicated it was difficult getting the ISPs signed and clients #1, #2 and #4's ISP's had not been signed by their GUs to indicate their input or agreement with the ISPs.</p> <p>9-3-4(a)</p>			

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview, the facility failed for 1 of 1 new client admitted to the home, (client #2), to ensure assessments were completed within 30 days after admission.</p> <p>Findings include:</p> <p>Client #2's records were reviewed on 05/01/13 at 3:17 PM. The record indicated client #2 was admitted on 11/30/12. Client #2's record indicated client #2 was admitted on the medication, Adderall (inattention), Abilify (depression), Bupropion (depression) and Prozac (depression). Client #2's admission information contained a BSP (Behavior Support Plan) dated 12/03/04. The BSP indicated client #2's behaviors included verbal aggression, physical aggression, property destruction, compliance/refusals, stealing and fire setting. Client #2's ISP (Individual Support Plan) dated 12/27/12 did not contain a behavioral assessment for client #2 and indicated, "Behavior Plan (Will have one)."</p>	W000210	<p>Client #2 does have a Behavior Support Plan on file currently. The Program Director and Behavior Support Specialist will be retrained on ensuring that all clients with targeted behaviors and prescribed psychotropic medications upon admission will have a behavior assessments completed, and then reassessed after 30 days to ensure that any updates needed, are made and approved by the team. Ongoing, the Area Director will review all new admissions after 60 days to ensure that all 30 days follow up meets are conducted and followed up on as needed. Completion Date: June 7, 2013 Responsible Party: Program Director and Behavior Consultant.</p>	06/07/2013			

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	<p>On 05/07/13 at 1:30 PM an interview with the Area Director (AD) was conducted. The AD indicated the behavioral assessment had not been completed within 30 days after admission and should have been.</p> <p>9-3-4(a)</p>			

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on interview and record review for 2 of 4 sampled clients (clients #1 and #4), the clients' Individual Support Plans (ISPs) failed to have programs in place to address client #1's elopement behavior and client #4's physical aggression.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 05/01/13 at 11:40 AM. Client #1's record contained the following dated documents:</p> <p>08/25/12: Summary of Internal Investigation Report indicated client #1, "left the group home 8/25/12 around 6:00 PM and walked (sic) his mom's house...No history of eloping from the group home since his move in date on 11/28/11...[House Manager (HM)] said that [client #1] always takes the trash out after dinner and comes back to the house without any problems. [Staff #7] and [staff #8] both stated that (sic) went to take the trash out and after about 20 minutes they noticed they did not see him. I asked why it took so long before they</p>	W000227	<p>Client #1's Behavior Support Plan has been updated to include elopement as a targeted behavior. Client #4's Behavior Support Plan has been updated to include physical aggression as a targeted behavior. Ongoing, the Program Director will complete IDTs and updates to the Individualized Support Plans, including but not limited to the ISPs, RMAPs, and BSPs as needed, after each incident and team meeting. Ongoing, the Area Director will complete random audits to ensure that team meetings are being held, and updates to the Individualized Plans are being completed. Completion Date: June 7, 2013 Responsible Party: Program Director, Behavior Consultant, and Area Director</p>	06/07/2013			

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	<p>notice (sic) he was gone (sic) they both stated [client #1] usually goes in his private area which is in the bathroom after taking the trash out...[staff #7] went to search for him for about 20 min (minutes) around the group home area and surrounding streets when the group home received a call. [Staff #8] received the phone call around 6:15 pm from [client #1's] mom's house stating he had walked to her house. [Client #1's] mom only lives a few blocks from the group home...."</p> <p>Client #1's record contained a Behavioral Support Plan (BSP) dated 06/06/12 which indicated client #1 had targeted behaviors which included: "Type 2 Resistance...Non-Severe Anger Control Problems...Physical Assault...Signs of Mental Health...."</p> <p>Client #1's record did not contain an updated BSP with elopement behavior.</p> <p>On 05/07/13 at 1:30 PM an interview with the Area Director (AD) was conducted. The AD indicated client #1's plan failed to list the behavior or give specific instructions on what staff were to do should the behavior occur.</p> <p>2. Client #4's record was reviewed on 05/02/13 at 12:05 PM. Client #4's record contained the following dated documents:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G432		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/08/2013	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3606 HIGHWOODS DR N INDIANAPOLIS, IN 46222			
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	<p>01/06/13: BDDS (Bureau of Developmental Disabilities Services) Report indicated, "Police was (sic) called on [client #4] because he was threatening staff lives (sic) with a knife. [Client #4] ran one staff outside with the knife and that's when she called the police. Staff made sure all clients were safe from [client #4]...we have all approvals from HRC (Human Rights Committee) and guardians to have the knives locked up. [Client #4] says he was upset because his mom did not call him nor was she answering his calls...."</p> <p>Client #4's record contained a BSP dated 05/09/12 which indicated client #4 had targeted behaviors which included: "Tattling...Arguing...Verbal Abuse...Bossing...Entering Others' Rooms...."</p> <p>Client #4's record did not contain an updated BSP with Physical Aggression, threatening behavior and any information regarding the knife issue.</p> <p>On 05/07/13 at 1:30 PM an interview with the AD was conducted. The AD indicated client #4's plan failed to list the behavior or give specific instructions on what staff were to do should the behavior occur.</p>						

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	9-3-4(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G432	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/08/2013
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W000263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview, the facility failed to obtain the health care representative (HCR) or guardian's approval before implementation of a Behavioral Support Plan (BSP) or behavioral medications for 2 of 4 sampled clients (clients #3 and #4) with restrictive programs.</p> <p>Findings include:</p> <p>1. Client #3's record was reviewed on 05/02/13 at 10:55 AM. Client #3's ISP (Individual Support Plan) dated 10/18/12 indicated client #3's mother was his HCR. Client #3's 12/30/12 BSP indicated client #3's behaviors included temper outbursts, hyperactivity, verbal assault, property destruction, self-injurious behaviors and boundaries. The BSP indicated client #3 took the following medications for his behaviors: Lorazepam (anti-anxiety), Haloperidol (anti-psychotic) and Depakote (mood stability). Client #3's record did not indicate the facility had obtained client #3's HCR approval of the BSP prior to the HRC approval of the</p>	W000263	<p>The Program Director will be trained on the correct process for retrieving the appropriate approvals for the Behavior Support Plans, behavior controlling medications, and the use of sedatives before appointments. The Program Director will seek guardian approvals for all psychotropic medications and the Behavior Support Plan for client #3 and 4. Ongoing, the new Program Director will correctly retrieve the approvals for all future Behavior Controlling/Sedatives from the Guardian/Health Care Representative first, then once received, will get the appropriate approval from the Human Rights Committee, before implementing. Ongoing, the Area Director will complete random quarterly audits to ensure that all of the proper approvals are in place from the IDTs. Completion Date: June 7, 2013 Responsible Party: Program Director and Area Director</p>	06/07/2013

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	<p>plan.</p> <p>On 05/07/13 at 1:30 PM an interview with the Area Director (AD) was conducted. The AD indicated the facility was to obtain the HRC's or guardian's approval prior to implementation of the BSPs.</p> <p>2. Client #4's record was reviewed on 05/02/13 at 12:05 PM. Client #4's ISP (Individual Support Plan) dated 05/20/12 indicated client #4's mother was his guardian. Client #4's 05/09/12 BSP indicated client #4's behaviors included: tattling, arguing, verbal abuse, bossing and entering others' rooms. The BSP indicated client #4 took the following medications for his behaviors: Risperidone (antipsychotic) and Divalproex (mood stability). Client #4's record did not indicate the facility had obtained client #4's guardian approval of the BSP prior to the HRC approval of the plan.</p> <p>On 05/07/13 at 1:30 PM an interview with the AD was conducted. The AD indicated the facility was to obtain the HRC's or guardian's approval prior to implementation of the BSPs.</p> <p>9-3-4(a)</p>				

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3606 HIGHWOODS DR N INDIANAPOLIS, IN 46222
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W000268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation and interview, the facility failed for 2 of 4 sampled clients (clients #2 and #3) and 2 additional clients (clients #5 and #7) who live in the group home, to promote their dignity by ensuring clients wore clothing that fit well and wore an adequate amount of clothing around others in the home.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 04/30/13 from 4:00 PM until 6:15 PM. During the observation time clients #2 and #5's trousers continued to fall down from their waist when they did not hold the pants up with their hands. Staff #1, #2 and #3 did not assist clients #2 or #5 to obtain a belt or to prompt them to change clothes.</p> <p>On 05/07/13 at 1:30 PM an interview with the Area Director (AD) was conducted. The AD indicated clients #2 and #5 should wear clothes that fit properly.</p> <p>2. Observations were conducted at the group home on 05/01/13 from 6:28 AM</p>	W000268	<p>All staff will be retrained on client's dignity and appearance. This will include ensuring that clients are not wearing clothing that is too big, unfit, or in bad shape. The Home Manager will review all clients' clothing and ensure that no ill-fitting clothing is available to the clients. This will include purchasing new clothing, repairing old clothing, and/or purchasing a belt for each client's personal use. The Program Director will work with the IDT's for clients 2,5, 3, and 7 to include formal dignity training in each individualized plan. Ongoing, the Home Manager and/or Program Director will complete random observations to ensure that the staff are assisting the clients with proper clothing choices and are respecting client's dignity, both in and out of the home. Completion Date: June 7, 2013 Responsible Party: Home Manager and Program Director</p>	06/07/2013			

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	<p>until 7:47 AM. At 6:35 AM client #7 entered the kitchen/dining room area in a thin cotton sleeveless nightgown. The nightgown length came to the bottom of her buttock cheeks and her underwear was observed. Male clients #2 and #4 were in the kitchen/dining area when client #7 was in the same room. At 6:56 AM client #3 walked into the kitchen/dining room with his chest bare and wearing boxer underwear. Staff #5 verbally prompted him to get his medications (in the same area) before he showered. Client #3 took his medications as clients #2, #4 and #7 were in the area. At 7:04 AM client #5 entered the kitchen/dining area holding the waist band of his jeans. During the observation time client #5's trousers continued to fall down from his waist when he did not hold them up with his hands.</p> <p>On 05/07/13 at 1:30 PM an interview with the AD. The AD indicated client #5 should wear clothes that fit properly. She further indicated client #3 should not be walking around the house with no shirt and in boxer underwear. She indicated client #7 should not be wearing her nightgown out into the public areas of the house.</p> <p>9-3-5(a)</p>				

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed for 3 of 4 sampled clients (clients #2, #3 and #4), by not ensuring clients received nursing services according to their medical needs: by not ensuring medication orders were accurate on the MAR (Medication Administration Record) (client #3) and by not ensuring staff obtained adequate amounts of clients' (client #2 and #4) prescribed medication so they don't run out of medications.</p> <p>Findings include:</p> <p>On 04/30/13 at 11:43 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following medication errors:</p> <p>04/18/12: "Dr [name] reduced [client #3's] Depakote (behaviors) from 1500 mg (milligram) QD (daily) to 1000 mg QD on 11/10/11. The 11-11 MAR (Medication Administration Record) and physician's orders did reflect the appropriate medication reduction on 11-10-11. The 12-11 MAR was changed by hand to reflect the current medication order. The</p>	W000331	<p>The Program Nurse was retrained at the time of the incident, on reviewing all client Physician orders and Medication Administration Records for accuracy. All staff were retrained at the time of the incident on medication administration, and reporting missing, inaccurate, and incorrect medications as they become aware. The Home Manager was retained on ordering medications appropriately from the pharmacy as needed to ensure timely delivery. Indiana MENTOR has since changed to a new pharmacy and has a procedure in place for correctly ordering medications weekly to ensure no missing meds. This also includes a procedure for when mistakes are made. Ongoing, the Williams' Brother's Pharmacy conducts quarterly audits to ensure that all errors are addressed and corrected. Ongoing, the Program Nurse will complete random audits of the med cabinets to ensure that all appropriate medications are in the house as needed and prescribed. Completion Date: April 5, 2013 Responsible Party: Home Manager and Program Nurse, and Pharmacy Personnel</p>	06/07/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G432	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/08/2013
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3606 HIGHWOODS DR N INDIANAPOLIS, IN 46222
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	<p>1-12 through 4-18-12 MAR did not reflect the current med, and the pharmacy did not send the correct dosage of Depakote. Because of both of these errors on the pharmacy part, [client #3] was given 1500 mg of Depakote QD from 1-1-12 thru 4-18-12. The Home Manager said she discovered the error when reviewing [client #3's] medications. The Program Nurse said she contacted Dr [name] on 4-18-12 as soon as she became aware of the error. Dr [name] confirmed the order for Depakote 1000 mg QD. The orders were faxed to the pharmacy and she corrected the MAR. [Client #3] received the correct amount of medication on 4-19-12 after confirming the dosage with Dr [name]. The Program Nurse is going to be retrained on reviewing the physician's orders and Med Sheets to ensure accuracy. The Program Nurse will continue to monitor [client #3] for negative effects of the extra Depakote." A BDDS Follow-up Report dated 05/01/12 indicated, "...[Client #3] did not have any negative effects from receiving the wrong dose and his doctor had no concerns...The reason why it was not caught was due to the fact that everything matched up on the MARs. The nurse will keep her own records to make sure the pharmacy didn't make any mistakes when new medications arrive...."</p> <p>The Summary of Internal Investigation</p>			

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	<p>Report dated 04/24/12 indicated, "[Client #3] has been receiving an additional 500 mg of Depakote...Factual Findings: Dr [name] reduced [client #3's] Depakote from 1500 mg QD to 1000 mg QD on 11-10-11. The 11-11 MAR reflects the appropriate medication reduction on 11-10-11. The 11-11 Physician's Order reflects the appropriate medication order. The pharmacy did not make the appropriate change on the printed MAR. The 12-11 MAR was changed by hand to reflect the current medication order. The 1-12 through 4-18-12 MAR did not reflect the current med. The 12-11 through April 2012 Physician Orders (PO) do not reflect the current medication order...[nurse] said she revised the December MAR to reflect he current medication order, but did not realize the subsequent MARs and POs did not reflect the current changes...Conclusion: [Client #3] did not receive the correct order of Depakote from 1-1-12 through 4-18-12."</p> <p>11/27/12: "[Client #4] did not receive his 9:00 PM medication which was Risperidone (behaviors) 3 mg and his Divalproex (behaviors) 250 mg. This was due to the pharmacy not being able to deliver medication on time because of holidays. The program nurse contacted his doctor and he instructed her to continue as scheduled. [Client #4] had no</p>						

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	<p>negative effects or behaviors from the missed medication. [Client #4] will continue to be monitored for his health and safety."</p> <p>03/05/13: "[Client #2] Vyvanse (ADHD/Attention Deficit Hyperactivity Disorder) 70 mg was not given to him on 03/05/13 because the pharmacy did not deliver the medication in time. [Client #2] had no negative effects from not receiving his medication. [Client #2's] doctor instructed the nurse to continue the medication as scheduled. [Client #2's] home manager will start notifying the pharmacy when she sees his medication coming to an end without their being any refills in the house. [Client #2] will continue to be monitored for his health and safety."</p> <p>On 05/07/13 at 1:30 PM an interview with the Area Director (AD) was conducted. The AD indicated medications that are not given as prescribed are considered medication errors as staff are not following the physician's orders. She further indicated medications should be ordered timely so staff do not run out of medications for the clients.</p> <p>9-3-6(a)</p>				

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3606 HIGHWOODS DR N INDIANAPOLIS, IN 46222
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W000368	<p>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.</p> <p>Based on record review and interview, the facility failed for 3 of 4 sampled clients (clients #2, #3 and #4) and 1 additional client (client #7), who take medications prescribed by the physician, to administer medications as ordered.</p> <p>Findings include:</p> <p>On 04/30/13 at 11:43 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following medication errors:</p> <p>04/18/12: "Dr [name] reduced [client #3's] Depakote (behaviors) from 1500 mg (milligram) QD (daily) to 1000 mg QD on 11/10/11. The 11-11 MAR (Medication Administration Record) and physician's orders did reflect the appropriate medication reduction on 11-10-11. The 12-11 MAR was changed by hand to reflect the current medication order. The 1-12 through 4-18-12 MAR did not reflect the current med, and the pharmacy did not send the correct dosage of Depakote. Because of both of these errors on the pharmacy part, [client #3] was</p>	W000368	<p>The Program Nurse was retrained at the time of the incident, on reviewing all client Physician orders and Medication Administration Records for accuracy. All staff were retrained at the time of the incident on medication administration, and reporting missing, inaccurate, and incorrect medications as they become aware. The Home Manager was retained on ordering medications appropriately from the pharmacy as needed to ensure timely delivery. Indiana MENTOR has since changed to a new pharmacy and has a procedure in place for correctly ordering medications weekly to ensure no missing meds. This also includes a procedure for when mistakes are made. Ongoing, the Williams' Brother's Pharmacy conducts quarterly audits to ensure that all errors are addressed and corrected. Ongoing, the Program Nurse will complete random audits of the med cabinets to ensure that all appropriate medications are in the house as needed and prescribed. Completion Date: June 7, 2013 Responsible Party: Home Manager and Program Nurse, and Pharmacy Personnel</p>	06/07/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G432		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/08/2013	
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	<p>given 1500 mg of Depakote QD from 1-1-12 thru 4-18-12. The Home Manager said she discovered the error when reviewing [client #3's] medications. The Program Nurse said she contacted Dr [name] on 4-18-12 as soon as she became aware of the error. Dr [name] confirmed the order for Depakote 1000 mg QD. The orders were faxed to the pharmacy and she corrected the MAR. [Client #3] received the correct amount of medication on 4-19-12 after confirming the dosage with Dr [name]. The Program Nurse is going to be retrained on reviewing the physician's orders and Med Sheets to ensure accuracy. The Program Nurse will continue to monitor [client #3] for negative effects of the extra Depakote." A BDDS Follow-up Report dated 05/01/12 indicated, "...[Client #3] did not have any negative effects from receiving the wrong dose and his doctor had no concerns...The reason why it was not caught was due to the fact that everything matched up on the MARs. The nurse will keep her own records to make sure the pharmacy didn't make any mistakes when new medications arrive..."</p> <p>The Summary of Internal Investigation Report dated 04/24/12 indicated, "[Client #3] has been receiving an additional 500 mg of Depakote...Factual Findings: Dr [name] reduced [client #3's] Depakote from 1500 mg QD to 1000 mg QD on</p>						

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	<p>11-10-11. The 11-11 MAR reflects the appropriate medication reduction on 11-10-11. The 11-11 Physician's Order reflects the appropriate medication order. The pharmacy did not make the appropriate change on the printed MAR. The 12-11 MAR was changed by hand to reflect the current medication order. The 1-12 through 4-18-12 MAR did not reflect the current med. The 12-11 through April 2012 Physician Orders (PO) do not reflect the current medication order...[nurse] said she revised the December MAR to reflect he current medication order, but did not realize the subsequent MARs and POs did not reflect the current changes...Conclusion: [Client #3] did not receive the correct order of Depakote from 1-1-12 through 4-18-12."</p> <p>09/12/12: "[Client #7] received her Clonazepam 0.5 mg earlier than she was supposed to. [Client #7] was giving (sic) her Clonazepam at 7:00 AM instead of 9:00 PM. [Client #7's] home manager notified the nurse who then called [client #7's] primary doctor. [Client #7's] doctor told staff to discontinue the med for the day and to restart as normal the following. [Client #7] had no negative effects from receiving the medication early and she (sic) doing just fine. This was the staff (sic) first time passing medication in the home. The staff said she became</p>			

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	<p>confused when reading the card. She thought the card said to give the med at 7:00 AM in reality she was only suppose (sic) to count the medication at 7:00 AM. The staff has been retrained on comparing doctor's orders with the medication. [Client #7] will continue to be monitored for her health and safety."</p> <p>11/27/12: "[Client #4] did not receive his 9:00 PM medication which was Risperidone (behaviors) 3 mg and his Divalproex (behaviors) 250 mg. This was due to the pharmacy not being able to deliver medication on time because of holidays. The program nurse contacted his doctor and he instructed her to continue as scheduled. [Client #4] had no negative effects or behaviors from the missed medication. [Client #4] will continue to be monitored for his health and safety."</p> <p>03/05/13: "[Client #2] Vyvanse (ADHD/Attention Deficit Hyperactivity Disorder) 70 mg was not given to him on 03/05/13 because the pharmacy did not deliver the medication in time. [Client #2] had no negative effects from not receiving his medication. [Client #2's] doctor instructed the nurse to continue the medication as scheduled. [Client #2's] home manager will start notifying the pharmacy when she sees his medication</p>						

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	<p>coming to an end without their being any refills in the house. [Client #2] will continue to be monitored for his health and safety."</p> <p>On 05/07/13 at 1:30 PM an interview with the Area Director (AD) was conducted. The AD indicated medications that are not given as prescribed are considered medication errors as staff are not following the physician's orders.</p> <p>9-3-6(a)</p>			

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W000436	<p>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.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (client #1), who wore glasses, the facility failed to ensure and/or train client #1 to use his eyeglasses.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 04/30/13 from 4:00 PM until 6:15 PM and on 05/01/13 from 6:28 AM until 7:47 AM. During both observations client #1 was not wearing his eyeglasses nor were any verbal prompts made to client #1 to put on his eyeglasses.</p> <p>Client #1's record was reviewed on 05/01/13 at 11:40 AM. Client #1's vision examination dated 12/01/11 indicated client #1 was prescribed eyeglasses and was to use them for "constant wear." Client #1's 12/06/12 ISP (Individual Support Plan) did not indicate a formal training objective for wearing the eyeglasses.</p>	W000436	All Direct Care Staff will be retrained on Indiana MENTOR's policy and procedure for ensuring the individuals are using adaptive equipment as prescribed. This retraining will include using the adaptive equipment, prompting the client's to properly use the equipment, and what to do when they refuse. The Program Director will be retrained on including a formal training objective for those individuals who refuse/need desensitization. The Program Director will complete a training objective for clients 1 and 4 for use of their glasses as prescribed. Ongoing, the Home Manager and/or Program Director will complete random Active Treatment observations three times per week for the first four weeks, and then once a week on going to ensure that all adaptive equipment is used properly. Ongoing the Home Manager and/or Program Director will complete random documentation reviews three times per week for the first four weeks, and then once a week on going to ensure that all adaptive equipment is	06/07/2013			

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	<p>On 05/07/13 at 1:40 PM an interview was conducted with the Area Director (AD). The AD indicated client #1 should be wearing his glasses. She indicated the ISP did not contain any formal training in this area.</p> <p>9-3-7(a)</p>		<p>used properly. Completion Date: June 7, 2013 Responsible Party: Home Manager and Program Director.</p>	

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W000460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 1 client (client #7) who was on a modified diet to follow diet orders.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 04/30/13 from 4:00 PM until 6:15 PM. At 5:45 PM client #7 was seated at the table. At 5:45 PM client #7 obtained a piece of french bread from the serving dish and placed it on her plate. At 5:50 PM client #7 placed lettuce and tomatoes in her bowl and started eating the lettuce with her fingers. The lettuce pieces were 2" (inches) by 1" in size. Client #7 shoved several pieces of lettuce in her mouth at one time using her fingers. At 5:51 PM staff #2 placed a 4" by 3" piece of lasagna on her plate. At 5:55 PM client #7 used her fork and picked up a piece of lasagna noodle 2" by 1" and then one 1" x 5 inches and used both hands to shove the noodle in her mouth. Client #7 continued to eat large bites of the lasagna until it was gone. Client #7 took spinach which had been placed in her bowl and placed strings of</p>	W000460	<p>The Direct Care Staff have been retrained on client #7's individualized Support Plan. This includes the mechanically soft diet restrictions, the choking protocol, and meal time staffing requirements. These staff were retrained specifically on cutting up foods, prompting client #7 to slow down while eating and take smaller bites each time. Ongoing, the Program Nurse, Home Manager, and/or Program Director will complete random meal time observations to ensure that staff are properly prompting clients to slow down, take smaller bites, and are preparing food appropriately according to dining specifications for each client. Completion Date: June 7, 2013 Responsible Party: Program Nurse, Home Manager, and Program Director</p>	06/07/2013	

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	<p>the cooked spinach 1 1/2 inches long into her mouth several times without chewing or clearing her mouth before placing another bite in her mouth. At 6:08 PM client #7 picked up the plain 4" by 3" french bread and started chewing on it, using her mouth to pull and tear the bread. Client #7 was not assisted by staff #1, #2 or #3 to cut up her food prior to eating and staff did not prompt her to slow down or to take small bites.</p> <p>Client #7's records were reviewed on 05/01/13 at 11:18 AM. Client #7's record review included review of the following dated documents:</p> <p>07/26/12: Physical Examination indicated client #7 was ordered a Mechanical Soft diet.</p> <p>09/13/12: ISP (Individual Support Plan) indicated client #7 was at risk for choking and had a risk plan/choking protocol.</p> <p>02/04/13: Choking Protocol indicated client #7 was a risk for choking and preventative measures included: "1. Staff assist as needed to prepare foods to consistency as ordered. 2. Staff remind to eat at a slower rate & to swallow before another bite. 3...5. Follow Mechanical Soft Diet..."</p>						

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	<p>04/2013: Physician Orders indicated client #7 was to be on a "Mechanical Soft Diet - Encourage her to eat slowly...avoid hard rolls/breads/vegetables...."</p> <p>04/05/13: Quarterly Nutrition Assessment indicated client #7's current diet order was for a Mechanical Soft diet.</p> <p>On 05/01/13 at 2:45 PM a review of the agency's 05/16/05 document on "Diet Textures" was reviewed. The document indicated the foods on a Mechanical Soft diet were to be cut into small 1/2" pieces, raw vegetables were to be grated/finely chopped and bread was to be cut into 1" squares and soaked.</p> <p>On 05/07/13 at 1:30 PM an interview with the Area Director (AD) was conducted. The AD indicated client #7's meal should have been cut into small pieces and client #7 should have been reminded to slow down and take small bites while eating.</p> <p>9-3-8(a)</p>			