

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G418	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/13/2012
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254
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W000C	<p>This visit was for a recertification and state licensure survey.</p> <p>This visit was in conjunction with the post certification revisit (PCR) to complaint #00096573 investigated on 10/13/11.</p> <p>Survey Dates: January 9, 10, 11, 13, 2012</p> <p>Facility number: 000932 Provider number: 15G418 Aim number: 100244560</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/23/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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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W014C	<p>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 record review and interview, the facility failed for 2 of 3 client finances reviewed (#2, #3) to maintain their financial system to ensure client funds entrusted to the facility had no missing funds.</p> <p>Findings include:</p> <p>The client financial record book and cash on hand (at the group home) entrusted to the facility were reviewed on 1/11/12 at 2:38p.m. Client #2's "Petty Cash Ledger" indicated he had a current balance of \$51.96. Client #2's actual cash on hand on 1/11/12 was \$36.27 with the last documentation done on 12/22/11. Client #3's "Petty Cash Ledger" indicated client #3 had \$14.39. Client #3's actual cash on hand was \$11.95 with the last documentation during 12/11.</p> <p>Interview on 1/11/12 at 2:38p.m. of staff #2 (home manager) indicated the clients' funds entrusted to the facility and kept in the group home had not been updated since 12/11. Staff #2 indicated client transactions and receipts were not being recorded on the petty cash ledgers when the transactions had taken place. Staff #2 indicated the client actual funds on hand</p>	W0140	<p>All consumers' financial files have been reviewed and corrected. The HM received retraining on client finances including the need to ensure that all client transactions and receipts are being recorded on the petty cash records as transactions occur and the need to ensure that they are reviewing and reconciling all client financial records a minimum of weekly. For four weeks, the PD will review the petty cash ledgers weekly to ensure that all transactions are being recorded as they occur. Ongoing, the HM will review and reconcile all client financial records a minimum of weekly and record all transactions as they occur. The Program Director will review the client finances a minimum of monthly to ensure that all transactions are being recorded and reconciled accurately and in a timely manner. All client finances will be turned in monthly to the Client Financial Specialist for review. Responsible party: Home Manager, Program Director, Client Financial Specialist</p>	02/12/2012			

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	should equal the balance on the "Petty Cash Ledger." 9-3-2(a)			
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W0149	<p>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, the facility failed for 1 of 6 reportable incidents reviewed (clients #1, #4) to implement policy and procedures in regard to immediately reporting allegations of abuse to the administrator.</p> <p>Findings include:</p> <p>Record review of facility incident reports was done on 1/9/12 at 1:38p.m. The following allegation of suspected/alleged abuse was not immediately reported to the facility administrator: An incident report dated 1/4/12 indicated client #4 had informed a direct care staff on 1/2/12 that client #1 had inappropriately touched him (hugged and kissed him) on 1/2/12. The incident report indicated the program director/administrator wasn't notified until 1/3/12 of the allegation.</p> <p>Record review was done on 1/11/12 at 2:20p.m. of the facility's policy and procedures. The facility's policy titled "Report of Abuse/Neglect/Exploitation Received" (dated 5/5/06) indicated: "Staff will immediately contact the program director or on-call supervisor."</p> <p>Interview on 1/11/12 at 2:40p.m. of staff #1 (program director) indicated the facility had not followed its policy and procedures to report suspected client abuse immediately to the</p>	W0149	<p>All direct care staff working at this home will be retrained on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents. The Home Manager will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 3 times per week for 2 months to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes. After the 2 month period, the HM will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 1 time per week to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes.</p> <p>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</p>	02/12/2012			

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	<p>administrator. Staff #1 indicated facility direct care staff were aware on 1/2/12 of an inappropriate touch allegation by client #4 regarding client #1. Staff #1 indicated they were not informed of the allegation until 1/3/12. Staff #1 indicated they should have been immediately informed of the allegation on 1/2/12.</p> <p>9-3-2(a)</p>				

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W0153	<p>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.</p> <p>Based on record review and interview, the facility failed for 1 of 6 alleged abuse/neglect incidents (clients #1, #4) reviewed to immediately report allegations to the administrator.</p> <p>Findings include:</p> <p>Record review of facility incident reports was done on 1/9/12 at 1:38p.m. The following allegation of suspected/alleged abuse was not immediately reported to the facility administrator: An incident report dated 1/4/12 indicated client #4 had informed a direct care staff on 1/2/12 that client #1 had inappropriately touched him (hugged and kissed him) on 1/2/12. The incident report indicated the program director/administrator wasn't notified until 1/3/12 of the allegation.</p> <p>Staff #1 (program director) was interviewed on 1/11/12 at 2:40p.m. Staff #1 indicated facility direct care staff were aware on 1/2/12 of an inappropriate touch allegation by client #4 regarding client #1. Staff #1 indicated they were not informed of the allegation until 1/3/12. Staff #1 indicated they should have been</p>	W0153	<p>All direct care staff working at this home will be retrained on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents. The Home Manager will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 3 times per week for 2 months to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes. After the 2 month period, the HM will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 1 time per week to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes.</p> <p>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</p>	02/12/2012

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	immediately informed of the allegation on 1/2/12. 9-3-2(a)				

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W0227	<p>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 record review and interview, the facility failed for 1 non-sampled client (#4) to ensure client #4's individual support plan (ISP) had a training program in place to address the identified behavior of inappropriate touch and reporting inappropriate touch.</p> <p>Findings include:</p> <p>Facility incident reports were reviewed on 1/9/12 at 1:38p.m. A 1/4/12 incident report indicated client #4 had possibly been involved with inappropriate touching with a peer. The 1/4/12 report indicated client #4 had a history of inappropriate sexual touching.</p> <p>Record review for client #4 was done on 1/11/12 at 3:04p.m. Client #4's 4/28/11 Risk Management Plan indicated client #4 may not report sex abuse due to his past history and client #4 displays behaviors which may provoke abuse by others. Client #4's undated ISP did not indicate client #4's had a training program to address inappropriate touch.</p> <p>Staff #1 was interviewed on 1/11/12 at 3:04p.m. Staff #1 indicated client #4 had</p>	W0227	<p>Program Director will hold an IDT to assess Client #4 ability to report inappropriate sexual touching. Program Director will review Client #4 Risk Plan and ISP and develop training objectives as needed based on the Risk Plan stating that Client #4 presents with a risk for inappropriate sexual touching. The Program Director will receive retraining on QMRP responsibilities including ensuring that goals/objectives are developed as needed to ensure consumers are working on tasks that will allow them to become more independent based on the results obtained from completing comprehensive functional assessments and risk plans. Ongoing the PD will ensure that all consumers have current ISPs, goals and objectives based on the needs assessed in the Risk Plans to assist them in becoming more independent. Ongoing the Area Director will review the next 3 ISPs written by the Program Director to ensure that goals/objectives are developed ensure consumers are working on tasks that will allow them to become more independent. Responsible Party: Program Director, Area Director</p>	02/12/2012			

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	a history of inappropriate touching. Staff #1 indicated client #4 did not have a training program in place to address the identified need regarding inappropriate touching. 9-3-4(a)			
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W0368	<p>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 1 of 6 clients (#2) who received medications, to ensure each client received the medication per the current physician's orders.</p> <p>Findings include:</p> <p>The record of client #2 was reviewed on 1/11/12 at 12:07p.m. Client #2's 1/12 medication administration record (MAR) indicated client #2 was to receive Ear Drops 6.5% 5 drops each ear two times a day for 5 days, with the order ending on 1/3/12. The 1/12 MAR indicated client #2 only received the ear drops one time per day on 1/1/12 and 1/2/12. The MAR indicated client #2 then had received the ear drops on 1/4/12, 1/5/12, 1/6/12 and 1/7/12.</p> <p>Interview of staff #2 on 1/11/12 at 3:27p.m. indicated client #2 had not received his ear drops per physician orders. Staff #2 indicated the ear drops were to be given two times per day and end on 1/3/12. Staff #2 indicated the facility staff continued to give client #2 the ear drops through 1/7/12.</p> <p>9-3-6(a)</p>	W0368	<p>All direct care staff received retraining on 1/30/12 on Medication Administration which included how to document medications that are administered and what to do if a medication has been discontinued. (see attachment). The Home Manager received retraining on the need to ensure that Medication Administration Records for all clients are reviewed a minimum of weekly to ensure accuracy and completion. For 4 weeks, the Home Manager will complete Medication Administration observations at least twice weekly to ensure that staff are administering and documenting medications correctly and accurately. After the four weeks, the Home Manager will complete Medication Observations at least weekly to ensure that staff are administering and documenting medications correctly and accurately. The Home Manager will review all consumers Medication Administration Records a minimum of weekly to ensure accuracy and completion.</p> <p>Responsible Party: Home Manager, Program Director, Program Nurse</p>	02/12/2012

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W046C	<p>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 3 sampled clients (#2) to ensure client #2 received his diet (8 ounces whole milk with each meal) as ordered.</p> <p>Findings include:</p> <p>Observations were done at the group home on 1/9/12 from 4:44p.m. to 6:17p.m. and on 1/10/12 from 6:34a.m. to 8:20a.m. Client #2 ate supper at 6:02p.m. on 1/9/12 and breakfast at 7:22a.m. on 1/10/12 without receiving whole milk. During supper there was no milk on the table and during breakfast there was only low fat 2 percent milk.</p> <p>Client #2's record was reviewed on 1/11/12 at 12:07p.m. Client #2's 8/30/11 physician's orders indicated client #2 was to receive 8 ounces whole milk with every meal. The Dietician noted on 10/7/11: goal to gain weight, client #2 was to be encouraged to receive a double portion diet and 8 ounces whole milk with every meal.</p> <p>Interview of staff #1 on 1/10/12 at 6:37a.m. indicated there was no whole milk in the group home. Staff #1 indicated</p>	W0460	<p>Client #2 diet orders were changed to have him receive Ensure dietary supplement instead of whole milk since he did not care for whole milk. All Direct care staff received retraining on 1/30/12 to include ensuring that #2 received Ensure as directed on his Medication Administration Record. Staff were also retrained that if Ensure was not present in the home that they were to notify the Home Manager and/or Program Director. (see attachment) The Home Manager will receive retraining on the need to ensure that consumers have any required dietary supplements available to them in the home as directed on the consumers Medication Administration Records. For four weeks, the Home Manager and/or Program Director will complete Mealttime observations at least twice weekly to ensure that Client #2 is provided with Ensure at meals as directed by the Medication Administration records. After the 4 weeks the Home Manager and/or Program Director will complete Mealttime observations at least twice weekly to ensure that Client #2 is provided with Ensure at meals as directed by the Medication Administration records. Responsible Party: Home Manager, Program Director, Program Nurse</p>	02/12/2012			

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	client #2's current physician's orders indicated client #2 was to receive 8 ounces whole milk with every meal. 9-3-8(a)				