

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902
---	---

(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
W000000	<p>This visit was for the investigation of complaint #IN00143842.</p> <p>Complaint #IN00143842: SUBSTANTIATED, Federal/state deficiencies related to the allegations are cited at W120.</p> <p>Dates of Survey: 3/27, 4/1, and 4/3/2014.</p> <p>Provider Number: 15G282 AIM Number: 100243610 Facility Number: 000802</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed April 4, 2014 by Dotty Walton, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902			
(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			
W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on observation, record review, and interv 1 of 3 sampled clients (client A), who attended outside/contracted workshop for day services, t failed to ensure the outside workshop met clien identified need of supervision during toileting/t</p> <p>Findings include:</p> <p>On 3/27/14 at 11:45am and on 4/1/14 at 7:30pm, review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports indicated the following for client A: -A 1/20/14 BDDS report for an incident on 1/20/14 at 3:00pm indicated the facility staff "arrived at [name of day services] to pick up consumers...[Both the workshop and group home] staff were unable to locate [client A]...After 40 (forty) minutes [client A] was located (alone) in the bathroom on the toilet."</p> <p>On 3/27/14 at 1:00pm, client A was observed at the contracted workshop. Client A sat in an oversized wheelchair on a Hoyer lift sling with her right and left legs on the foot rests. Client A had continuous oxygen administered by a nasal cannula (into her nose). At 1:20pm, client A was sitting in her wheelchair as</p>	W000120	<p>Agency provides risk plans, protocols, and concerns to outside day program and aids in training with the staff to ensure proper procedures are known for client A and all other clients in services. Agency also has a communication log between agency and outside day service to be able to address any concerns. The Program director meets monthly with the day service agency to further address and issues and concerns and to ensure quality care is being maintained. The manager from mentor went to the day service to provide additional training and insight for client A's toileting and transfers. Agency also conducted observations for client A's care at the day program after the training to ensure proper procedures were being followed. The day service agency is implementing new risk plan/procedure in regards to client A toileting/transfers to ensure all staff are properly trained and aware of what to do. Day service is also resolving the buzzer issue to ensure of system is in place it goes to correct personel. Indiana Mentor is doing at least 2 manager visits per month for the next 6 months to ensure proper implementation of this and will continue with monthly</p>	05/01/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902		
(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	
	<p>described and was pushed back to her work station by the contracted workshop nurse. At 1:20pm, client A and the workshop nurse both indicated client A had been assisted from the bathroom by the nurse. At 1:20pm, client A's workshop supervisor indicated client A was assisted to and from the bathroom every two hours and more often when client A requested. At 1:20pm, client A's workshop supervisor indicated the workshop nurse now had to sign a log kept on the workshop supervisor's desk which indicated when client A was assisted to the toilet by the nurse and when client A was returned to client A's workstation. Client A's workshop supervisor indicated the log was developed after the 1/20/14 incident. The Supervisor stated client A was left alone in the bathroom "for at least 20-25 minutes or up to 40 minutes" by two workshop nursing personnel. The workshop supervisor stated client A could not be located on 1/20/14 at the workshop, "now" the workshop tracks client A's locations, when, where, and the staff responsible for client A. At 1:30pm, client A indicated she did not recall the incident details and stated "I think I fell asleep" while left sitting on the toilet.</p> <p>On 3/27/14 at 1:30pm, client A went on break and was pushed in her oversized</p>		<p>meetings with day program. Responsible Parties: Dana Langley-PD, Bona Vista Complete Date: 5/1/2014</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902
---	---

(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
--------------------	--	---------------	---	----------------------

	<p>wheelchair to the break area by her workshop supervisor. At 1:30pm, the identified bathroom in which client A was assisted to/from on 1/20/14 and 3/27/14 was observed. The bathroom was located down a short hallway from the warehouse areas. The bathroom had a buzzer beside the toilet which was activated four (4) times within a ten (10) minute time period. During this time, no staff answered the buzzer and the buzzer was not heard inside the bathroom. At 1:40pm, a maintenance person was located outside the bathroom in the warehouse area and indicated the buzzer rang at a desk behind the work areas. The maintenance person indicated if no staff were near the desk, the buzzer would not be heard.</p> <p>On 3/27/14 at 1:15pm, an interview with the workshop Registered Nurse (RN) and Licensed Practical Nurse (LPN) was conducted. The RN and LPN both indicated client A took three (3) nursing personnel to transfer her from the wheelchair to the toilet each time client A went to the bathroom. Both indicated the workshop Hoyer lift was broken, awaiting repairs and until it was repaired, client A would take three nursing personnel to transfer her. At 1:50pm, the LPN indicated the nursing staff signs client A out and in on a record to indicate</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902		
(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	
	<p>where client A was while at workshop if the nursing personnel take client A to the bathroom. The LPN indicated the bathroom buzzer sent a signal to where the nurses station used to be several months ago and no alarms/buzzers were available for client A to use while in the bathroom to summon assistance by the staff at workshop currently. The LPN indicated currently, after the three nursing personnel transfer client A to the toilet, one nurse stood outside the bathroom door, and waited for client A to verbally summon them. The LPN and the RN both indicated client A did not have a documented toileting plan for use at the workshop. Both the RN and LPN indicated no toileting plan was in place on 1/20/14 for client A. The LPN stated "it's in my head," (the plan) and indicated she needed to document client A's toileting plan. Both indicated the two discharged workshop nursing staff left client A on the toilet on 1/20/14 and neglected to assist/supervise client A. Both the RN and LPN indicated client A had been having medical issues at that time and client A needed the nursing staff at the workshop to be attentive to client A. The RN and LPN both indicated client A's medical problems included her Oxygen levels and she was admitted to the hospital for pneumonia during the period of time</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902
---	---

(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
--------------------	--	---------------	---	----------------------

	<p>around 1/20/14.</p> <p>On 3/27/14 at 2:00pm, an interview with the Lead Adult Services Coordinator (LASC) was conducted. The LASC indicated workshop staff neglected to meet client A's needs when client A was left on the toilet alone for forty minutes and she could not be located when the group home staff came to pick up client A from workshop at the end of the day. The LASC indicated client A was dependent on staff to transfer her to/from the toilet, on continuous oxygen, used a wheelchair, and could not bear weight to stand on her own.</p> <p>On 3/27/14 at 2:15pm, an interview with the LASC was conducted. The LASC indicated the two staff involved in the incident on 1/20/14 were terminated from employment and the allegation of neglect of duties was substantiated. The LASC indicated client A had no formal plan before the incident occurred on 1/20/14 for her workshop toileting needs.</p> <p>On 3/27/14 at 4:00pm, and on 4/1/14 at 8:30pm, client A's record from the group home was reviewed. The record contained Client A's 1/28/14 unsigned "Toileting Plan" which outlined a step by step method of transferring client A safely to/from her wheelchair to the toilet.</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902
---	---

(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
--------------------	--	---------------	---	----------------------

	<p>The Plan indicated "Due to the diagnosis(sic) of Cerebral Palsy and muscle spasticity. [Client A] utilizes a wheelchair for mobilization and needs the physical support of staff...to the restroom facility as well as to transfer to the toilet. [Client A] tends to refuse to assist with transfers and has a history of dropping while transferring...One Direct Support Professional will wait outside of the restroom facility door to give [client A] privacy...." Client A's 10/15/13 ISP (Individual Support Plan) and 4/26/13 "Risk Plan" both indicated client A required assistance of the facility staff to transfer and to use the restroom. Client A's 2/6/14 "Updated Individual Specifics" plan indicated "Requires assistance in the restroom...Uses wheelchair, left arm splint, and toe spacers (for mobility needs)...Falling Plan: [client A] is at risk for falling during transfers...Toileting Plan...One Direct Support Professional will wait outside of the restroom facility door...."</p> <p>On 3/27/14 at 3:50pm, an interview with the residential facility's QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client A was transferred from her wheelchair to the toilet with a Hoyer lift at the group home. The QIDP indicated she was not aware that client A could not summon</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902
---	---

(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
--------------------	--	---------------	---	----------------------

	<p>assistance using the buzzer inside the workshop bathroom. The QIDP indicated she developed the 1/28/14 "Toileting Plan" and thought the workshop had implemented client A's 1/28/14 plan after the incident of 1/20/14. The QIDP indicated client A's medical needs were not met on 1/20/14 by the contracted workshop when the incident occurred. The QIDP indicated it was unsafe to leave client A unsupervised/alone on the toilet for forty minutes. The QIDP indicated client A's 1/20/14 incident was neglectful.</p> <p>This federal tag relates to complaint #IN00143842.</p> <p>9-3-1(a)</p>			
--	---	--	--	--