

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220			
(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 an extended recertification and state licensure survey.</p> <p>Dates of survey: October 21, 24, 29, 30, 31 and November 5, 2013.</p> <p>Facility Number: 001009 Provider Number: 15G495 AIMS Number: 100244970</p> <p>Surveyor: Claudia Ramirez, RN</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed November 12, 2013 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:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

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

W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <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, for 2 of 4 sample clients (clients #2 and #3), the facility failed to maintain an accurate accounting system for each client's personal fund account.</p> <p>Findings include:</p> <p>On 10/30/13 at 11:50 AM a review of July 2013, August 2013, September 2013 and October 2013 client personal fund accounts for clients #1, #2, #3 and #4, was conducted with the QIDP (Qualified Intellectual Disabilities Professional). An interview was conducted with the QIDP on 10/30/13 at 11:55 AM. The QIDP indicated they did not track spending of clients #2 and #3's personal funds as the agency was not the representative payee. He indicated clients #2 and #3 received monthly money from the representative payee for their personal funds, the money was not tracked and there were no receipts to indicate how or when the money was spent.</p> <p>Client #2's records were reviewed on 10/30/13 at 1:40 PM. Client #2's ISP (Individual Support Plan) dated 10/28/13</p>	W000140	<p>As of November 1, 2013 client's 2 and 3 finances are being tracked each month. The team for client 2 will review and assess her ability to carry money on her at any given time. If it is decided that she is able to carry this cash on her, a specified amount will be determined. Based on the results of the team decision, the ISP and RMAP will be updated. The team for client 3 will review and assess his ability to carry money on him at any given time. If it is decided that he is able to carry this cash on him, a specified amount will be determined. Based on the results of the team decision, the ISP and RMAP will be updated. The Program Director and Home Manager will be retrained on client finances. This training will include tracking all client finances even if Indiana MENTOR is not the representative payee. Indiana MENTOR's policy and procedure for client finances include the Home Manager tracking all transactions completed by, or with assistance for, the client. This includes all petty cash that each client has, even if Indiana MENTOR is not representative payee. Once the Home Manager has balanced all transactions, the Program Director reconciles all</p>	12/05/2013
---------	---	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>indicated client #2 was not able to independently handle her money and required assistance.</p> <p>Client #3's records were reviewed on 10/30/13 at 2:35 PM. Client #3's ISP dated 08/12/13 indicated client #3 was not able to independently handle his money and required assistance.</p> <p>An interview was conducted on 10/31/13 at 3:11 PM, with the Area Director (AD). The AD indicated clients #2 and #3 were not independent in handling their money and required total assistance from the agency/staff. The AD indicated the agency should assist the clients in handling the money and all of the money should be accounted for with receipts.</p> <p>9-3-2(a)</p>		<p>accounts and turns them into the Client Finance Specialist. The Area Director will complete random quarterly finance audits, per the Indiana MENTOR policy. The Area Director will complete weekly audits on the accounts at this group home for the first 4 weeks. After the 4 weeks, the Area Director will complete monthly audits for 3 months. After the 3 months, the Area Director will complete random audits ongoing per the Indiana MENTOR policy and procedure. Ongoing, the Home Manager will balance all accounts, including petty cash, and the Program Director will reconcile all balanced accounts. Ongoing, the Area Director will complete random quarterly audits. Responsible Party: Home Manager, Program Director, Area Director Completion Date: December 5, 2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220			
(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			
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. Based on observation, record review and interview, the QIDP (Qualified Intellectual Disabilities Professional) failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 additional clients (clients #5, #6, #7 and #8) to ensure behavioral needs/objectives, drug withdrawal criteria and approvals into clients' Behavior Plans; failed to coordinate evacuation drills and accounting of client funds; and failed to monitor for implementation of training objectives, revision/update of active treatment plans, schedules and comprehensive functional assessments.</p> <p>Findings include:</p> <p>1. Please refer to W140. The QIDP failed for 2 of 4 sample clients (clients #2 and #3), to maintain an accurate accounting system for each client's personal fund account.</p> <p>2. Please refer to W227. The QIDP failed for 1 of 4 sampled clients (client #4), to ensure the client's BSP (Behavior Support Plan) addressed the client's identified behavioral needs.</p>	W000159	<p>1. Please refer to W140. As of November 1, 2013 client's 2 and 3 finances are being tracked each month. The team for client 2 will review and assess her ability to carry money on her at any given time. If it is decided that she is able to carry this cash on her, a specified amount will be determined. Based on the results of the team decision, the ISP and RMAP will be updated. The team for client 3 will review and assess his ability to carry money on him at any given time. If it is decided that he is able to carry this cash on him, a specified amount will be determined. Based on the results of the team decision, the ISP and RMAP will be updated. The Program Director and Home Manager will be retrained on client finances. This training will include tracking all client finances even if Indiana MENTOR is not the representative payee. Indiana MENTOR's policy and procedure for client finances include the Home Manager tracking all transactions completed by, or with assistance for, the client. This includes all petty cash that each client has, even if Indiana MENTOR is not representative payee. Once the Home Manager has balanced all transactions, the</p>	12/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>3. Please refer to W249. The QIDP failed for 2 of 4 sampled clients (clients #2 and 4), to implement the clients' Individual Support Plans (ISP) as written.</p> <p>4. Please refer to W250. The QIDP failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4), to implement/update and individualize the active treatment schedules (ATS).</p> <p>5. Please refer to W259. The QIDP failed for 2 of 4 sampled clients (clients #2 and #4), to ensure the comprehensive functional assessments (CFAs) were reviewed and updated annually.</p> <p>6. Please refer to W260. The QIDP failed for 1 of 4 sampled clients (client #2), to revise the Individual Support Plan (ISP) within 365 days of the previous ISP.</p> <p>7. Please refer to W263. The QIDP failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) with restrictive programs, to obtain the health care representative (HCR) or guardian's (GU) approval before implementation of a Behavioral Support Plan.</p> <p>8. Please refer to W312. The QIDP failed for 3 of 3 sampled clients (clients #1, #3 and #4) who were on medications</p>		<p>Program Director reconciles all accounts and turns them into the Client Finance Specialist. The Area Director will complete random quarterly finance audits, per the Indiana MENTOR policy. The Area Director will complete weekly audits on the accounts at this group home for the first 4 weeks. After the 4 weeks, the Area Director will complete monthly audits for 3 months. After the 3 months, the Area Director will complete random audits ongoing per the Indiana MENTOR policy and procedure. Ongoing, the Home Manager will balance all accounts, including petty cash, and the Program Director will reconcile all balanced accounts. Ongoing, the Area Director will complete random quarterly audits. 2. Please refer to W227Based on the team's recommendation, PICA will be added back into to the Behavior Support Plan for client 4. The target behavior of PICA was previously removed due to no current history of this behavior. The team felt that at the time, it was best to remove this from the plan. Client 4 does have an appropriate protocol in place as the result of the incident. An updated Behavior Support Plan will be put into place to include the revised target behavior of PICA, per the previous protocol. The Program Director will be retrained on assessments</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>related to behaviors, by not ensuring the clients' Behavior Support Plan (BSP) included the medication or a titration plan for the medications in the plan.</p> <p>9. Please refer to W440. The QIDP failed for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7 and #8) who resided in the home, by not ensuring an evacuation drill was conducted at least every 90 days on the day shift.</p> <p>On 10/31/13 at 3:11 PM an interview was conducted with the AD (Area Director). The AD indicated the QIDP failed in the following areas: to maintain accurate accounting systems for client personal funds; to ensure BSPs contained identified client behaviors; to implement the clients ISPs as written; to implement/update ATSS to ensure the CFAs were reviewed and updated annually; to ensure ISPs were reviewed annually; to obtain the HCR or GU's approval before implementation of a BSP; to ensure the BSPs contained titration plans and to ensure evacuations drills were conducted on the day shifts.</p> <p>9-3-3(a)</p>		<p>and protective measures being out into place as the result of each incident. These assessments will include meeting with the team to discuss revising the High Risk Plan, the Individualized Support Plan, and the Behavior Support Plan, all as needed. Ongoing, per Indiana MENTOR procedures, all Behavior Support Plans will be approved by the individuals team, and the followed up by an approval from the Human Rights Committee. Both areas will review the plans in detail to discuss the target behaviors that are listed, and to ensure that all targets are included and appropriate, with a plan to reduce in the least restrictive manner. 3. Please refer to W249 All staff will be retrained on client #3's medication administration goals. This retraining will include running goals formally and informally to ensure that the clients are receiving the best possible care. The Home Manager and/or Program Director will complete medication administration observations 3 times a week for the first 4 weeks. After the 4 initial weeks, the Home Manager and/or Program Director will complete 2 medication administration observations per week for 3 weeks. Ongoing, the Home Manager and/or Program Director will continue to complete weekly (once a week) random medication administration</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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>observation. In completing these observations, the Home Manager and/or Program Director will ensure that staff correctly completes medication administration for each client. In times of error, the staff will receive additional training. All staff will be retrained on client #3's medication administration goals. This retraining will include running goals formally and informally to ensure that the clients are receiving the best possible care. The Home Manager and/or Program Director will complete medication administration observations 3 times a week for the first 4 weeks. After the 4 initial weeks, the Home Manager and/or Program Director will complete 2 medication administration observations per week for 3 weeks. Ongoing, the Home Manager and/or Program Director will continue to complete weekly (once a week) random medication administration observation. In completing these observations, the Home Manager and/or Program Director will ensure that staff correctly completes medication administration for each client. In times of error, the staff will receive additional training. 4. Please refer to W250 The Program Director will complete an Active Treatment schedule for client's 1, 2, 3, 4, 5, 6, 7, and 8. The Program Director will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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	
			retrained on Active Treatment schedules. This retraining will include how to complete them, what is to be including, how often to review them, and the follow up and training of staff when it pertains to the Active Treatment schedules for each client. The Program Director and/or Home Manager will retrain all Direct Support Staff on the new Active Treatment schedules. This training will include where these schedules can be found, how it applies to the direct care staff, how to implement, and the client specifics of each plan. The Home Manager and/or Program Director will complete active treatment observations 3 times a week for the first 4 weeks. After the 4 initial weeks, the Home Manager and/or Program Director will complete 2 active treatment observations per week for 3 weeks. Ongoing, the Home Manager and/or Program Director will continue to complete weekly (once a week) random active treatment observations. In completing these observations, the Home Manager and/or Program Director will ensure that staff correctly completes active treatment for each client. In times of error, the staff will receive additional training. 5. Please refer to W259 The Program Director and Home Manager will work to complete CFAs for client's 1, 2, 3, 4, 5, 6, 7, and 8. The Program Director and Home		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>Manager will be retrained on completing CFAs for all clients. This training will include the importance of these CFA's, the reason for them, how to complete them, and when to complete them. Ongoing, the Area Director will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter. 6. Please refer to W260 The Program Director will work with the team to ensure that Client 2's ISP is up to date and does not exceed the annual due date in future years. The Program Director will be retrained on ensuring that Individualized Support Plans are completed on time, and do not exceed the 365 day timeframe. The Program Director will review ISPs for clients 1, 3, 4, 5, 6, 7, and 8 to ensure none are outdated. If outdated, the Program Director will work with the teams to get them caught up. Ongoing, the Area Director will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter. 7. Please refer to W263 The Program Director will obtain consent for client 1's medication regimen. Obtaining consent includes reviewing the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>medication, side effects, dosage, and reasons for the medication with the guardian. The guardian will then approve of this medication. Along with approving the specific medication regimen, the Program Director will also assist the guardian with reviewing the usage for the medication, by reviewing the Behavior Support Plan that describes the target behaviors. All behavior support plans require guardian and Human Rights Committee approvals before implementation. The Program Director will obtain consent for client 2's medication regimen. Obtaining consent includes reviewing the medication, side effects, dosage, and reasons for the medication with the guardian. The guardian will then approve of this medication. Along with approving the specific medication regimen, the Program Director will also assist the guardian with reviewing the usage for the medication, by reviewing the Behavior Support Plan that describes the target behaviors. All behavior support plans require guardian and Human Rights Committee approvals before implementation. The Program Director will obtain consent for client 2's medication regimen. Obtaining consent includes reviewing the medication, side effects, dosage, and reasons for the medication with the guardian. The guardian will then approve of this medication. Along with approving the specific medication regimen, the Program Director will also assist the guardian with reviewing the usage for the medication, by reviewing the Behavior Support Plan that describes the target behaviors. All behavior support plans require guardian and Human Rights Committee approvals before implementation. The Program Director will obtain consent for client 3's medication regimen. Obtaining consent includes reviewing the medication, side effects, dosage, and reasons for the medication with the guardian. The guardian will then approve of this</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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>medication. Along with approving the specific medication regimen, the Program Director will also assist the guardian with reviewing the usage for the medication, by reviewing the Behavior Support Plan that describes the target behaviors. All behavior support plans require guardian and Human Rights Committee approvals before implementation. The Program Director will obtain consent for client 4's medication regimen. Obtaining consent includes reviewing the medication, side effects, dosage, and reasons for the medication with the guardian. The guardian will then approve of this medication. Along with approving the specific medication regimen, the Program Director will also assist the guardian with reviewing the usage for the medication, by reviewing the Behavior Support Plan that describes the target behaviors. All behavior support plans require guardian and Human Rights Committee approvals before implementation. The Program Director will be retrained on obtaining the appropriate approvals for the psychotropic medications and the Behavior Support Plan that includes these medication regimens. These are to be obtained at the annual meetings, and reviewed no less than quarterly, but more as needed, per Indiana MENTOR policy. The Area Director will audit 2 books a</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>week for the first 4 weeks. After the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter. 8. Please refer to W312 The Behavior Consultant will review all Behavior Support Plans of clients 1, 3, and 4 to address the recommendations of the titration plans that are included. The titration plan for client 1 will be reviewed and rewritten to include a measurable data and to determine what measurable component will be used to indicate a 75% improvement rate. Once this is determined a new, more specific titration plan will be included with this behavior support plan. The titration plan for client 3 will be reviewed and rewritten to include a measurable data and to determine what measurable component will be used to indicate a 75% improvement rate. Once this is determined a new, more specific titration plan will be included with this behavior support plan. The titration plan for client 4 will be reviewed and rewritten to include a measurable data and to determine what measurable component will be used to indicate a 75% improvement rate. Once this is determined a new, more specific titration plan will be included with this behavior support plan. The Behavior Consultant will review the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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	
			Behavior Support Plans for clients 2, 5, 6, 7, and 8, to ensure that all other titration plans are made more specific and include a measurable component and able to show a 75% improvement rate. All Behavior Support Plans will continue to be reviewed by the team and the Human Rights Committee for approval before implementation. The Area Director will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter. 9. Please refer to W440 The Direct Support Staff will be retrained on Indiana MENTOR's policy and Procedures for completing the monthly fire drills. The Home Manager and/or Program Director will work together to ensure that all staff have access to Indiana MENTOR's schedule for all expected fire drill dates and times. The Home Manager and/or Program Director will review all completed fire drills to ensure that they are completed correctly, at the right time, on the right day, and within the right timeframe, among other things. Responsible Party: Home Manager, Program Director, Area Director Director Completion Date: December 5, 2013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220			
(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			
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. Based on record review and interview for 1 of 4 sampled clients (client #4), the client's BSP (Behavior Support Plan) failed to address the client's identified behavioral needs.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records from 10/01/12 to 10/20/13 were reviewed on 10/21/13 at 11:44 AM.</p> <p>A 02/13/13 BDDS (Bureau of Developmental Disabilities Services) report of an incident on 02/12/13 at 11:00 AM indicated, "On 02/12/13. [client #4] had a colonoscopy in [name of hospital]. During the colonoscopy [client #4] was under sedation. During the procedure the Dr.'s (doctors) (sic) some concern as they found a tooth pick in his colon. Dr's (sic) say no damage occurred while the tooth picks (sic) was in his colon, and they are not sure how long it was in there. Dr.'s (sic) had no problem removing the tooth pick, and the rest if (sic) the procedure went accordingly (sic). [Client #4] is fine, and Dr.'s (sic) recommended [client</p>	W000227	Based on the team's recommendation, PICA will be added back into to the Behavior Support Plan for client 4. The target behavior of PICA was previously removed due to no current history of this behavior. The team felt that at the time, it was best to remove this from the plan. Client 4 does have an appropriate protocol in place as the result of the incident. An updated Behavior Support Plan will be put into place to include the revised target behavior of PICA, per the previous protocol. The Program Director will be retrained on assessments and protective measures being put into place as the result of each incident. These assessments will include meeting with the team to discuss revising the High Risk Plan, the Individualized Support Plan, and the Behavior Support Plan, all as needed. Ongoing, per Indiana MENTOR procedures, all Behavior Support Plans will be approved by the individuals team, and the followed up by an approval from the Human Rights Committee. Both areas will review the plans in detail to discuss the target behaviors that are listed,	12/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>#4] (sic) on a High fiber Diet and prescribe (sic) an over the counter citra cell (sic) to continue better health...." A follow-up BDDS report dated 02/15/13 indicated, "We do not know if [client #4] swallowed the toothpick intentionally or not. [Client #4] does have a history of chewing on his clothes, but never issued any PICA (eating non-edible objects) concerns. As of 02/15/13 a PICA protocol has been developed for [client #5] and (sic) waiting for the approval for his guardian to approve the new PICA protocol...."</p> <p>Client #4's records were reviewed on 10/30/13 at 3:30 PM. Client #4's BSP dated 01/23/13 indicated client #4's behaviors included self-injurious behavior and pulls/chews on shirt. The BSP did not include PICA behavior. Client #4's prior BSP dated 01/23/12 indicated client #4's behaviors included PICA.</p> <p>On 10/31/13 at 3:11 PM an interview was conducted with the Area Director (AD). The AD indicated she did not know why the PICA behavior had been removed from client #4's BSP and since he had a history of the behavior it should have been included in the current 01/23/13 BSP. She indicated the current plan needed to be updated to include this behavior.</p>		<p>and to ensure that all targets are included and appropriate, with a plan to reduce in the least restrictive manner. Responsible Party: Home Manager, Program Director, Area Director Completion Date: December 5, 2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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
	9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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	
W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed for 2 of 4 sampled clients (clients #2 and 4), to implement the clients' Individual Support Plans(ISP) as written.</p> <p>Findings include:</p> <p>1. Observations were conducted in the group home on 10/29/13 from 4:15 PM until 5:45 PM and staff #1, #2 and the House Manager were on duty. The observation included a 5:00 PM medication administration. At 4:39 PM staff #1 prepared client #3's medications and administered the medications at 5:33 PM through client #3's G-tube (gastrostomy tube). Staff #1 did not prompt client #3 to clean the G-tube site after the medication administration.</p> <p>Client #3's records were reviewed on 10/30/13 at 2:35 AM. Client #3's ISP dated 08/12/13 included the following goal: "After the medication pass (sic) over, [client #3] will clean around his</p>	W000249	All staff will be retrained on client #3's medication administration goals. This retraining will include running goals formally and informally to ensure that the clients are receiving the best possible care. The Home Manager and/or Program Director will complete medication administration observations 3 times a week for the first 4 weeks. After the 4 initial weeks, the Home Manager and/or Program Director will complete 2 medication administration observations per week for 3 weeks. Ongoing, the Home Manager and/or Program Director will continue to complete weekly (once a week) random medication administration observation. In completing these observations, the Home Manager and/or Program Director will ensure that staff correctly completes medication administration for each client. In times of error, the staff will receive additional training. All staff will be retrained on client #3's medication administration goals. This retraining will include	12/05/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220			
(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>G-tube...." Client #3 did not clean around the G-tube.</p> <p>On 10/31/13 at 3:11 PM an interview with the Area Director (AD) was conducted. The AD indicated staff #1 should have implemented client #3's goal as written.</p> <p>2. Observations were conducted in the group home on 10/29/13 from 4:15 PM until 5:45 PM and staff #1, #2 and the House Manager were on duty. The observation included a 5:00 PM medication administration. At 5:03 PM staff #1 prepared client #4's medications while client #4 was in the medication room. Staff #1 opened the medication room door and called out into the kitchen that she needed some water for client #4. Staff #2 brought a glass of water to the door and handed it to staff #1. Client #4 was not observed to obtain water for his medications.</p> <p>Client #4's records were reviewed on 10/30/13 at 3:30 PM. Client #4's ISP dated 10/23/12 included the following goal: "At medication times, [client #4] will get his own water to take his medications with...." Client #4 did get his own water.</p> <p>On 10/31/13 at 3:11 PM an interview</p>		<p>running goals formally and informally to ensure that the clients are receiving the best possible care. The Home Manager and/or Program Director will complete medication administration observations 3 times a week for the first 4 weeks. After the 4 initial weeks, the Home Manager and/or Program Director will complete 2 medication administration observations per week for 3 weeks. Ongoing, the Home Manager and/or Program Director will continue to complete weekly (once a week) random medication administration observation. In completing these observations, the Home Manager and/or Program Director will ensure that staff correctly completes medication administration for each client. In times of error, the staff will receive additional training. Responsible Party: Home Manager, Program Director, Area Director Completion Date: December 5, 2013</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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	
	with the Area Director (AD) was conducted. The AD indicated staff #1 should have implemented client #4's goal as written.  9-3-4(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220			
(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			
W000250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on record review and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4), to implement/update and individualize their active treatment schedules (ATS).</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 10/30/13 at 12:06 PM. The ATS in the record was dated 11/20/10.</p> <p>Client #2's records were reviewed on 10/30/13 at 1:40 PM. The ATS in the record was dated 11/20/10.</p> <p>Client #3's records were reviewed on 10/30/13 at 2:35 PM. The record did not contain an ATS.</p> <p>Client #4's records were reviewed on 10/30/13 at 3:30 PM. The ATS in the record was dated 11/20/10.</p> <p>On 10/31/13 at 3:11 PM an interview with the Area Director (AD) was conducted. The AD indicated the ATS was to be updated along with the ISP (Individual Support Plan). She indicated</p>	W000250	The Program Director will complete an Active Treatment schedule for client's 1, 2, 3, 4, 5, 6, 7, and 8. The Program Director will be retrained on Active Treatment schedules. This retraining will include how to complete them, what is to be including, how often to review them, and the follow up and training of staff when it pertains to the Active Treatment schedules for each client. The Program Director and/or Home Manager will retrain all Direct Support Staff on the new Active Treatment schedules. This training will include where these schedules can be found, how it applies to the direct care staff, how to implement, and the client specifics of each plan. The Home Manager and/or Program Director will complete active treatment observations 3 times a week for the first 4 weeks. After the 4 initial weeks, the Home Manager and/or Program Director will complete 2 active treatment observations per week for 3 weeks. Ongoing, the Home Manager and/or Program Director will continue to complete weekly (once a week) random active treatment observations. In completing these observations,	12/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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 ATS in the records were outdated for clients #1, #2 and #4 and there was no ATS for client #3.</p> <p>9-3-4(a)</p>		<p>the Home Manager and/or Program Director will ensure that staff correctly completes active treatment for each client. In times of error, the staff will receive additional training. Responsible Party: Home Manager, Program Director, Area Director Completion Date: December 5, 2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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	
W000259	<p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on interview and record review for 2 of 4 sampled clients (clients #2 and #4), the facility failed to ensure the comprehensive functional assessment (CFA) was reviewed and updated annually.</p> <p>Findings include:</p> <p>Client #2's records were reviewed on 10/30/13 at 1:40 PM. The CFA was dated 10/01/11.</p> <p>Client #4's records were reviewed on 10/30/13 at 3:30 PM. The CFA was dated 07/20/07.</p> <p>On 10/31/13 at 3:11 PM an interview with the Area Director (AD) was conducted. The AD indicated the CFAs are to be updated annually and these were not completed in the annual time frame.</p> <p>9-3-4(a)</p>	W000259	<p>The Program Director and Home Manager will work to complete CFAs for client's 1, 2, 3, 4, 5, 6, 7, and 8. The Program Director and Home Manager will be retrained on completing CFAs for all clients. This training will include the importance of these CFA's, the reason for them, how to complete them, and when to complete them. Ongoing, the Area Director will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter. Responsible Party: Home Manager, Program Director, Area Director Completion Date: December 5, 2013</p>	12/05/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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	
W000260	<p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on interview and record review for 1 of 4 sampled clients (client #2), the QIDP (Qualified Intellectual Disabilities Professional) failed to revise the Individual Support Plan (ISP) within 365 days of the previous ISP.</p> <p>Findings include:</p> <p>Client #2's records were reviewed on 10/30/13 at 1:40 PM. Client #2's ISP was dated 10/10/12.</p> <p>On 10/31/13 at 3:11 PM an interview with the Area Director (AD) was conducted. The AD indicated the ISPs were to be completed within 365 days of the previous ISP. She indicated client #2's ISP had taken place on 10/28/13. She indicated the ISP was not timely.</p> <p>9-3-4(a)</p>	W000260	<p>The Program Director will work with the team to ensure that Client 2's ISP is up to date and does not exceed the annual due date in future years. The Program Director will be retrained on ensuring that Individualized Support Plans are completed on time, and do not exceed the 365 day timeframe. The Program Director will review ISPs for clients 1, 3, 4, 5, 6, 7, and 8 to ensure none are outdated. If outdated, the Program Director will work with the teams to get them caught up. Ongoing, the Area Director will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter.</p> <p>Responsible Party: Home Manager, Program Director, Area Director Completion Date: December 5, 2013</p>	12/05/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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	
W000263	<p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; 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 (GU) approval before implementation of a Behavioral Support Plan for 4 of 4 sampled clients (clients #1, #2, #3 and #4) with restrictive programs.</p> <p>Findings include:</p> <p>1. Client #1's records were reviewed on 10/30/13 at 12:06 PM. Client #1's record indicated client #1 had a guardian. Client #1's BSP dated 01/11/13 indicated client #1's behaviors included resistance to instruction, incontinence and anxiety during appointments. The BSP indicated client #1 was on the following medications for the behaviors: Venlafaxine (anti-depressant), Lithium (mood stabilization) and Clozapine (anti-psychotic). The BSP did not indicate written informed consent was obtained from client #1's GU for the BSP.</p> <p>On 10/31/13 at 3:11 PM an interview was conducted with the Area Director (AD). The AD indicated client #1's BSP was not</p>	W000263	<p>The Program Director will obtain consent for client 1's medication regimen. Obtaining consent includes reviewing the medication, side effects, dosage, and reasons for the medication with the guardian. The guardian will then approve of this medication. Along with approving the specific medication regimen, the Program Director will also assist the guardian with reviewing the usage for the medication, by reviewing the Behavior Support Plan that describes the target behaviors. All behavior support plans require guardian and Human Rights Committee approvals before implementation. The Program Director will obtain consent for client 2's medication regimen. Obtaining consent includes reviewing the medication, side effects, dosage, and reasons for the medication with the guardian. The guardian will then approve of this medication. Along with approving the specific medication regimen, the Program Director will also assist the guardian with reviewing the usage for the medication, by reviewing the Behavior Support Plan that describes the target behaviors. All behavior support</p>	12/05/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220			
(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>signed by the GU.</p> <p>2. Client #2's records were reviewed on 10/30/13 at 1:40 PM. Client #2's record indicated client #2 had a HCR. Client #2's BSP dated 01/16/13 indicated client #2's behaviors included bossing, gossiping, temper outbursts and verbal aggression. The BSP indicated client #2 was on the following medications for seizures and behaviors: Clorazepate and Tegretol. The BSP did not indicate written informed consent was obtained from client #2's HCR for the BSP.</p> <p>On 10/31/13 at 3:11 PM an interview was conducted with the Area Director (AD). The AD indicated client #2's BSP was not signed by the HCR.</p> <p>3. Client #3's records were reviewed on 10/30/13 at 2:35 PM. Client #3's record indicated client #3 had a GU. Client #3's BSP dated 08/13/13 indicated client #3's behaviors included aggressive outburst, physical aggression, taking others' property without permission, negative self talk and vacating. The BSP indicated client #3 was on the following medications for the behaviors: Diazepam (anti-anxiety), Lamotrigine (mood stabilizer) and Carbamazepine (anti-convulsant/mood stabilizer). The BSP did not indicate written informed</p>		<p>plans require guardian and Human Rights Committee approvals before implementation. The Program Director will obtain consent for client 3's medication regimen. Obtaining consent includes reviewing the medication, side effects, dosage, and reasons for the medication with the guardian. The guardian will then approve of this medication. Along with approving the specific medication regimen, the Program Director will also assist the guardian with reviewing the usage for the medication, by reviewing the Behavior Support Plan that describes the target behaviors. All behavior support plans require guardian and Human Rights Committee approvals before implementation. The Program Director will obtain consent for client 4's medication regimen. Obtaining consent includes reviewing the medication, side effects, dosage, and reasons for the medication with the guardian. The guardian will then approve of this medication. Along with approving the specific medication regimen, the Program Director will also assist the guardian with reviewing the usage for the medication, by reviewing the Behavior Support Plan that describes the target behaviors. All behavior support plans require guardian and Human Rights Committee approvals before implementation. The Program Director will be</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>consent was obtained from client #3's GU for the BSP.</p> <p>On 10/31/13 at 3:11 PM an interview was conducted with the Area Director (AD). The AD indicated client #3's BSP was not signed by the GU.</p> <p>4. Client #4's records were reviewed on 10/30/13 at 3:30 PM. Client #4's record indicated client #4 had a HCR. Client #4's BSP dated 01/23/13 indicated client #4's behaviors included self-injurious behavior and pulls/chews on shirt. The BSP indicated client #4 was on the following medications for the behaviors: Sertraline (anti-anxiety). The BSP did not indicate written informed consent was obtained from client #4's HCR for the BSP.</p> <p>On 10/31/13 at 3:11 PM an interview was conducted with the Area Director (AD). The AD indicated client #4's BSP was not signed by the HCR.</p> <p>9-3-4(a)</p>		<p>retrained on obtaining the appropriate approvals for the psychotropic medications and the Behavior Support Plan that includes these medication regimens. These are to be obtained at the annual meetings, and reviewed no less than quarterly, but more as needed, per Indiana MENTOR policy. The Area Director will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter. Responsible Party: Home Manager, Program Director, Area Director Completion Date: December 5, 2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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	
W000312	<p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #3 and #4) who were on medications related to behaviors, by not ensuring the clients' Behavior Support Plan (BSP) included a titration plan for the medications in the plan.</p> <p>Findings include:</p> <p>1. Client #1's records were reviewed on 10/30/13 at 12:06 PM. Client #1's BSP dated 01/11/13 indicated client #1's behaviors included resistance to instruction, incontinence and anxiety during appointments. The BSP indicated client #1 was on the following medications for the behaviors: Venlafaxine (anti-depressant), Lithium (mood stabilization) and Clozapine (anti-psychotic). The BSP's Description of criteria for medication reduction indicated, "Recommendations for medication review will be based upon data collected through program data forms. Recommendations will be based on data indicating significant, sustained</p>	W000312	<p>The Behavior Consultant will review all Behavior Support Plans of clients 1, 3, and 4 to address the recommendations of the titration plans that are included. The titration plan for client 1 will be reviewed and rewritten to include a measurable data and to determine what measurable component will be used to indicate a 75% improvement rate. Once this is determined a new, more specific titration plan will be included with this behavior support plan. The titration plan for client 3 will be reviewed and rewritten to include a measurable data and to determine what measurable component will be used to indicate a 75% improvement rate. Once this is determined a new, more specific titration plan will be included with this behavior support plan. The titration plan for client 4 will be reviewed and rewritten to include a measurable data and to determine what measurable component will be used to indicate a 75% improvement rate. Once this is determined a new, more specific titration plan will be included with this behavior support plan. The Behavior</p>	12/05/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220			
(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>reduction in behavior (e.g. (example): at least 75% improvement in rate, duration or intensity of behaviors to increase lasting no less than 6 consecutive months...." The BSP did not contain a measurable component to determine what the rate was in order to calculate a, "75% improvement in rate." The BSP did not contain a measurable titration plan.</p> <p>On 10/31/13 at 3:11 PM an interview was conducted with the Area Director (AD). The AD indicated client #1's BSP should contain a measurable titration plan.</p> <p>2. Client #3's records were reviewed on 10/30/13 at 2:35 PM. Client #3's BSP dated 08/13/13 indicated client #3's behaviors included aggressive outburst, physical aggression, taking others' property without permission, negative self talk and vacating. The BSP indicated client #3 was on the following medications for the behaviors: Diazepam (anti-anxiety), Lamotrigine (mood stabilizer) and Carbamazepine (anti-convulsant/mood stabilizer). The BSP did not contain a titration plan.</p> <p>On 10/31/13 at 3:11 PM an interview was conducted with the Area Director (PD). The AD indicated client #3's BSP should contain a titration plan.</p>		<p>Consultant will review the Behavior Support Plans for clients 2, 5, 6, 7, and 8, to ensure that all other titration plans are made more specific and include a measurable component and able to show a 75% improvement rate. All Behavior Support Plans will continue to be reviewed by the team and the Human Rights Committee for approval before implementation. The Area Director will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter. Responsible Party: Home Manager, Program Director, Area Director Completion Date: December 5, 2013</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>3. Client #4's records were reviewed on 10/30/13 at 3:30 PM. Client #4's BSP dated 01/23/13 indicated client #4's behaviors included self-injurious behavior and pulls/chews on shirt. The BSP indicated client #4 was on the following medications for the behaviors: Sertraline (anti-anxiety). The BSP's Description of criteria for medication reduction indicated, "Recommendations for medication review will be based upon data collected through program data forms. Recommendations will be based on data indicating significant, sustained reduction in behavior (e.g. (example): at least 75% improvement in rate, duration or intensity of behaviors to increase lasting no less than 6 consecutive months...." The BSP did not contain a measurable component to determine what the rate was in order to calculate a, "75% improvement in rate." The BSP did not contain a measurable titration plan.</p> <p>On 10/31/13 at 3:11 PM an interview was conducted with the Area Director (AD). The AD indicated client #4's BSP should contain a measurable titration plan.</p> <p>9-3-5(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220			
(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			
W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Health Care Services for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 1 additional client (client #6). The facility's health care services failed to ensure each clients' nursing needs were met by neglecting to ensure medical tests, risk plans and diagnostic evaluations were completed. The facility's health care services failed to train staff regarding G-tube (gastrostomy tube) medication administration and failed to ensure medical screening, and consultant recommendations and dietary measures were implemented. The facility's health care services failed to ensure pharmacy and nursing assessments were completed quarterly, failed to ensure controlled drugs were secure and failed to dispenses drugs without error per MD (medical doctor) orders.</p> <p>Findings include:</p> <p>1. Please refer to W323. The facility nursing services failed for 2 of 4 sampled clients (clients #1 and #4) to have an annual hearing screening examination.</p>	W000318	Please review W323 The particular primary care physician for clients 1 and 4 completes all documentation and paperwork orally via dictation. His office then faxes a report to the Program Nurse regarding the outcome of the appointment. The Program Nurse will then be responsible for ensuring that this paperwork, along with Indiana MENTOR's annual physical form, is included in each client's annual appointment book and permanent historical files. The Program Nurse will be retrained on Indiana MENTOR's annual physical form. This training will include the importance of all components of this form being completed, and ensuring that the doctor reviews all areas during the annual physical, including but not limited to the annual hearing screening. This retraining will also include the importance of the appropriate documentation to be included in the annual physical appointment, and that all concerns are followed up on. The Program Nurse will be retrained on ensuring that all paperwork is filed appropriately in each client's personal file for future review and usage. The Area Director and/or Clinical Supervisor will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area	12/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>2. Please refer to W331. The facility nursing services failed for for 4 of 4 sampled clients (clients #1, #2, #3 and #4), by not ensuring clients received nursing services according to their medical needs: by failing to obtain monthly blood tests for client #1; by failing to obtain an updated PT (Physical Therapy) Evaluation after a series of falls for client #1; by failing to ensure client #1 obtained an annual hearing evaluation; by failing to update risk plans and include specific information for clients #1, #2, #3 and #4; by failing to obtain updated Dexascans for clients #2 and #4; by failing to ensure client #2's dental health recommendations were addressed to use a power toothbrush and timer; by failing to add recommended dietary information to the MAR (Medication Administration Record) for client #3; by failing to add specific G-tube medication administration guidelines to the MAR for client #3; by failing to calculate and document calorie intake for client #3 per dietary recommendations; and by failing to administer medication as ordered for client #3 after a seizure medication was ordered to be increased.</p> <p>3. Please refer to W336. The facility nursing services failed for 3 of 4 sampled clients (clients #1, #2 and #4), to conduct quarterly nursing assessments of the</p>		<p>Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter. Please review W331 The Program Nurse will work with the Home Manager to ensure that client 1 completes his monthly labs, as prescribed by the doctor, ongoing/as needed. The Program Nurse will then ensure that all results of these labs are filed in the appropriate medical file for client 1. The Program Nurse will work to obtain a PT evaluation for client 1 due to a series of previous falls. The Program Nurse will then ensure that all results are filed in the appropriate medical file for client 1. The Program Nurse will retrieve the supporting documentation to show that client 1 did have a completed hearing examination at the time of his annual physical. The Program Nurse will then ensure that all results are filed in the appropriate medical file for client 1. The Program Nurse will review all protocols/high risk plans for clients 1, 2, 3, and 4. These will be all be updated to include new information. The Program Nurse will be retrained on completing protocols/high risk plans. This retraining will include the appropriate tools for completing these forms and how often to review and revise them. The Program Nurse will work to get a completed Dexascan for client 2 and 4. The</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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>clients' health status and medical needs.</p> <p>4. Please refer to W340. The facility nursing services failed for 1 of 1 sampled client (client #3) who received liquid medications given by G-tube (gastrostomy) to ensure staff were trained in health care for proper medication administration.</p> <p>5. Please refer to W362. The facility nursing services failed for 2 of 4 sampled clients (clients #1 and #2), to have a quarterly pharmacist review completed in a timely fashion.</p> <p>6. Please refer to W368. The facility nursing services failed for 1 of 4 sampled clients (client #1) and 1 additional client (client #6), who take medications prescribed by the physician, to administer medications as ordered.</p> <p>7. Please refer to W369. The facility nursing services failed for 1 of 18 medication doses administered at the 5:00 PM medication administration, to follow physician orders for administering medication to 1 of 1 sample client (client #3).</p> <p>8. Please refer to W381. The facility nursing services failed for 1 of 2 sampled clients (client #2) who took a controlled</p>		<p>Program Nurse will then ensure that all results are filed in the appropriate medical file for clients 2 and 4. The Program Director and/or Home Manager will ensure that a new power toothbrush and timer is purchased for client 2, as recommended by the dentist. The Program Director will work with the team to implement a new program for the use of the power toothbrush and the timer. The Program Nurse, Home Manager, and Program Director will be retrained on ensuring follow up to all appointments is discussed with the team and completed within the recommended timeframe.</p> <p>The Program Nurse will add the recommended dietary information to client 3's Medication Administration Record. The Program Nurse will add specific G-Tube medication administration guidelines to the MAR for client 3. The Program Nurse will put documentation in place to assist staff with implementing and documenting calorie intake for 3, per the dietary recommendations. The Program Nurse will ensure that the increase in seizure medication was implemented through appropriate measures. Please review W336 The Program Nurse will be retrained on Indiana MENTOR's policy and procedure regarding the Quarterly Nursing Assessments. This training will include, but is not limited to, completing, tracking,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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	
	substance medication prescribed by the physician, to ensure controlled substances were double locked.  9-3-6(a)		implementing, and following up on the results of the assessments. The Program Nurse states that all Quarterly Nursing Assessments for September 2013 were completed, however, not filed. The Program Nurse will file all past paperwork. The Program Nurse will be retrained on Indiana MENTOR's policy on documentation. This training will include, but is not limited to, completing the nursing documentation per the Program Nurse job responsibilities, but also filing the paperwork in the appropriate place according to the Medical Files Table of Contents. The Program Nurse will complete the Quarterly Nursing Assessments for December 2013 for clients 1, 2, 3, 4, 5, 6, 7, and 8. The Program Nurse will ensure that all documentation to support these completed assessments is in the file on or before the 10th of the following month. The Area Director and/or Clinical Supervisor will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter. Please review W340 The Direct Support Staff (DSPs) will be retrained on medication administration as it pertains to client 3's G-tube and the protocol that accompanies it.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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>This will include checking the placement of the tube, utilizing the appropriate amount of fluid to ensure accuracy, what medications to pass and when, and what to do if issues arise (who to contact). In order to ensure that staff are completing the medication administration appropriately, the Program Nurse and/or Home Manager, will complete medication administration observations. 3 weekly observations will occur within the first 4 weeks. After the first 4 weeks, observations will be completed twice a week for 3 weeks. After the remaining 3 weeks, observations will occur no less than once a week, per Indiana MENTOR policy and procedures. Please review W362</p> <p>The quarterly pharmacy reviews were completed in September 2013, according to the schedule, as planned, however the pharmacy failed to document the visit as expected. The Program Nurse will be retrained on the expectation of nursing follow up after each quarterly review. The Home Manager will be retrained on assisting the nurse with the follow up that is needed due to the quarterly pharmacy assessments. The Area Director and/or Clinical Supervisor will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>Director will audit 1 book a quarter. Please review W368</p> <p>The Direct Support Staff (DSPs) will be retrained on medication administration. This training will include, Indiana MENTOR's policy and procedure for passing medications, the documentation showing the medication has been passed, and who to report issues to and when. In order to ensure that staff are completing the medication administration appropriately, the Program Nurse and/or Home Manager, will complete medication administration observations. 3 weekly observations will occur within the first 4 weeks. After the first 4 weeks, observations will be completed twice a week for 3 weeks. After the remaining 3 weeks, observations will occur no less than once a week, per Indiana MENTOR policy and procedures. Please review W369</p> <p>The Direct Support Staff (DSPs) will be retrained on medication administration. This training will include, Indiana MENTOR's policy and procedure for passing medications, the documentation showing the medication has been passed, and who to report issues to and when. In order to ensure that staff are completing the medication administration appropriately, the Program Nurse and/or Home Manager, will complete medication administration observations. 3 weekly observations will occur</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>within the first 4 weeks. After the first 4 weeks, observations will be completed twice a week for 3 weeks. After the remaining 3 weeks, observations will occur no less than once a week, per Indiana MENTOR policy and procedures. Please review W381 The Direct Support Staff (DSPs) will be retrained on Indiana MENTOR's policy and procedure for double locking all controlled medications. This training will include the importance of this, and what to do should this present a problem with being completed. In order to ensure that staff are keeping all medications locked up appropriately, the Program Nurse and/or Home Manager, will complete medication administration observations. 3 weekly observations will occur within the first 4 weeks. After the first 4 weeks, observations will be completed twice a week for 3 weeks. After the remaining 3 weeks, observations will occur no less than once a week, per Indiana MENTOR policy and procedures. Responsible Party: Program Nurse, Area Director, and/or Clinical Supervisor Completion Date: December 5, 2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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	
W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (clients #1 and #4) to have an annual hearing screening examination.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 10/30/13 at 12:06 PM. Client #1's last recorded hearing evaluation was conducted on 02/29/12.</p> <p>Client #4's records were reviewed on 10/30/13 at 3:30 PM. Client #4's last recorded hearing evaluation was conducted on 06/09/10.</p> <p>On 10/31/13 at 3:11 PM an interview with the Area Director (AD) was conducted. The AD indicated clients #1 and #4 did not have annual hearing screening examinations. She indicated it was the nurse's responsibility to ensure this was completed timely.</p> <p>9-3-6(a)</p>	W000323	<p>The particular primary care physician for clients 1 and 4 completes all documentation and paperwork orally via dictation. His office then faxes a report to the Program Nurse regarding the outcome of the appointment. The Program Nurse will then be responsible for ensuring that this paperwork, along with Indiana MENTOR's annual physical form, is included in each client's annual appointment book and permanent historical files. The Program Nurse will be retrained on Indiana MENTOR's annual physical form. This training will include the importance of all components of this form being completed, and ensuring that the doctor reviews all areas during the annual physical, including but not limited to the annual hearing screening. This retraining will also include the importance of the appropriate documentation to be included in the annual physical appointment, and that all concerns are followed up on. The Program Nurse will be retrained on ensuring that all paperwork is filed appropriately in each client's personal file for future review and usage. The Area Director and/or Clinical Supervisor will audit 2 books a week for the first 4 weeks. After</p>	12/05/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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
			the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter. Responsible Party: Program Nurse, Area Director, and/or Clinical Supervisor Completion Date: December 5, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220			
(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			
W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility failed to ensure 4 of 4 sampled clients (clients #1, #2, #3 and #4), received nursing services according to their medical needs: by failing to obtain monthly blood tests for client #1; by failing to obtain an updated PT (Physical Therapy) Evaluation after a series of falls for client #1; by failing to ensure client #1 obtained an annual hearing evaluation; by failing to update risk plans and include specific health care information for clients #1, #2, #3 and #4; by failing to obtain updated Dexascans for clients #2 and #4; by failing to ensure client #2's dental health recommendations were addressed to use a power toothbrush and timer; by failing to add recommended dietary information to the MAR (Medication Administration Record) for client #3; by failing to add specific G-tube (gastrostomy) medication administration guidelines to the MAR for client #3; by failing to calculate and document calorie intake for client #3 per dietary recommendations; and by failing to administer medication as ordered for client #3 after a seizure medication was ordered to be increased.</p> <p>Findings include:</p>	W000331	<p>1. The Program Nurse will work with the Home Manager to ensure that client 1 completes his monthly labs, as prescribed by the doctor, ongoing/as needed. The Program Nurse will then ensure that all results of these labs are filed in the appropriate medical file for client 1. The Program Nurse will work to obtain a PT evaluation for client 1 due to a series of previous falls. The Program Nurse will then ensure that all results are filed in the appropriate medical file for client 1. The Program Nurse will retrieve the supporting documentation to show that client 1 did have a completed hearing examination at the time of his annual physical. The Program Nurse will then ensure that all results are filed in the appropriate medical file for client 1. The Program Nurse, Home Manager, and Program Director will be retrained on ensuring follow up to all appointments is discussed with the team and completed within the recommended timeframe. The Program Nurse will review all protocols/high risk plans for clients 1, 2, 3, and 4. These will be all be updated to include new information. The Program Nurse will be retrained on completing protocols/high risk plans. This retraining will include the</p>	12/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>1. Client #1's records were reviewed on 10/30/13 at 12:06 PM. Client #1's Individual Support Plan (ISP) was dated 08/20/13 and indicated he was to have monthly CBC (Complete Blood Count) testing. The ISP indicated client #1 used a walker for mobility, was at risk for falls and had fallen on: 12/10/12, 12/23/12, 12/30/12, 01/03/13 twice, and 03/15/13. Health Risk protocols included but were not limited to: Fall Risk, Constipation, Pacemaker, Seizures and Choking. The protocols were all dated 05/2012. Client #1's record contained a hearing evaluation dated 02/27/12. Client #1's record indicated client #1 had a PT (Physical Therapy) Evaluation on 10/26/11. There were no further documents to indicate the CBC was being drawn monthly, the hearing evaluation updated, a PT updated evaluation was obtained related to the falls, or the risk plans updated. The fall plan did not indicate when or how to use the walker.</p> <p>On 10/31/13 at 3:11 PM an interview with the Licensed Practical Nurse (LPN) was conducted. The LPN indicated she believed the CBCs had been conducted monthly for client #1, but indicated there were no results in the record. She indicated there was no hearing update in the record after the 02/27/12 evaluation</p>		<p>appropriate tools for completing these forms and how often to review and revise them. The Program Nurse will complete an updated Fall Protocol for client 1. This will include the usage of his walker, including but not limited to how and when to use the specified walker. 2. The Program Nurse will work to get a completed Dexascan for client 2. The Program Nurse will then ensure that all results are filed in the appropriate medical file for client 2. The Program Director and/or Home Manager will ensure that a new power toothbrush and timer is purchased for client 2, as recommended by the dentist. The Program Director will work with the team to implement a new program for the use of the power toothbrush and the timer. The Program Nurse, Home Manager, and Program Director will be retrained on ensuring follow up to all appointments is discussed with the team and completed within the recommended timeframe. The Program Nurse will review all protocols/high risk plans for clients 1, 2, 3, and 4. These will be all be updated to include new information. The Program Nurse will be retrained on completing protocols/high risk plans. This retraining will include the appropriate tools for completing these forms and how often to review and revise them. 3. The Program Nurse will add the recommended dietary information</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>and the health risk protocols had not been updated.</p> <p>2. Client #2's records were reviewed on 10/30/13 at 1:40 PM. Client #2's ISP dated 10/12/12 indicated her diagnoses included, but were not limited to, seizures and osteopenia (bone loss). Client #2's record contained a seizure protocol/plan dated 06/07/12 and an Osteopenia protocol dated 06/07/12. The record did not contain an updated plan or any indication the nurse had reviewed the plans after 06/07/12. The Osteopenia Protocol indicated client #2 should have a Dexascan every 2 year to follow progression of the bone loss. There was no documentation in the record to indicate client #2 had followed this recommendation. Client #2's last documented Dexascan was dated 06/17/08. Client #2's dental examination dated 04/03/13 indicated for her dental health she was use a power toothbrush and timer, to time brushing her teeth. Client #2's record did not contain any documentation to indicate this health recommendation was being addressed or monitored.</p> <p>On 10/31/13 at 3:11 PM an interview with the Licensed Practical Nurse (LPN) was conducted. The LPN indicated she had no documentation to indicate a</p>		<p>to client 3's Medication Administration Record. The Program Nurse will be retrained to review all dietary reviews completed and to work with the Home Manager and the Program Director (and other team members) to ensure that all recommendations are completed and followed up on. The Program Nurse will add specific G-Tube medication administration guidelines to the MAR for client 3. Specifically, the Program Nurse will add the following to the MAR for client 3: Staff should utilize G-tube for feedings if client 3 does not consume 2 meals (720 calories or more) per day. Client 3 in on a regular diet, with seconds offered. Snacks offered BID (twice a day) Encourage 8 cups of fluid per day. The Program Nurse will work with the Home Manager and Program Director to ensure that the direct support staff are trained on the changes to the MAR, including but not limited to the G-Tube medication administration guidelines for client 3. The Program Nurse will put documentation in place to assist staff with implementing and documenting calorie intake for client 3, per the dietary recommendations. The Program Nurse will work with the Home Manager and Program Director to ensure that the direct support staff are trained on the counting of the calorie intake and the documentation to record it for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>Dexascan had been completed after the 06/17/08 scan. She also indicated there was no documentation to indicate client #2 was following the dental health recommendation to use a power toothbrush and timer. She further indicated there was no documentation to indicate the risk protocols had been updated.</p> <p>3. Client #3's records were reviewed on 10/30/13 at 2:35 PM. Client #3's ISP dated 08/12/13 indicated he was admitted on 07/15/13 and had a G-tube for feedings if needed and for medications. His diagnoses included, but were not limited to, seizures, dementia, headaches and asthma. Client #3's record contained risk protocols which included, but were not limited to: Seizures Protocol, Feeding Tube Protocol, Fall Risk Protocol and Pain Protocol. Client #3's October 2013 Physician Orders medications included medicines for seizures, four prn (as needed) medications for headache which included controlled drugs. The orders indicated all client #3's medications were to be given through his G-tube. The Feeding Tube Protocol did not included checking the tube for placement or specific medication administration guidelines. The Pain Protocol did not indicate which prn medication to use for a headache. Client #3's 07/22/13 initial</p>		<p>client 3. The Program Nurse will review all protocols/high risk plans for clients 1, 2, 3, and 4. These will be all be updated to include new information. The Program Nurse will be retrained on completing protocols/high risk plans. This retraining will include the appropriate tools for completing these forms and how often to review and revise them. Specifically, the Program Nurse will update client 3's G-tube protocol to include the checking the placement of the G-tube before use. The Program Nurse will work with the Home Manager and Program Director to ensure that all staff are trained on the updated protocol and specifically on checking the placement of client 3's G-tube. Secondly, the Program Nurse will update client 3's Pain Protocol to include more specific instructions on what PRN medication is to be used for headaches. The Program Nurse will work with the Home Manager and Program Director to ensure that all staff are trained on the updated protocol. The Program Nurse will ensure that the increase in seizure medication (Lamictal) was implemented through appropriate measures. The Program Nurse will be retrained on Indiana MENTOR's policy and procedures for implementing a new/update medication as prescribed. 4. The Program</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220			
(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>Nutritional Assessment indicated, "G-tube to be used for feeding if he does not eat at least 2 meals per day (720 Kcals) (Calories)." The assessment indicated, "Add to MAR (Medication Administration Record): 1. Regular diet, offer second helpings; 2. Snacks BID (twice daily); 3. Encourage at least 8 cups of fluid daily...." A Quarterly Nutritional Assessment dated 10/15/13 indicated, "...Add to MAR: 1. Regular diet, seconds as desired; 2. Encourage 8 cups fluid/day. The MARS from July 2013 to October 2013 had not been updated to reflect these recommendations. The record did not contain any documentation of the amount of calories client #3 was consuming in two meals or specifically what the meals were to consist of. Client #3's record contained a Medical Appointment form dated 10/16/13. The form indicated he was seen by his neurologist (for seizures) and the neurologist ordered, "Increase Lamictal to 100 mg (milligram) twice a day." The October 2013 MAR contained orders for 150 mg of Lamictal daily. The October 2013 MAR indicated the Lamictal had not been increased as of 10/30/13.</p> <p>On 10/31/13 at 3:11 PM an interview with the Licensed Practical Nurse (LPN) was conducted. The LPN indicated the</p>		<p>Nurse will work to get a completed Dexascan for client 4. The Program Nurse will then ensure that all results are filed in the appropriate medical file for client 4. The Program Nurse will review all protocols/high risk plans for clients 1, 2, 3, and 4. These will be all be updated to include new information. The Program Nurse will be retrained on completing protocols/high risk plans. This retraining will include the appropriate tools for completing these forms and how often to review and revise them. Specifically, the Program Nurse will update client 4's Osteopenia protocol to include the need for a dexascan every 2 years to follow up with the client's ongoing bone loss. The Area Director and/or Clinical Supervisor will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter. Addendum: The Home Manager, Program Nurse, and/or Program Director will review the medication administration records (MARs) no less than every Monday, Wednesday, and Friday for the first 4 weeks. After the 4 initial weeks and ongoing, the Home Manager, Program Nurse, and/or Program Director will review the MARs randomly, no less than 2 times per week, per</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>risk protocols needed to be more specific and the G-tube protocol needed to specifically indicate how staff were to administer client #3's medications. She indicated the Lamictal had not been increased. She further indicated there was no mechanism which tracked the amount of calories client #3 consumed.</p> <p>4. Client #4's records were reviewed on 10/30/13 at 3:30 PM. Client #4's ISP dated 10/23/12 indicated his diagnoses included, but were not limited to, seizures and osteopenia. Client #4's record included but was not limited to the following risk protocols: constipation, reflux, fall, choking and osteoporosis (more severe bone loss than osteopenia). The protocols were all dated 06/07/12. The record did not contain updated plans or any indication the nurse had reviewed the plans after 06/07/12. The Osteopenia Protocol indicated client #4 should have a Dexascan every 2 year to follow progression of the bone loss. There was no documentation in the record to indicate client #4 had followed this recommendation. Client #4's last documented Dexascan was dated 01/25/11.</p> <p>On 10/31/13 at 3:11 PM an interview with the Licensed Practical Nurse (LPN) was conducted. The LPN indicated she</p>		<p>Indiana MENTOR policy and procedure for documentation review. In addition to the book audits that will be completed by the Clinical Supervisor and/or the Area Director, the Program Nurse will implement the Weekly/Monthly Nursing Progress Report. This report was designed to assist nursing staff with ensuring that all weekly, bi-weekly, and monthly duties are completed and on time. For the first 4weeks, the Area Director and/or Clinical Supervisor will meet with the Program Nurse once a week during a scheduled meeting to review the 'Weekly/Monthly Nursing Progress Report' that is in progress. This will be a designated meeting to discuss what the nurse has accomplished, what is still left to do, and to assist in creating a work plan to get all left over items accomplished. After the first initial 4 weeks, the Area Director and/or clinical supervisor will meet with the Program Nurse once every 2 weeks to continue to review the 'Weekly/Monthly Nursing Progress Report' that is in progress at the time. This will continue for 4 additional weeks. Following the follow up 4 weeks, the Area Director and/or Clinical Supervisor will continue to meet with the Program Nurse no less than once a month. This meeting will consist of continuing to review the ongoing 'Weekly/Monthly</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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	
	had no documentation to indicate a Dexascan had been completed after the 01/25/11 scan. She further indicated there was no documentation to indicate the risk protocols had been updated.  9-3-6(a)		Nursing Progress Report' that is in progress at the time. Ongoing, the Program Nurse will continue to utilize the 'Weekly/Monthly Nursing Progress Report', and turn it in at the beginning of the following month to be reviewed by the Area Director and/or Clinical Supervisor for any further follow up that may need to be completed or discussed. Responsible Party: Program Nurse, Area Director, and/or Clinical Supervisor Completion Date: December 5, 2013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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
W000336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview for 3 of 4 sampled clients (clients #1, #2 and #4), the facility's nursing services failed to conduct quarterly nursing assessments of the clients' health status and medical needs.</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 10/30/13 at 12:06 PM. Client #1's record indicated a "Quarterly Nursing Assessment" was conducted in 12/2012, 03/2013 and 06/2013. There were no quarterly assessments in the record after 06/2013. Client #1's Individual Support Plan (ISP) dated 08/30/13 indicated client #1's diagnoses included, but were not limited to: Seizure Disorder, Coronary Artery Disease with pacemaker, Osteoarthritis and high cholesterol. Client #1's 10/2013 physician's orders indicated client #1 received routine medications.</p> <p>Client #2's records were reviewed on 10/30/13 at 1:40 PM. Client #2's record indicated a "Quarterly Nursing</p>	W000336	The Program Nurse will be retrained on Indiana MENTOR's policy and procedure regarding the Quarterly Nursing Assessments. This training will include, but is not limited to, completing, tracking, implementing, and following up on the results of the assessments. The Program Nurse states that all Quarterly Nursing Assessments for September 2013 were completed, however, not filed. The Program Nurse will file all past paperwork. The Program Nurse will be retrained on Indiana MENTOR's policy on documentation. This training will include, but is not limited to, completing the nursing documentation per the Program Nurse job responsibilities, but also filing the paperwork in the appropriate place according to the Medical Files Table of Contents. The Program Nurse will complete the Quarterly Nursing Assessments for December 2013 for clients 1, 2, 3, 4, 5, 6, 7, and 8. The Program Nurse will ensure that all documentation to support these completed assessments is in the file on or before the 10th of the	12/05/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>Assessment" was conducted in 12/2012, 03/2013 and 06/2013. There were no quarterly assessments in the record after 06/2013. Client #2's Individual Support Plan (ISP) dated 10/10/12 indicated client #2's diagnoses included, but were not limited to: Seizure Disorder, Osteoporosis, Legal Blindness and Cerebral Palsy. Client #2's 10/2013 physician's orders indicated client #2 received routine medications.</p> <p>Client #4's records were reviewed on 10/30/13 at 3:30 PM. Client #4's record indicated a "Quarterly Nursing Assessment" was conducted in 12/2012, 03/2013 and 06/2013. There were no quarterly assessments in the record after 06/2013. Client #4's Individual Support Plan (ISP) dated 10/23/12 indicated client #4's diagnoses included, but were not limited to: Congenital Blindness, Obsessive Compulsive Disorder, Osteoporosis, History of Left Hip Fracture and Constipation. Client #4's 10/2013 physician's orders indicated client #4 received routine medications.</p> <p>On 10/31/13 at 3:11 PM an interview with the Licensed Practical Nurse (LPN) was conducted. The LPN indicated she had completed all the quarterlies in September 2013 but they were not in the files and they were in her computer. She</p>		<p>following month. The Area Director and/or Clinical Supervisor will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter. Responsible Party: Program Nurse, Area Director, and/or Clinical Supervisor Completion Date: December 5, 2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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>indicated there were several medical documents that were not in the files as they should be.</p> <p>On 10/31/13 at 3:11 PM an interview with the Area Director (AD) was conducted. The AD indicated the quarterlies should be up to date and should be filed in the client files and not in the nurses computer.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220			
(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			
W000340	<p>483.460(c)(5)(i) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. Based on observation, record review and interview, the facility failed to ensure staff were trained in health care for 1 of 1 sampled client (client #3) who received liquid medications given by G-tube (gastrostomy) at the 5:00 PM medication pass, for proper medication administration.</p> <p>Findings include:</p> <p>1. Observations were conducted in the group home on 10/29/13 from 4:15 PM until 5:45 PM and staff #1, #2 and the House Manager (HM) were on duty. The observation included a 5:00 PM medication administration. At 4:39 PM staff #1 prepared client #3's medications, which included 2 pills and 2 liquids. At 4:39 PM on 10/29/13 staff #1 indicated client #3's two pills were to be crushed and mixed with water to dissolve and he would get them through his G-tube (gastrostomy tube). She indicated those medications would be contained in one syringe. Staff #1 poured one liquid medication into a plastic medicine cup</p>	W000340	The Direct Support Staff (DSPs) will be retrained on medication administration as it pertains to client 3's G-tube and the protocol that accompanies it. This will include checking the placement of the tube, utilizing the appropriate amount of fluid to ensure accuracy, what medications to pass and when, and what to do if issues arise (who to contact). In order to ensure that staff are completing the medication administration appropriately, the Program Nurse and/or Home Manager, will complete medication administration observations. 3 weekly observations will occur within the first 4 weeks. After the first 4 weeks, observations will be completed twice a week for 3 weeks. After the remaining 3 weeks, observations will occur no less than once a week, per Indiana MENTOR policy and procedures. Responsible Party: Program Nurse and/or Home Manager Completion Date: December 5, 2013	12/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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>and drew the contents into a syringe. Staff #1 poured a different colored liquid medication into a new plastic medicine cup and drew the contents into a separate syringe. Staff #1 indicated each medication except the pills which were crushed and mixed with water, were in separate syringes. Staff #1 indicated she had a total of 3 syringes of medications for client #3. On 10/29/13 at 5:18 PM, after client #3 opened his tube, staff #1 attached a small tube and using the syringe attempted to administer one of the liquid medicine via the tube. The medication would not go down the tube and spilled onto a towel over client #3's jeans. Staff #1 indicated there was a problem with the tube as the medicine was not going in it properly. Staff #1 exited client #3's bedroom, while he waited there sitting in a recliner, and advised the HM she was having problems with the tubing and what should she do. Staff #1 indicated she was going to get a different tubing and the HM indicated he was going to contact the nurse. The HM contacted the nurse and the nurse advised to use a [name] carbonated soft-drink to clear the tube before any further medications were attempted. Staff #1 measured a second dosage and drew up the medication she spilled into another syringe. Staff #1 poured the carbonated soft-drink into a cup without measuring</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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>and drew it into a syringe and indicated she was going to flush the tube with the carbonated soft-drink. Staff #1 returned to client #3's bedroom, attached the tube and used the syringe to push the carbonated soft-drink through the tube. She followed the carbonated soft-drink with the liquid in each one of the syringes. The liquid medications were not diluted with water and no water was used before, between each medication, or after the medication pass was completed. Staff #1 did not check for tube placement prior to administration of client #3's medications.</p> <p>Client #3's October 2013 MAR (Medication Administration Record) was reviewed on 10/30/13 at 11:35 AM. Client #3's October 2013 MAR indicated client #3 orders for the G-tube included, "Flush G-tube w (with)/75 ml (milliliter) of water before and after every med pass."</p> <p>Client #3's Gastrostomy Feeding Protocol dated 07/15/13 indicated, "...Add medications...then add 10 cc (cubic centimeters) more water...If anything clogged may use 1 - 2 oz (ounces) [name] carbonated soft-drink to flush."</p> <p>Client #3's Feeding Tube Protocol dated 07/09/13 indicated, "...Check for residual feeding by aspirating stomach contents</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>prior to each feeding...."</p> <p>On 10/31/13 at 3:11 PM an interview with the Licensed Practical Nurse (LPN) was conducted. The LPN indicated she had not written the protocols. She indicated staff should check for tube placement prior to administration of the medications. She also indicated staff failed to follow the order for administering a 75 cc water flush before and after medications. She indicated the protocol needed to be more specific in detailing exactly how the medications were to be given and how any tube feeding should be administered.</p> <p>9-3-6(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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	
W000362	<p>483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview the facility failed for 2 of 4 sampled clients (clients #1 and #2), to have a quarterly pharmacist review completed in a timely fashion.</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 10/30/13 at 12:06 PM. The physician's orders dated 10/2013 indicated client #1 was prescribed medications. The record review failed to indicate the pharmacist's quarterly reviews had been completed timely from 10/2012 through 10/29/13. Client #1's most recent pharmacy review was dated 06/23/13. There were no additional pharmacy reviews.</p> <p>Client #2's records were reviewed on 10/30/13 at 1:40 PM. The physician's orders dated 10/2013 indicated client #2 was prescribed medications. The record review failed to indicate the pharmacist's quarterly reviews had been completed timely from 10/2012 through 10/29/13. Client #2's most recent pharmacy review was dated 06/23/13. There were no additional pharmacy reviews.</p>	W000362	<p>The quarterly pharmacy reviews were completed in September 2013, according to the schedule, as planned, however the pharmacy failed to document the visit as expected. The Program Nurse will be retrained on the expectation of nursing follow up after each quarterly review. The Home Manager will be retrained on assisting the nurse with the follow up that is needed due to the quarterly pharmacy assessments. The Area Director and/or Clinical Supervisor will audit 2 books a week for the first 4 weeks. After the initial 4 weeks, the Area Director will audit 1 book a week for three weeks. After the follow up 3 weeks, the Area Director will audit 1 book a quarter. Responsible Party: Program Nurse and/or Home Manager, Area Director and/or Clinical Supervisor Completion Date: December 5, 2013</p>	12/05/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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>On 10/31/13 at 3:11 PM an interview with the Area Director (AD) was conducted. The AD indicated there were no additional documents for review.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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	
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 1 of 4 sampled clients (client #1) and 1 additional client (client #6), who take medications prescribed by the physician, to administer medications as ordered.</p> <p>Findings include:</p> <p>On 10/21/13 at 11:44 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports and internal incident/accident reports was completed and included the following medication errors:</p> <p>12/11/12: "A med error had occurred for [client #6] the evening of 12/11/12 at 5:30 PM. [Staff #1] initialed on the med sheet that meds were given on 12/11/12, but in fact the meds were not given do (sic) to the med was still inside the bubble packs. The meds that were missed that night were the following: Therems M Tab (once daily vitamin), Namenda tab 10 mg (milligram) (twice daily) (dementia), oyster shell tab 500 mg (3 times daily vitamin), Tricor 145 mg tab (once daily) (high cholesterol)...."</p>	W000368	The Direct Support Staff (DSPs) will be retrained on medication administration. This training will include, Indiana MENTOR's policy and procedure for passing medications, the documentation showing the medication has been passed, and who to report issues to and when. In order to ensure that staff are completing the medication administration appropriately, the Program Nurse and/or Home Manager, will complete medication administration observations. 3 weekly observations will occur within the first 4 weeks. After the first 4 weeks, observations will be completed twice a week for 3 weeks. After the remaining 3 weeks, observations will occur no less than once a week, per Indiana MENTOR policy and procedures. Addendum: The Home Manager, Program Nurse, and/or Program Director will review the medication administration records (MARs) no less than every Monday, Wednesday, and Friday for the first 4 weeks. After the 4 initial weeks and ongoing, the Home Manager, Program Nurse, and/or Program Director will review the MARs randomly, no less than 2 times per week, per Indiana MENTOR policy and procedure	12/05/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>01/02/13: "Staff (non-identified) gave [client #1] another housemates (sic) medications during the 9:00 PM med pass on 01/02/13. The incorrect meds that [client #1] received included Bentropine (sic) 1 mg (Parkinson's), Colace 250 mg (stool softer), Selbamate (sic)1200 mg (seizures), Zyprexa 15 mg (anti-psychotic) and Trileptal 900 mg (seizures)...."</p> <p>05/12/13: "[Client #1] was not able to take his 100 mg of Clozapine (schizophrenia) at 9:00 PM on 05/12/13 due to medication not available in the home...."</p> <p>On 10/31/13 at 3:11 PM an interview was conducted with the AD (Area Director). The AD indicated medications that were not given as prescribed were considered medication errors as staff were not following the physician's orders.</p> <p>9-3-6(a)</p>		for documentation review. Responsible Party: Program Nurse and/or Home Manager Completion Date: December 5, 2013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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	
W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 1 of 18 medication doses administered at the 5:00 PM medication administration, the facility failed to follow physician's orders for administering medication to 1 of 1 sample client (client #3).</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 10/29/13 from 4:15 PM until 5:45 PM and staff #1, #2 and the House Manager were on duty. The observation included a 5:00 PM medication administration. At 4:39 PM staff #1 prepared client #3's medications, which included 2 pills and 2 liquids. Client #3 pills included Lamictal (seizures) and Lactase (digestive enzyme). At 4:39 PM on 10/29/13 staff #1 indicated client #3's two pills were to be crushed and mixed with water to dissolve and he would get them through his G-tube (gastrostomy tube). On 10/29/13 client #3 was given his medication at 5:33 PM.</p> <p>Client #3's October 2013 MAR</p>	W000369	The Direct Support Staff (DSPs) will be retrained on medication administration. This training will include, Indiana MENTOR's policy and procedure for passing medications, the documentation showing the medication has been passed, and who to report issues to and when. In order to ensure that staff are completing the medication administration appropriately, the Program Nurse and/or Home Manager, will complete medication administration observations. 3 weekly observations will occur within the first 4 weeks. After the first 4 weeks, observations will be completed twice a week for 3 weeks. After the remaining 3 weeks, observations will occur no less than once a week, per Indiana MENTOR policy and procedures. Addendum: The Home Manager, Program Nurse, and/or Program Director will review the medication administration records (MARs) no less than every Monday, Wednesday, and Friday for the first 4 weeks. After the 4 initial weeks and ongoing, the Home Manager, Program Nurse, and/or Program Director will review the MARs randomly, no less than 2 times per week, per Indiana	12/05/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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>(Medication Administration Record) was reviewed on 10/30/13 at 11:35 AM. Client #3's October 2013 MAR indicated client #3 was to get 3 pills and 2 liquid medications at the 5:00 PM medication administration. The October 2013 MAR indicated one of the pills client #3 was ordered included Valium 10 mg (milligram) (seizures/anxiety). The October 2013 MAR was signed indicating it was given however client #3 did not receive this medication during the observed medication pass on 10/29/13.</p> <p>On 10/31/13 at 3:11 PM an interview with the Area Director (AD) was conducted. The AD indicated medications should be given as ordered and client #3 should have received the Valium on 10/29/13.</p> <p>9-3-6(a)</p>		<p>MENTOR policy and procedure for documentation review. Responsible Party: Program Nurse and/or Home Manager Completion Date: December 5, 2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220			
(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			
W000381	<p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security.</p> <p>Based on observation, interview and record review, the facility failed for 1 of 2 sampled clients (client #2) who took a controlled substance medication prescribed by the physician, to ensure controlled substances were double locked.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 10/29/13 from 4:15 PM until 5:45 PM and staff #1, #2 and the House Manager were on duty. The observation included a medication administration. At 4:49 PM client #2 came to the medication administration area. Staff #1 obtained a black metal box from the medication cabinet, opened the lid to the box and stated, "[Client #2] gets a controlled medicine which is in this box." Staff #1 was interviewed at 4:50 PM on 10/29/13 and was asked if the black box was locked and she indicated it was not. She indicated the key had broken off and the lock had not worked for approximately a month.</p> <p>Client #2's records were reviewed on 10/29/13 at 1:40 PM. Client #2's 10/2013 Physician Orders indicated client #2</p>	W000381	The Direct Support Staff (DSPs) will be retrained on Indiana MENTOR's policy and procedure for double locking all controlled medications. This training will include the importance of this, and what to do should this present a problem with being completed. In order to ensure that staff are keeping all medications locked up appropriately, the Program Nurse and/or Home Manager, will complete medication administration observations. 3 weekly observations will occur within the first 4 weeks. After the first 4 weeks, observations will be completed twice a week for 3 weeks. After the remaining 3 weeks, observations will occur no less than once a week, per Indiana MENTOR policy and procedures. Responsible Party: Program Nurse and/or Home Manager Completion Date: December 5, 2013	12/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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>medications included the drug Clorazepate, a controlled medication.</p> <p>On 10/31/13 at 3:11 PM an interview with the Area Director (AD) was conducted. The AD indicated controlled drugs were to be double locked.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/05/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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	
W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based on record review and interview, the facility failed for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7 and #8) who resided in the home, by not ensuring an evacuation drill was conducted at least every quarter on the day shifts.</p> <p>Findings include:</p> <p>On 10/21/13 at 2:35 PM, record reviews were completed of the facility's evacuation drills for the period of 10/01/12 through 10/20/13. The review of the evacuation drill records included evacuation drills which were conducted for personnel and clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>There were no recorded day shift drills conducted in 2012. The first day shift drill was on 01/07/13 at 7:57 AM, the next day shift drill was conducted on 04/14/13 at 11:30 AM and there were no drills conducted after the 04/14/13 day drill.</p> <p>On 10/31/13 at 3:11 PM an interview with the Area Director (AD) was conducted. The AD indicated the drills were to be conducted every quarter and there were no additional evacuation drills for review.</p> <p>9-3-7(a)</p>	W000440	The Direct Support Staff will be retrained on Indiana MENTOR's policy and Procedures for completing the monthly fire drills. The Home Manager and/or Program Director will work together to ensure that all staff have access to Indiana MENTOR's schedule for all expected fire drill dates and times. The Home Manager and/or Program Director will review all completed fire drills to ensure that they are completed correctly, at the right time, on the right day, and within the right timeframe, among other things. Responsible Party: Home Manager and/or Program Director Completion Date: December 5, 2013	12/05/2013	