

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G720	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2015
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 82 BENNY LN NORTH VERNON, IN 47265
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W 0000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: April 21, 22, 23 and 24, 2015</p> <p>Facility number: 004396 Provider number: 15G720 AIM number: 200511360</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the governing body failed to exercise operating direction over the facility by failing to ensure: 1) the common area walls of the group home were free of dents, marks, scuffs and discoloration, 2) the wood trim on the outside of the house was repainted and 3) client #3's recliner was free of stains and discoloration.</p>	W 0104	<p>Area Director will arrange for common areas of home to be repainted.</p> <p>QIDP and Home Manager will complete monthly checks of home to ensure that all common areas remain in good condition including painting throughout. They will report any issues to Area Director as soon as possible so items can be repaired.</p>	05/24/2015

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

TITLE

(X6) DATE

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

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	<p>Findings include:</p> <p>Observations were conducted at the group home on 4/21/15 from 3:00 PM to 5:47 PM and 4/22/15 from 6:11 AM to 8:06 AM.</p> <p>1) During the observations at the group home, the common area (kitchen, dining room, living room, medication area and hallways) walls were discolored, scuffed, marked, dented and nicked. This affected clients #1, #2, #3 and #4.</p> <p>On 4/21/15 at 3:20 PM, the Home Manager indicated the common areas of the group home needed to be repaired and repainted.</p> <p>On 4/22/15 at 6:55 AM, staff #3 stated "it's due" when asked when the common areas were most recently painted.</p> <p>2) During the observations at the group home, the paint on the trim around the doors on the outside of the group home was peeling exposing the wood underneath. The paint was peeling off and missing in several areas around the exterior doors. This affected clients #1, #2, #3 and #4.</p> <p>On 4/21/15 at 3:20 PM, the Home Manager indicated the trim around the</p>			
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	<p>doors on the exterior of the home needed to be repainted.</p> <p>On 4/22/15 at 10:13 AM, the Program Director indicated the exterior trim around the doors needed to be repainted.</p> <p>3) During the observations at the group home, client #3's tan recliner had areas on the armrests and seat that were discolored and stained.</p> <p>On 4/22/15 at 7:45 AM, staff #3 indicated client #3 was due to get a new recliner.</p> <p>On 4/22/15 at 7:50 AM, the Home Manager (HM) stated, "it's awful, stained, going to replace" when asked about client #3's recliner. The HM indicated client #3's recliner was stained and needed to be replaced.</p> <p>9-3-1(a)</p>						
W 0140 Bldg. 00	<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.</p> <p>Based on record review and interview for 4 of 4 clients living in the group home</p>	W 0140	Area Director will retrain QIDP on keeping accurate accounting of clients' funds. Program Director	05/24/2015			

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	<p>(#1, #2, #3 and #4), the facility failed to keep an accurate accounting of the clients' funds.</p> <p>Findings include:</p> <p>On 4/21/15 at 3:17 PM, a review of the clients' funds indicated the following:</p> <ul style="list-style-type: none"> -Client #1's December 2014 to April 2015 Cash On Hand Record indicated client #1 had \$67.91 in his account at the group home. The Home Manager (HM) counted client #1's funds and the amount was \$37.91. -Client #2's December 2014 to March 2015 Cash On Hand Record indicated client #2 had \$40.12 in her account at the group home. The HM counted client #2's funds and the amount was \$20.12. -Client #3's December 2014 to March 2015 Cash On Hand Record indicated client #3 had \$43.82 in her account at the group home. The HM counted client #3's funds and the amount was \$23.82. -Client #4's March 2015 Cash On Hand Record indicated client #4 had \$17.36 in her account at the group home. The HM counted client #4's funds and the amount was \$16.11. <p>While counting the clients' funds, the HM indicated the difference in the ledger and actual amount was due to the Program Director (PD) removing funds from the</p>		will review clients funds weekly to ensure there is an accurate accounting of funds. Area Director will review clients' funds monthly to ensure that an accurate account of clients' funds is being kept by the QIDP.	

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	<p>clients' accounts. The HM indicated the PD put money in an envelope so the clients had access to their funds to go out spending. The HM indicated the envelopes were stored in an area that was accessible to the staff in order for the clients to spend their money. The HM indicated the money counted during the survey was locked in a locked box only accessible by the HM and the PD. The HM was able to locate the envelopes during the review of the clients' funds and verify there was no missing money from the clients' accounts.</p> <p>On 4/21/15 at 3:55 PM when the HM asked client #4 how much money she took out of her account on 4/21/15, client #4 indicated she took \$1.25 to work.</p> <p>On 4/21/15 at 4:09 PM, the HM indicated the ledger should account for money taken out of the clients' accounts at the time the money was withdrawn.</p> <p>On 4/21/15 at 5:39 PM, the PD indicated she put Post It notes in the client finance binder indicating the amount that was taken out of the clients' finances and placed in an envelope where the staff had access to the money. The PD indicated she did not document the withdrawal of the funds since the clients had not spent the money. The PD indicated the money</p>			

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W 0159 Bldg. 00	<p>withdrawn from the clients' accounts did not need to be documented on the ledger until the clients spent the money.</p> <p>9-3-2(a)</p> <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 record review and interview for 1 of 2 clients in the sample (#4), the Qualified Intellectual Disabilities Professional (QIDP) failed to conduct regular reviews of client #4's progress toward meeting her training objectives.</p> <p>Findings include:</p> <p>On 4/22/15 at 9:27 AM, client #4's record indicated there were no monthly reviews of client #4's progress toward meeting her training objectives in February and March 2015. There were monthly reviews conducted from April 2014 to January 2015 in the record.</p> <p>On 4/22/15 at 10:22 AM, the QIDP indicated she did not conduct the monthly reviews of client #4's progress in February and March 2015. The QIDP</p>	W 0159	<p>Area Director will retrain QIDP on integrating, coordinating and monitoring clients' program plans and active treatment programs to include client specific training needs as addressed in the ISP and or assessments.</p> <p>The QIDP and Area Director will meet monthly, to review program plans, active treatment plans and health care plans to ensure progress or lack of progress is addressed and changes to plans are made as needed.</p>	05/24/2015

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W 0248 Bldg. 00	<p>indicated the monthly reviews she completed were in the client's record.</p> <p>9-3-3(a)</p> <p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 1 of 1 client (#4) who attended day program #2, the facility failed to ensure the day program had a copy of client #4's Behavior Support Plan.</p> <p>Findings include:</p> <p>On 4/21/15 at 2:24 PM, a review of client #4's record at day program #2 indicated there was no Behavior Support Plan in the record.</p> <p>On 4/22/15 at 9:27 AM, a review of client #4's record at the group home indicated client #4 had a Behavior Support Plan, dated February 2015.</p> <p>On 4/22/15 at 10:06 AM, the Program Director indicated day program #2 should have a copy of client #4's current Behavior Support Plan.</p>	W 0248	<p>QIDP in conjunction with behavioral consultant will ensure that all day programs have a current copy of client's behavior support plan and are trained on current plan.</p> <p>QIDP will complete monthly observations to day program site to monitor and ensure that behavior plans are available and are being implemented as written.</p>	05/24/2015

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W 0249 Bldg. 00	<p>9-3-4(a)</p> <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 for 1 of 2 clients in the sample (#3) and one additional client (#2), the facility failed to implement client #3's mealtime plan, client #3's gait belt protocol, client #3's ambulation plan, and client #2's medication training objective as written.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 4/21/15 from 3:00 PM to 5:47 PM and 4/22/15 from 6:11 AM to 8:06 AM. On 4/21/15 at 5:34 PM, client #3 started to eat her dinner. During the mealtime observation, client #3's dining plan was not on the table and available for staff to reference during the meal. On 4/22/15 at 6:47 AM, client #3 was eating her breakfast. During the mealtime</p>	W 0249	<p>QIDP and/or Home Manager will retrain staff client # 3's mealtime plan, gait belt protocol and ambulation plan and client #2's medication training objective.</p> <p>QIDP/Home Manager and or Nurse will do a daily observation for 2 weeks to ensure that the clients' mealtime plan, gait belt protocol, ambulation plan and medication objective are being implemented as written.</p> <p>QIDP/Home Manager and or Nurse will do an observation 3x a week for 2 weeks to ensure that the clients' mealtime plan, gait belt protocol, ambulation plan and medication objective are being implemented as written.</p> <p>Following the first month of more frequent observations, the QIDP and/or Home Manager will complete weekly observations for</p>	05/24/2015

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	<p>observation, client #3's dining plan was not on the table and available for staff to reference during the meal.</p> <p>On 4/22/15 at 8:41 AM, a review of client #3's record was conducted. Client #3's Risk Management Assessment and Plan (RMAP), dated 1/6/15, indicated, in part, "Provided an altered dietary consistency due to choking concerns and risk of aspiration. Dysphagia plan are (sic) located in Dining Plan Book and Daily Record Book. Staff should have the dining plan book in view while eating."</p> <p>On 4/22/15 at 10:22 AM, the Program Director (PD) indicated she expected the staff to have the dining plan book in view during meals. The PD was unable to locate the dining plan book at the group home. The PD indicated client #3's RMAP should be implemented as written for having the dining plan book in view during meals.</p> <p>2) On 4/21/15 at 3:53 PM, client #3 was assisted by staff #5 to transfer from her wheelchair to a recliner. Staff #3 held onto client #3's hands to assist client #3. During the transfer, client #3's gait belt was not used. On 4/22/15 at 7:54 AM, client #3 was assisted by staff #5 to transfer from her recliner to her</p>		2 months and then monthly ongoing to ensure the clients' mealtime plan, gait belt protocol, ambulation plan and medication objective are being implemented as written.	

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	<p>wheelchair. During the transfer, staff #5 held onto client #3's hands. Staff #5 did not use client #3's gait belt during the transfer.</p> <p>On 4/22/15 at 8:41 AM, a review of client #3's record was conducted. Client #3's Individual Support Plan, dated 1/6/15, indicated, in part, "Staff provide 1:1 (one on one) support while she is ambulating for direction and stability. A gait belt is also used during waking hours. A Fall Protocol and Gait Belt Protocol are present and in place."</p> <p>On 4/23/15 at 2:56 PM, a review of client #3's Gait Belt Protocol, dated 8/3/12, indicated, in part, "Encourage and remind client that gait belt and assistance is (sic) needed. Always use gait belt when walking with, or transferring client. Unsteady when walking and transferring. Leaning sideways, forward or backward when walking... Always use gait belt for any of above to provide a strong anchor for staff to grasp and to prevent client and staff injury while assisting client."</p> <p>On 4/23/15 at 2:46 PM, the nurse indicated the staff should utilize client #3's gait belt during transfers.</p> <p>On 4/24/15 at 9:57 AM, the Area Director indicated in an email that client</p>			

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	<p>#3's gait belt protocol should be implemented as written.</p> <p>3) Observations were conducted at the group home on 4/21/15 from 3:00 PM to 5:47 PM and 4/22/15 from 6:11 AM to 8:06 AM. During the observations, client #3 did not ambulate with assistance from staff. Client #3 was transported in her wheelchair during the observations.</p> <p>On 4/22/15 at 8:41 AM, a review of client #3's record was conducted. Client #3's RMAP, dated 1/6/15, indicated, in part, "[Client #3] wears a gait belt during waking hours. She is able to walk for short distances with staff side by side. She is encouraged to ambulate in her home but has a wheelchair made to her specifications for long distance travel and transporting. This wheelchair has a safety belt which is used each time to ensure she remains seated while being transported via wheelchair." The RMAP indicated, "She is able to walk for short distances with staff side by side. She can sit and stand by herself and will use a hand rail for support. She at times will stand without staff direction and will walk a few steps without assistance so staff monitor her closely. Staff to ensure obstacles are out of her way while ambulating."</p>			

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	<p>On 4/23/15 at 2:46 PM, the nurse indicated client #3 should not be using her wheelchair for transportation while at the group home. The nurse indicated client #3 should be assisted by staff, using her gait belt, to ambulate within the group home. The nurse indicated the wheelchair was for long distances and transportation to the day program. The nurse indicated client #3 should be out of her wheelchair while at the group home.</p> <p>4) An observation was conducted at the group home on 4/21/15 from 3:00 PM to 5:47 PM. At 3:38 PM, client #2 received Tussin Expectorant for cough. Client #2 received a flush with water of her G-tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach) following the administration of the medication. Client #2 was not prompted to hold her syringe during the flush. On 4/22/15 at 7:16 AM, staff #3 administered client #2's medications to her while client #2 was in the living room. Staff #3 did not prompt client #2 to hold her syringe when she flushed her G-tube with water.</p> <p>On 4/22/15 at 7:32 AM, a review of client #2's medication administration training objective was conducted. Client #2's Individual Support Plan, dated 3/15/15, indicated she had a medication</p>			

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W 0259 Bldg. 00	<p>training objective to hold her syringe during flushes - following a medication pass or treatment.</p> <p>On 4/24/15 at 9:57 AM, the Area Director indicated in an email that client #2's medication administration training objective should be implemented as written.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & 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 record review and interview for 1 of 2 clients in the sample (#4), the facility failed to ensure client #4's comprehensive functional assessment (CFA) was reviewed for relevancy and updated as needed at least annually.</p> <p>Findings include:</p> <p>On 4/22/15 at 9:27 AM, a review of client #4's record indicated her most recent CFA was dated 6/26/13. There was no documentation on the CFA or in client #4's record indicating her CFA was reviewed and updated since 6/26/13.</p>	W 0259	<p>Area Director will retrain QIDP on completing annual assessments for all clients.</p> <p>QIDP will update annual assessments for all clients to determine needs/goals.</p> <p>QIDP in conjunction with IDT will review completed CBC to develop objectives/goals for each client. QIDP will ensure that ISP will be updated to reflect changes any objectives/goals. QIDP will ensure that goal tracking sheets match ISP objectives.</p> <p>The QIDP and Area Director will meet monthly and at</p>	05/24/2015

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W 0268 Bldg. 00	<p>On 4/22/15 at 10:22 AM, the Program Director indicated client #4's CFA should be reviewed annually.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, interview and record review for 1 of 2 clients in the sample (#3), the failed failed to remove client #3's gait belt when the belt was not being used to ensure the client's dignity.</p> <p>Findings include:</p> <p>An observation was conducted at the facility-operated day program on 4/21/15 from 1:05 PM to 1:49 PM. On 4/21/15 during the observation, client #3's extra wide gait belt was up on her chest. Client #3 looked uncomfortable. On 4/21/15 at 1:30 PM, the day program Home Manager (HM) repositioned client #3's gait belt so the belt was around her waist. At 1:31 PM, the gait belt was again covering client #3's chest and remained covering her chest during the remainder of the observation.</p>	W 0268	<p>thesemeetings will review that all assessments are completed and/or revised for allclients to ensure needs/goals are being addressed.</p> <p>QIDP and/or Home Manager will retrain staff on client #3's use of gait belt and protocol for removing gait belt when not in use. QIDP and/or Home Manager will complete daily observations for 2 weeks to ensure that gait belt protocol is being implemented as written. QIDP and/or Home Manager will complete observations 3x aweek to ensure that gait belt protocol is being implemented as written. QIDP and/or Home Manager will complete observations 1x a week for one month to ensure that gate belt protocol is being implemented as written. QIDP and/or Home Manager will complete monthly observations for 2 months and then ongoing, to ensure that gait belt protocol is being implemented as written.</p>	05/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G720	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2015
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 82 BENNY LN NORTH VERNON, IN 47265
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	<p>On 4/21/15 at 1:30 PM, the day program HM stated client #3's gait belt "rides up" when client #3 sits down. At 1:40 PM, the HM indicated there was no plan to remove client #3's gait belt during the day program. The HM indicated client #3 wore the gait belt while at the day program, including when client #3 was seated in her wheelchair with a lap belt secured. The HM stated client #3 "seems uncomfortable."</p> <p>Observations were conducted at the group home on 4/21/15 from 3:00 PM to 5:47 PM and 4/22/15 from 6:11 AM to 8:06 AM. During the observations at the group home, client #3 was wearing a gait belt. Client #3 had the gait belt on at all times including when client #3 was in her recliner, wheelchair and dining room chair. On 4/21/15 at 3:53 PM, client #3 was transferred from her wheelchair to her recliner. Staff #5 held onto client #3's hands during the transfer and did not use the gait belt. During the observations, client #3's gait belt was not positioned around her waist. The gait belt was covering her chest.</p> <p>On 4/21/15 at 5:19 PM, staff #7 indicated client #3's gait belt was removed once she gets her pajamas on and client #3 was not going to be up walking anymore.</p>			

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	<p>On 4/22/15 at 7:33 AM, staff #8 indicated client #3's gait belt was put on her after her shower in the morning. Staff #8 indicated the purpose of the gait belt was to assist client #3 during ambulation. Staff #8 indicated client #3 wore the gait belt all day and the gait belt was not removed until bedtime.</p> <p>On 4/22/15 at 8:41 AM, a review of client #3's record was conducted. Client #3's Individual Support Plan, dated 1/6/15, indicated, in part, "Staff provide 1:1 (one on one) support while she is ambulating for direction and stability. A gait belt is also used during waking hours. A Fall Protocol and Gait Belt Protocol are present and in place." The plan indicated, "[Client #3] ambulates with 1:1 assistance due to her limited vision. She wears a gait belt for support and direction and walks best with staff assistance walking by her side, arm holding gait belt and arm holding [client #3's] arm. A Fall Protocol and Gait Belt Protocol are in place. Staff need to ensure there are no obstacles in her path. She should be encouraged to ambulate while in her home and at Day Services and staff track each day the distance that she walks. When in the community and for transporting, she utilizes a wheelchair with safety belt for long distance</p>			

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	<p>traveling. [Client #3] can sit and stand by herself and can rock in a recliner independently. While rocking in her recliner, she may slouch down in the chair but most of the time will independently re-position herself. She will use hand rails for support in the bathroom and stand independently while waiting. She at times will stand without staff direction and will walk a few steps without assistance. She is encouraged by staff to change her seated position and choice of position, i.e.. offer a different choice of chair."</p> <p>Client #3's Risk Management Assessment and Plan, dated 1/6/15, indicated, in part, "[Client #3] wears a gait belt during waking hours. She is able to walk for short distances with staff side by side. She is encouraged to ambulate in her home but has a wheelchair made to her specifications for long distance travel and transporting. This wheelchair has a safety belt which is used each time to ensure she remains seated while being transported via wheelchair." The plan indicated, "Fall Protocol and Gait Belt Protocol in place. She wears a gait belt during waking hours. She is able to walk for short distances with staff side by side. She can sit and stand by herself and will use a hand rail for support. She at times will</p>			

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	<p>stand without staff direction and will walk a few steps without assistance so staff monitor her closely. Staff to ensure obstacles are out of her way while ambulating." There was no documentation in the plan indicating the gait belt could be removed for client #3's comfort when she was in her wheelchair with the safety belt fastened.</p> <p>On 4/23/15 at 2:56 PM, a review of client #3's Gait Belt Protocol, dated 8/3/12, indicated, in part, "Encourage and remind client that gait belt and assistance is (sic) needed. Always use gait belt when walking with, or transferring client. Unsteady when walking and transferring. Leaning sideways, forward or backward when walking... Always use gait belt for any of above to provide a strong anchor for staff to grasp and to prevent client and staff injury while assisting client." There was no documentation in the plan indicating the gait belt could be removed for client #3's comfort when she was in her wheelchair with the safety belt fastened.</p> <p>On 4/23/15 at 2:46 PM, the nurse indicated client #3 had, in the past when in her recliner, stood up independently and walked around her recliner or toward the dining room table. The nurse stated client #3 had not stood up and walked</p>			

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 82 BENNY LN NORTH VERNON, IN 47265			
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W 0312 Bldg. 00	<p>independently for "months." The nurse indicated the gait belt would not be needed when she was in her wheelchair, secured with a lap belt. The nurse indicated the gait belt was in place for staff to assist client #3 while ambulating. The nurse stated the facility should "look at" removing the gait belt when client #3 was using her wheelchair.</p> <p>9-3-5(a)</p> <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 for 2 of 2 clients in the sample with psychotropic medications (#3 and #4), the facility failed to ensure the medication reduction plan was attainable.</p> <p>Findings include:</p> <p>On 4/22/15 at 8:41 AM, a review of client #3's record was conducted. Client #3's Behavior Support Plan, dated January 2015, indicated she was prescribed Zyprexa for physical aggression (plan indicated physical</p>			W 0312	<p>QIDP in conjunction with the Behavior Consultant will review and develop a medication reduction plan for client's 3 and 4 to ensure it is attainable and meets all necessary requirements for a medication reduction plan.</p> <p>Area Director will review all medication reduction plans annually and as needed when there is a new medication ordered to ensure it meets the necessary requirements and is attainable.</p>		05/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G720	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2015
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	<p>aggression was the behavior addressed by the medication). The targeted behavior in the plan was self-injurious behavior (not defined in the plan). Physical aggression was not a targeted behavior. The Medication Management Plan, not dated, indicated Zyprexa was prescribed to address self-injurious behavior as an anti-anxiety medication. The Description of Criteria for Medication Reduction indicated, "Behavior to Decrease: Self-Injurious Behavior (SIB). Criteria for Reduction: 1 episode of SIB per day." The plan did not indicate the timeframe client #3 needed to have 1 episode per day in order for the psychotropic medication to be reduced. The plan was not attainable.</p> <p>On 4/22/15 at 9:27 AM, a review of client #4's record was conducted. Client #4's Behavior Support Plan, dated February 2015, indicated she was prescribed Prozac for depression. On 4/22/15 at 2:47 PM, the Program Director sent, by email, the Medication Management Plan, not dated, for review. The plan to reduce the use of the medication indicated, "At least 20% reduction in symptom frequency from baseline, maintained across 4 consecutive quarters." The plan did not indicate the baseline. The plan was not attainable.</p>			

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W 0371 Bldg. 00	<p>On 4/22/15 at 10:22 AM, the Program Director stated the clients' medication reduction plans were "poorly written" and needed to be revised.</p> <p>9-3-5(a)</p> <p>483.460(k)(4) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. Based on observation, record review and interview for 1 of 2 clients in the sample (#4), the facility failed to ensure client #4 had a training objective to increase her medication administration skills.</p> <p>Findings include:</p> <p>On 4/22/15 from 6:11 AM to 8:06 AM, an observation was conducted at the group home. At 6:42 AM, client #4 received her medications from staff #3. Staff #3 did not inform client #4 what medications she was receiving, their purpose and potential side effects. Staff #3 did not implement a medication training objective.</p> <p>On 4/22/15 at 6:44 AM, staff #3</p>	W 0371	<p>QIDP in conjunction with the IDT will develop a medication training objective for client #4.</p> <p>QIDP and/or Home Manager will retrain staff on client #4's medication training objective.</p> <p>QIDP and/or Home Manager will complete weekly observations for 3 months to ensure the medication objective is being implemented as written.</p> <p>QIDP and/or Home Manager will complete ongoing monthly observations to ensure the medication objective is being implemented as written.</p>	05/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G720	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2015
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	<p>indicated client #4 did not have a program plan to increase her medication administration skills.</p> <p>On 4/22/15 at 7:25 AM, client #4 stated she could "pretty much tell you all of my meds." When asked if she had a training objective to increase her medication administration skills, client #4 did not respond.</p> <p>On 4/22/15 at 9:27 AM, a review of client #4's record was conducted. Client #4's Individual Support Plan, dated 7/19/14, did not include a training objective to increase her medication administration skills. Client #4's comprehensive functional assessment, dated 6/26/13, indicated client #4 could not take her own medication. There was no additional information in the CFA regarding client #4's medication administration skills. Client #4's Risk Management Assessment and Plan (RMAP), dated 7/19/14, indicated client #4 could not administer medications as prescribed based on physical limitations. The RMAP indicated, "[Client #4] can generally state the name of her medications or know in a simple manner what each medication is used for. [Client #4] generally knows the approx (approximate) time she receives these medications as well. Staff will assist in</p>			

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W 0382 Bldg. 00	<p>removing medications from packaging, then [client #4] is generally able to place in her mouth and administer herself."</p> <p>On 4/22/15 at 10:06 AM, the Program Director (PD) indicated client #4 knew the names of her medications and the time she receives her medication. The PD stated client #4 could "generally" give a description of her medications. The PD indicated client #4 did not have a medication training objective. The PD stated, "Don't think she needs one" due to physically not being able to manage taking her medications.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to ensure staff kept all drugs and biologicals locked except when being prepared for administration.</p> <p>Findings include:</p>	W 0382	<p>QIDP and/or Home Manager will retrain staff on drug storage to include that all drugs are kept locked except when being prepared for administration.</p> <p>QIDP and/or Home Manager will complete weekly observations for 3 months to ensure the drugs are being stored appropriately.</p>	05/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G720	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2015
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W 0436 Bldg. 00	<p>An observation was conducted at the group home on 4/22/15 from 6:11 AM to 8:06 AM. At 6:42 AM, staff #3 left the medication room to administer client #4's medications in the dining room. Staff #3 left the medication cabinet to client #4's medications unlocked. Staff #3 left the medication room unlocked when she left the medication room. Staff #3 returned to the medication room at 6:44 AM. At 7:16 AM, staff #3 entered the dining room to administer client #2's medications. Staff #3 left client #2's medication cabinet unlocked as well as the medication room. This affected clients #1, #2, #3 and #4.</p> <p>On 4/22/15 at 10:06 AM, the Program Director indicated the clients' medications should be locked when not being prepared for administration.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p>		QIDP and/or Home Manager will complete ongoing monthly observations to ensure the drugs are being stored appropriately	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G720	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/24/2015
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 82 BENNY LN NORTH VERNON, IN 47265		
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	<p>Based on observation, record review and interview for 1 of 2 clients in the sample (#3), the facility failed to ensure her wheelchair's armrests were in good repair.</p> <p>Findings include:</p> <p>On 4/21/15 from 1:05 PM to 2:37 PM, an observation was conducted at the facility-operated day program. During the observation, client #3's armrests on her wheelchair were covered with tape.</p> <p>On 4/21/15 at 1:05 PM, the Day Program Home Manager (DPHM) indicated client #3's armrests were taped due to the armrests being torn. The DPHM stated client #3's armrests had been taped "for a few months."</p> <p>On 4/21/15 from 3:00 PM to 5:47 PM, an observation was conducted at the group home. During the observation, client #3's armrests were covered with tape. At 3:24 PM, the Home Manager stated client #3's armrests had been taped for "a long time." At 3:24 PM, staff #5 indicated she started working at the group home in November 2014. Staff #5 indicated client #3's armrests had been taped since she started working at the group home.</p> <p>On 4/22/15 at 8:41 AM, a review of</p>	W 0436	<p>QIDP and/or Home Manager will train staff to complete adaily adaptive equipment checklist to ensure that all equipment is present andin good condition. Staff will also betrained on what to do if equipment is not present and/or not in good condition.</p> <p>QIDP and/or Home Manager will complete weekly checks ofadaptive equipment checklist and adaptive equipment to ensure it is present andin good condition.</p>	05/24/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G720		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/24/2015	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 82 BENNY LN NORTH VERNON, IN 47265			
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W 0440 Bldg. 00	<p>client #3's record was conducted. On 2/5/15, client #3's wheelchair was evaluated. The Medical Appointment Form indicated, "Eval (evaluated) current chair. Chair cost to repair is more than new chair cost. Will get quote for new chair." There was no additional information in client #3's record regarding obtaining a new wheelchair.</p> <p>On 4/22/15 at 10:22 AM, the Program Director indicated client #3's wheelchair was assessed in February 2015. The PD indicated client #3 was measured for a new chair. The PD indicated client #3's wheelchair needed to be replaced.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>Findings include:</p> <p>On 4/21/15 at 3:05 PM, a review of the facility's evacuation drills was conducted.</p>	W 0440	<p>QIDP and/or Home Manager will retrain staff on completing evacuation drills monthly.</p> <p>QIDP and/or Home Manager will review evacuation drills monthly to ensure they are being completed per the quarterly schedule for each shift of personnel.</p>	05/24/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G720	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2015
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 82 BENNY LN NORTH VERNON, IN 47265
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	<p>There was no evacuation drill conducted during the night shift (11:00 PM to 7:00 AM) from 9/11/14 to 4/21/15. The facility did not provide documentation of an overnight drill for December 2014 on 4/21/15. This affected clients #1, #2, #3 and #4.</p> <p>On 4/21/15 at 3:05 PM, the Home Manager indicated she contacted the office to receive a copy or fax of the overnight drill conducted in December 2014.</p> <p>On 4/22/15 at 6:28 AM, an evacuation drill was observed on the kitchen counter next to the evacuation drill binder. The evacuation drill on the counter was not a fax or copy as evidenced by the indentations on the form from the ink. The evacuation drill, dated 12/15/15 (incorrect date), indicated an evacuation drill was conducted during the night shift. The form was completed by staff #3.</p> <p>On 4/22/15 at 7:01 AM, staff #3 indicated she filled out the evacuation drill form during her shift from 4/21/15 to 4/22/15. Staff #3 indicated she recalled completing a drill during the overnight shift in December 2014. Staff #3 indicated she put the wrong date on the form when she filled it out. Staff #3 indicated she remembered doing the drill</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W 0488 Bldg. 00	<p>so she completed a new form.</p> <p>On 4/22/15 at 10:06 AM, the Program Director indicated the office was unable to locate a copy of the drill completed for December 2014. The PD indicated the facility should conduct quarterly drills for the night shift.</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 2 of 2 clients observed to eat their meals (#3 and #4), the facility failed to ensure the clients were involved in meal preparation.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/21/15 from 3:00 PM to 5:47 PM. At 4:40 PM, staff #5 was cooking hamburgers, sweet potatoes and hash browns in the kitchen. At 5:13 PM, staff #5 cut up client #4's hamburger. At 5:21 PM, staff #5 used a food processor to prepare client #3's hamburger. Client #4 was in the kitchen but was not</p>	W 0488	<p>QIDP and/or Home Manager will retrain staff on mealpreparation for all clients at all opportunities.</p> <p>QIDP and or Home Manager will complete a daily observationfor 2 weeks to ensure staff are implementing meal preparation opportunities forall clients.</p> <p>QIDP and or Home Manager will complete an observation 3x a weekfor 2 weeks to ensure staff are implementing meal preparation opportunities forall clients.</p> <p>QIDP and/or Home Manager will complete weekly observationsfor 2 months and then monthly ongoing to ensure that mealtime objectives arebeing implemented.</p>	05/24/2015			

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	<p>prompted or assisted to prepare her dinner. Client #3 was in her recliner during dinner preparation. Client #4 did not participate in preparing her dinner.</p> <p>An observation was conducted at the group home on 4/22/15 from 6:11 AM to 8:06 AM. Neither client #3 nor #4 was observed to assist with breakfast preparation. Both clients had cereal for breakfast.</p> <p>On 4/22/15 at 7:30 AM, client #4 indicated the staff pack her lunch for her. Client #4 indicated she was involved in packing her lunch by telling staff what she wanted to take and the staff packed it for her.</p> <p>On 4/22/15 at 7:30 AM, client #4 asked staff #8 if he packed a specific kind of soda. Staff #8 indicated he packed another kind of soda. Client #4 asked staff #8 to switch her drinks and he did. At 7:31 AM, staff #8 told client #4 he packed a pudding cup for her.</p> <p>On 4/22/15 at 7:32 AM, staff #8 indicated the evening shift staff pack the clients' lunches and the morning staff put the packed items into the clients' lunchboxes.</p> <p>On 4/22/15 at 10:06 AM, the Program</p>			

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	Director indicated the clients should be involved with meal preparation. 9-3-8(a)				