

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G606	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/27/2015
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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222
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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: 8/17/15, 8/18/15, 8/19/15, 8/24/15, 8/25/15 and 8/27/15.</p> <p>Facility Number: 001175 Provider Number: 15G606 AIMS Number: 100245640</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 record review and interview for 1 of 4 sampled clients (#4), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure client #4's personal finances/resources were not in excess of the predetermined maximum amount allowed by Medicaid.</p>	W 0104	<p>The Program Coordinator will be retrained on Indiana MENTOR's policy and procedures for ensuring accuracy with each client's finances on a weekly basis, or more.</p> <p>Indiana MENTOR's policy and procedures state that a client should not exceed \$2000 at one time total amounts for all accounts. This is per the Medicaid policy. The Program Coordinator will be retrained on this</p>	09/26/2015

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>Client #4's financial record was reviewed on 8/19/15 at 1:25 PM. Client #4's facility based cluster account ledger report dated 5/1/15 through 7/31/15 indicated the following:</p> <p>-5/1/15, Beginning balance was \$4,738.68.</p> <p>-5/1/15, Deposit of \$438.00 with an ending balance of \$5,176.68.</p> <p>-5/1/15, Deposit of \$856.00 with an ending balance of \$6,032.68.</p> <p>-5/1/15, Withdrawal of \$386.00 with an ending balance of \$5,646.68.</p> <p>-6/1/15, Withdrawal of \$386.00 with an ending balance of \$5,260.68.</p> <p>-6/3/15, Deposit of \$438.00 with an ending balance of \$5,698.68.</p> <p>-6/3/15, Deposit of \$856.00 with an ending balance of \$6,554.68.</p> <p>-7/1/15, Withdrawal of \$386.00 with an ending balance of \$6,168.68.</p> <p>-7/2/15, Deposit of \$438.00 with an ending balance of \$6,606.68.</p>		<p>policy.</p> <p>The team will meet to discuss client #4's money and to come up with a plan for a spend down.</p> <p>The Program Coordinator will meet with the Program Director (QIDP) no less than weekly, to review each client's finances for the week. At this meeting, the Program Coordinator must be able to verify all transactions completed by showing receipts and an accurate accounting of each client's funds. This will include reviewing the total amount of money for each client, to ensure that no one is over resources at any given time. The Program Coordinator and the Program Director will document via signature on the finance records that this was reviewed. This procedure will take place for the first 8 weeks.</p> <p>After the initial 8 weeks, the Program Coordinator and Program Director (QIDP) will continue to meet once every two weeks. At this meeting, the Program Coordinator must be able to verify all transactions completed by showing receipts and an accurate accounting of each client's funds. This will include reviewing the total amount of money for each client, to ensure that no one is over resources at any given time. The Program Coordinator and the Program Director will document via signature on the finance records that this was reviewed. This will continue for 8 more weeks.</p>	

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	<p>-7/2/15, Deposit of \$438.00 with an ending balance of \$7,462.68.</p> <p>AD (Area Director) #1 was interviewed on 8/19/15 at 2:00 PM. AD #1 indicated client #4's resources exceeded the \$2,000.00 Medicaid maximum limit.</p> <p>9-3-1(a)</p>		<p>Ongoing, the Program Coordinator will review each client's finances no less than weekly. The expectation is that the PC will document each transaction within 24 business hours.</p> <p>Ongoing, the Program Coordinator will review each client finances no less than weekly. This is to be tracked by weekly signatures/initialing on the client's finance records.</p> <p>Ongoing, the Program Coordinator and Program Director (QIDP) will meet no less than once a month to review each client's individual finances and sign off on all transactions. The Program Director (QIDP) will review each transaction to ensure a receipt is available and that it is documented correctly. This will include all additions and subtractions being completed correctly. The PD (QIDP) will also review the sheets for the weekly reviews to have been completed by the PC.</p> <p>Ongoing, all monthly finances are turned into the Client Finance Specialist by the 10th of the following month for an extra review. Should errors be found, the CFS will notify the PC, PD, and the Area Director for a plan on making the corrections.</p> <p>Ongoing, the Client Finance Specialist will continue to notify the Area Director when areas of concern are noticed so that additional follow up and retraining can be completed</p>	

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W 0159 Bldg. 00	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>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 for 3 of 4 sampled clients (#1, #2 and #3) plus 3 additional clients (#5, #6 and #7), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients #1, #2, #3, #5, #6 and #7's active treatment programs by failing to ensure staff working with client #1 were competent to implement his diabetic meal time protocol, to ensure client #1 was offered opportunities for choice and self-management, to ensure clients #2 and #3's CFA's (Comprehensive Functional Assessments) were completed, to ensure client #1's ISP (Individual Support Plan) was reviewed on an annual basis, to ensure the facility's HRC (Human Rights Committee) reviewed, approved and monitored clients #2 and #3's behavior management programs, to ensure the facility's HRC ensured clients #1, #2 or #3 or their legal guardian's gave their written informed consent for the use of psychotropic medications used for behavior management, to ensure clients #1, #2 and</p>	W 0159	<p>as needed.</p> <p>1.Please see W192 The Program Nurse will retrain all staff and the Program Coordinator on the appropriate dining plans for each client. This will include reviewing each client's dining protocols, and any dining restrictions that they may or may not have. The direct support staff will also be retrained on appropriately reporting any items missing from the menu making the menu incomplete for the day. This includes, but is not limited to reporting if they are unable to implement each client specific dining plan. For the first four weeks, the Program Nurse and/or Program Director (QIDP) will complete 3 meal time observations per week to ensure that the menu is being followed according to each client's dining plan. After the initial four weeks, the Program Nurse and/Program Director (QIDP) will complete no less than 1 meal observation per week ongoing. For the first four weeks, the Program Director (QIDP) will complete 2 random audits of the groceries per week to ensure that the menu items were appropriately purchased and to ensure the menu is being</p>	09/26/2015

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	<p>#3's use of psychotropic medications were included in a plan of reduction/active treatment program to reduce or eliminate the need for the medication and to ensure staff provided training in meal preparation when formal and informal training opportunities existed for clients #2, #5, #6 and #7.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The QIDP failed to integrate, coordinate and monitor client #1's active treatment program by failing to ensure staff working with client #1 were competent to implement his diabetic meal time protocol. Please see W192.</li> <li>2. The QIDP failed to integrate, coordinate and monitor client #1's active treatment program by failing to ensure client #1 was offered opportunities for choice and self-management. Please see W247.</li> <li>3. The QIDP failed to integrate, coordinate and monitor clients #2 and #3's active treatment programs by failing to ensure clients #2 and #3's CFA's were completed. Please see W259.</li> <li>4. The QIDP failed to integrate, coordinate and monitor client #1's active treatment program by failing to ensure</li> </ol>		<p>followed according to each client's dining plan. After the initial four weeks, the Program Director (QIDP) will complete no less than 1 audit per week for the next four weeks. After the second four weeks, the Program Director will complete no less than 1 audit per month of the groceries/menu/meal items made available to the client's, to ensure that all client specific dining plans are able to be followed appropriately. Ongoing, the Direct Support Professionals will complete each client's specific dining plan, and will report if they are unable to do so.</p> <p>1. Please see W247</p> <p>The Program Director will be retrained on appropriately completing the grocery shopping while in absence of a Program Coordinator. Upon hiring a new Program Coordinator, he/she will be trained on appropriately grocery shopping according to the client specific menus. The Direct Support Staff will be retrained on ensuring that each client is offered choice in daily decisions and self-management. This training will include but is not limited to client's rights and responsibilities. Upon hiring a new Program Coordinator, he/she will be trained on ensuring that each client is offered choice in daily decisions and self-management. This training will include but is not limited to client's rights and responsibilities.</p>	

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	<p>client #1's ISP was reviewed on an annual basis. Please see W260.</p> <p>5. The QIDP failed to integrate, coordinate and monitor clients #2 and #3's active treatment programs by failing to ensure the facility's HRC reviewed, approved and monitored clients #2 and #3's behavior management programs. Please see W262.</p> <p>6. The QIDP failed to integrate, coordinate and monitor clients #1, #2 and #3's active treatment programs by failing to ensure the facility's HRC ensured clients #1, #2 or #3 or their legal guardian's gave their written informed consent for the use of psychotropic medications used for behavior management. Please see W263.</p> <p>7. The QIDP failed to integrate, coordinate and monitor clients #1, #2 and #3's active treatment programs by failing to ensure clients #1, #2 and #3's use of psychotropic medications were included in a plan of reduction/active treatment program to reduce or eliminate the need for the medication. Please see W312.</p> <p>8. The QIDP failed to integrate, coordinate and monitor clients #2, #5, #6 and #7's active treatment programs by failing to ensure staff provided training in</p>		<p>For the first four weeks, the Program Nurse and/or Program Director (QIDP) will complete 3 meal time observations per week to ensure that the menu is being followed according to each client's dining plan, and that the client is offered appropriate choices. After the initial four weeks, the Program Nurse and/Program Director (QIDP) will complete no less than 1 meal observation per week ongoing. Ongoing, the DSPs will ensure that they follow the client specific menus and offer choices at all times.</p> <p>1.Please see W259 The Program Director will be retrained on appropriately completing the CFA's no less than annually. Upon hiring a new Program Coordinator, he/she will be trained on appropriately assisting with completing the CFA's no less than annually. The Program Director (QIDP) will complete the CFA's for client 2 and 3. The Program Director will turn in the annual CFA's to the Area Director for proof of completion no less than annually. Ongoing, the Program Director (QIDP) will ensure that the CFA's are completed no less than annually.</p> <p>1.Please refer to W260 The Program Director (QIDP) will review and complete client #1's Individualized support plan for the current year. The Program Director (QIDP) will be retrained</p>	

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	meal preparation when formal and informal training opportunities existed for clients #2, #5, #6 and #7. Please see W488.  9-3-3(a)		on Indiana MENTOR's policy regarding the Individualized Support Plans being reviewed and updated, no less than annually, but more as needed, and as the team feels appropriate. The Area Director/Administrator will review the next five ISPs written by this Program Director/QIDP, and will attend the next 5 team meetings to ensure all information is reviewed appropriately. The Area Director/Administrator reviews all annual Individual Support Plans and the annual renewal dates to ensure that the Program Director (QIDP) does not let any Individualized Support Plans expire and/or go over 365 days. Ongoing, the Program Director (QIDP) will ensure that all Individualized Support Plans are reviewed and completed no less than annually, but more if needed.  1.Please refer to W262 This Program Director (QIDP) will be retrained on the correct process for retrieving the appropriate approvals for the Behavior Support Plans. Ongoing, the new Program Director will correctly retrieve the approvals for all future Behavior Support Plans from the Guardian/Health Care Representative first, then once received, will get the appropriate approval from the Human Rights Committee, before implementing. Ongoing, the Area Director will	

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			<p>complete random quarterly audits to ensure that all of the proper approvals are in place from the IDTs.</p> <p>1.Please refer to W263 The Program Director will be trained on the correct process for retrieving the appropriate approvals for the Behavior Support Plans, behavior controlling medications, and the use of sedatives before appointments. The Program Director will seek guardian approvals for all psychotropic medications and the Behavior Support Plan for client #1, 2, and 3. Ongoing, the Program Director will correctly retrieve the approvals for all future Behavior Controlling/Sedatives from the Guardian/Health Care Representative first, then once received, will get the appropriate approval from the Human Rights Committee, before implementing. Ongoing, the Area Director will complete random quarterly audits to ensure that all of the proper approvals are in place from the IDTs.</p> <p>1.Please refer to W312 The Program Director will also be retrained on ensuring that titration plans are included in the Behavior Support Plans when applicable. The Behavior Specialist will add in the plan of titration for the psychotropic medications for client 1, 2, and 3's current Behavior Support Plan(s). Ongoing, the Program Director, in</p>	

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W 0192	483.430(e)(2)		<p>conjunction with the team, will ensure that the plan(s) of titration is/are included in the Behavior Support Plan for each client when applicable. Ongoing, the Program Director will correctly retrieve the approvals for all future Behavior Controlling medications and the titration plans, from the Guardian/Health Care Representative first, then once received, will get the appropriate approval from the Human Rights Committee, before implementing. Ongoing, the Area Director will complete random quarterly audits to ensure that all of the proper approvals are in place from the IDTs.</p> <p>1. Please refer to W488 The Direct Support Professionals will be retrained on completing formal and informal active treatment opportunities for each client at any given teaching moment. This training will include but not limited to the meal preparation times. The Program Director and/or Home Manager will complete 2 weekly active treatment observations for 4 weeks, and then 1 per week afterwards to ensure that all formal and informal training opportunities are being completed as expected. Ongoing, the Area Director will complete quarterly pop in visits to ensure that all policies and procedures are being followed.</p>	

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Bldg. 00	<p><b>STAFF TRAINING PROGRAM</b></p> <p>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure staff working with client #1 were competent to implement his diabetic meal time protocol.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/17/15 from 4:51 PM through 6:20 PM. At 6:08 PM, client #1 joined his housemates' at the dining room table to participate in the home's family style meal. The clients were offered a choice of milk, water or koolaid with their meal. Client #1 indicated he wanted koolaid with his meal. Staff #1 redirected client #1 from the koolaid and stated, "You can only have water." Client #1 was given water and not koolaid.</p> <p>Staff #1 was interviewed on 8/17/15 at 6:10 PM. Staff #1 indicated client #1 could have water and not koolaid since he was diabetic. Staff #1 indicated there was not sugar free koolaid or lemonade available for client #1.</p> <p>The home's Diabetic Menu dated</p>	W 0192	The Program Nurse will retrain all staff and the Program Coordinator on the appropriate dining plans for each client. This will include reviewing each client's dining protocols, and any dining restrictions that they may or may not have. The direct support staff will also be retrained on appropriately reporting any items missing from the menu making the menu incomplete for the day. This includes, but is not limited to reporting if they are unable to implement each client specific dining plan. For the first four weeks, the Program Nurse and/or Program Director (QIDP) will complete 3 meal time observations per week to ensure that the menu is being followed according to each client's dining plan. After the initial four weeks, the Program Nurse and/Program Director (QIDP) will complete no less than 1 meal observation per week ongoing. For the first four weeks, the Program Director (QIDP) will complete 2 random audits of the groceries per week to ensure that the menu items were appropriately purchased and to ensure the menu is being followed according to each client's dining plan. After the initial four weeks, the Program Director (QIDP) will complete no less than	09/26/2015			

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W 0210 Bldg. 00	<p>Summer 2015 was reviewed on 8/18/15 at 9:00 AM. The Diabetic Menu dated Summer 2015 indicated, "Sugar free beverages allowed: Coffee, Tea, Diet Pop, Water, Sugar free lemonade, sugar free koolaid or sugar free hot chocolate."</p> <p>AD (Area Director) #1 was interviewed on 8/19/15 at 2:00 PM. AD #1 indicated the Diabetic Menu dated Summer 2015 was the current menu that should be implemented in the home. AD #1 indicated client #1 should be offered a choice of sugar free beverages listed on the summer 2015 Diabetic Menu. AD #1 indicated the home should have sugar free beverage options available for client #1.</p> <p>Nurse #1 was interviewed on 8/19/15 at 2:13 PM. Nurse #1 indicated client #1 should be offered sugar free beverage options in addition to water during meals.</p> <p>9-3-3(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p>		<p>1 audit per week for the next four weeks. After the second four weeks, the Program Director will complete no less than 1 audit per month of the groceries/menu/meal items made available to the client's, to ensure that all client specific dining plans are able to be followed appropriately. Ongoing, the Direct Support Professionals will complete each client's specific dining plan, and will report if they are unable to do so.</p>	

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W 0210	<p>Based on record review and interview for 2 of 4 sampled clients (#2 and #3), the facility failed to ensure clients #2 and #3's CFA's (Comprehensive Functional Assessments) were completed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Client #2's record was reviewed on 8/18/15 at 11:00 AM. Client #2's record did not indicate documentation of a CFA. Client #2's physician's order form dated 7/23/15 indicated client #2's date of admission to the facility was 9/1/12.</li> <li>Client #3's record was reviewed on 8/18/15 at 11:08 AM. Client #3's record did not indicate documentation of a CFA. Client #3's physician's order form dated 7/23/15 indicated client #3's date of admission to the facility was 9/9/14.</li> </ol> <p>AD (Area Director) #1 was interviewed on 8/19/15 at 2:00 PM. AD #1 CFA's should be completed for clients #2 and #3 and then reviewed annually.</p> <p>9-3-4(a)</p>	W 0210	<p>The Program Director will be retrained on appropriately completing the CFA's no less than annually.</p> <p>Upon hiring a new Program Coordinator, he/she will be trained on appropriately assisting with completing the CFA's no less than annually.</p> <p>The Program Director (QIDP) will complete the CFA's for client 2 and 3.</p> <p>The Program Director will turn in the annual CFA's to the Area Director for proof of completion no less than annually.</p> <p>Ongoing, the Program Director (QIDP) will ensure that the CFA's are completed no less than annually.</p>	09/26/2015
W 0247 Bldg. 00	<p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include</p>			

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	<p>opportunities for client choice and self-management.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1 was offered opportunities for choice and self-management.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/17/15 from 4:51 PM through 6:20 PM. At 6:08 PM, client #1 joined his housemates' at the dining room table to participate in the home's family style meal. The clients were offered a choice of milk, water or koolaid with their meal. Client #1 indicated he wanted koolaid with his meal. Staff #1 redirected client #1 from the koolaid and stated, "You can only have water." Client #1 was given water and not koolaid.</p> <p>Staff #1 was interviewed on 8/17/15 at 6:10 PM. Staff #1 indicated client #1 could have water and not koolaid since he was diabetic. Staff #1 indicated there was not sugar free koolaid or lemonade available for client #1 to choose from.</p> <p>The home's Diabetic Menu dated Summer 2015 was reviewed on 8/18/15 at 9:00 AM. The Diabetic Menu dated Summer 2015 indicated, "Sugar free</p>	W 0247	<p>The Program Director will be retrained on appropriately completing the grocery shopping while in absence of a Program Coordinator. Upon hiring a new Program Coordinator, he/she will be trained on appropriately grocery shopping according to the client specific menus. The Direct Support Staff will be retrained on ensuring that each client is offered choice in daily decisions and self-management. This training will include but is not limited to client's rights and responsibilities. Upon hiring a new Program Coordinator, he/she will be trained on ensuring that each client is offered choice in daily decisions and self-management. This training will include but is not limited to client's rights and responsibilities. For the first four weeks, the Program Nurse and/or Program Director (QIDP) will complete 3 meal time observations per week to ensure that the menu is being followed according to each client's dining plan, and that the client is offered appropriate choices. After the initial four weeks, the Program Nurse and/Program Director (QIDP) will complete no less than 1 meal observation per week ongoing. Ongoing, the DSPs will ensure that they follow the client specific menus and offer choices at all times.</p>	09/26/2015

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W 0260 Bldg. 00	<p>beverages allowed: Coffee, Tea, Diet Pop, Water, Sugar free lemonade, sugar free koolaid or sugar free hot chocolate."</p> <p>AD (Area Director) #1 was interviewed on 8/19/15 at 2:00 PM. AD #1 indicated the Diabetic Menu dated Summer 2015 was the current menu that should be implemented in the home. AD #1 indicated client #1 should be offered a choice of sugar free beverages listed on the summer 2015 Diabetic Menu. AD #1 indicated the home should have sugar free beverage options available for client #1.</p> <p>Nurse #1 was interviewed on 8/19/15 at 2:13 PM. Nurse #1 indicated client #1 should be offered sugar free beverage options in addition to water during meals.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE</p> <p>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 record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1's ISP (Individual Support Plan) was reviewed on an annual basis.</p>	W 0260	<p>The Program Director (QIDP) will review and complete client #1's Individualized support plan for the current year.</p> <p>The Program Director (QIDP) will be retrained on Indiana MENTOR's</p>	09/26/2015

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W 0262 Bldg. 00	<p>Findings include:</p> <p>Client #1's record was reviewed on 8/18/15 at 10:30 AM. Client #1's ISP dated 2/21/14 did not indicate annual review or revision since 2/21/14.</p> <p>AD (Area Director) #1 was interviewed on 8/19/15 at 2:00 PM. AD #1 indicated client #1's ISP should be reviewed annually.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#2 and #3), the facility's HRC (Human Rights Committee) failed to review, approve and monitor clients #2 and #3's behavior management programs.</p>	W 0262	<p>policy regarding the Individualized Support Plans being reviewed and updated, no less than annually, but more as needed, and as the team feels appropriate.</p> <p>The Area Director/Administrator will review the next five ISPs written by this Program Director/QIDP, and will attend the next 5 team meetings to ensure all information is reviewed appropriately.</p> <p>The Area Director/Administrator reviews all annual Individual Support Plans and the annual renewal dates to ensure that the Program Director (QIDP) does not let any Individualized Support Plans expire and/or go over 365 days.</p> <p>Ongoing, the Program Director (QIDP) will ensure that all Individualized Support Plans are reviewed and completed no less than annually, but more if needed.</p> <p>This Program Director (QIDP) will be retrained on the correct process for retrieving the appropriate approvals for the Behavior Support Plans.</p> <p>Ongoing, the new Program Director will correctly retrieve the approvals for all future Behavior Support Plans from the Guardian/Health Care</p>	09/26/2015

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W 0263	<p>Findings include:</p> <p>1. Client #2's record was reviewed on 8/18/15 at 11:00 AM. Client #2's POF (Physician's Orders Form) dated 7/23/15 indicated client #2 received Abilify 10 milligrams daily (depression) and Pristiq 50 milligrams daily (depression). Client #2's record did not indicate documentation of HRC review, approval or monitoring of client #2's use of Abilify or Pristiq for behavior management.</p> <p>2. Client #3's record was reviewed on 8/18/15 at 11:08 AM. Client #3's POF dated 7/23/15 indicated client #3 received Zoloft 50 milligrams daily (depression). Client #3's record did not indicated documentation of HRC review, approval or monitoring of client #3's use of Zoloft for behavior management.</p> <p>AD (Area Director) #1 was interviewed on 8/19/15 at 2:00 PM. AD #1 indicated the facility's HRC should review, approve and monitor clients #2 and #3's use of psychotropic medication used for behavior management.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii)</p>		<p>Representative first, then once received, will get the appropriate approval from the Human Rights Committee, before implementing. Ongoing, the Area Director will complete random quarterly audits to ensure that all of the proper approvals are in place from the IDTs.</p>		

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Bldg. 00	<p><b>PROGRAM MONITORING &amp; CHANGE</b> 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 for 3 of 4 sampled clients (#1, #2 and #3), the facility's HRC (Human Rights Committee) failed to ensure clients #1, #2 or #3 or their legal guardians gave their written informed consent for the use of psychotropic medications used for behavior management.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 8/18/15 at 10:30 AM. Client #1's ISP (Individual Support Plan) dated 2/16/14 indicated client #1 was emancipated with a HCR (Health Care Representative) Client #1's Physician's Order Form (POF) dated 7/25/15 indicated client #1 received daily doses of Risperidone for management of Bipolar disorder and anxiety. Client #1's record did not indicate documentation of client #1's written informed consent for the use of Risperidone for behavior management.</p> <p>2. Client #2's record was reviewed on 8/18/15 at 11:00 AM. Client #2's ISP dated 10/14/14 indicated client #2 had a legal guardian. Client #2's POF dated</p>	W 0263	<p>The Program Director will be trained on the correct process for retrieving the appropriate approvals for the Behavior Support Plans, behavior controlling medications, and the use of sedatives before appointments. The Program Director will seek guardian approvals for all psychotropic medications and the Behavior Support Plan for client #1, 2, and 3.</p> <p>Ongoing, the Program Director will correctly retrieve the approvals for all future Behavior Controlling/Sedatives from the Guardian/Health Care Representative first, then once received, will get the appropriate approval from the Human Rights Committee, before implementing. Ongoing, the Area Director will complete random quarterly audits to ensure that all of the proper approvals are in place from the IDTs.</p>	09/26/2015

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W 0312 Bldg. 00	<p>7/23/15 indicated client #2 received Abilify 10 milligrams daily (depression). Client #2's record did not indicate documentation of client #2's guardian's written informed consent for the use of Abilify for behavior management.</p> <p>3. Client #3's record was reviewed on 8/18/15 at 11:08 AM. Client #3's ISP (Individual Support Plan) dated 10/14/14 indicated client #3 was emancipated. Client #3's POF dated 7/23/15 indicated client #3 received Zoloft 50 milligrams daily (depression). Client #3's record did not indicate documentation of client #3's written informed consent regarding the use of Zoloft for behavior management.</p> <p>AD (Area Director) #1 was interviewed on 8/19/15 at 2:00 PM. AD #1 indicated the use of psychotropic medications for behavior management should be utilized with the written informed consent of the client or their guardian.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE 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.</p>			

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	<p>Based on record review and interview for 3 of 4 sampled clients who used psychotropic medications (#1, #2 and #3), the facility failed to ensure clients #1, #2 and #3's use of psychotropic medications were included in a plan of reduction/active treatment program to reduce or eliminate the need for the medication.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 8/18/15 at 10:30 AM. Client #1's Physician's Order Form (POF) dated 7/25/15 indicated client #1 received daily doses of Risperidone (bipolar/anxiety) 1 milligram and Paroxetine (anxiety) 20 milligrams. Client #1's Behavior Support Plan (BSP) dated 4/21/14 indicated client #1 received Risperidone 1 milligram and Paroxetine 20 milligrams for anxiety. Client #1's 4/21/14 BSP did not indicate documentation of a plan of reduction/active treatment program regarding client #1's use of Risperidone or Paroxetine.</p> <p>2. Client #2's record was reviewed on 8/18/15 at 11:00 AM. Client #2's POF dated 7/23/15 indicated client #2 received Abilify 10 milligrams daily (depression) and Pristiq 50 milligrams daily</p>	W 0312	<p>The Program Director will also be retrained on ensuring that titration plans are included in the Behavior Support Plans when applicable. The Behavior Specialist will add in the plan of titration for the psychotropic medications for client 1, 2, and 3's current Behavior Support Plan(s). Ongoing, the Program Director, in conjunction with the team, will ensure that the plan(s) of titration is/are included in the Behavior Support Plan for each client when applicable. Ongoing, the Program Director will correctly retrieve the approvals for all future Behavior Controlling medications and the titration plans, from the Guardian/Health Care Representative first, then once received, will get the appropriate approval from the Human Rights Committee, before implementing. Ongoing, the Area Director will complete random quarterly audits to ensure that all of the proper approvals are in place from the IDTs.</p>	09/26/2015

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W 0368 Bldg. 00	<p>(depression). Client #2's record did not indicate documentation of a plan of reduction/active treatment program regarding client #2's use of Abilify or Pristiq for behavior management.</p> <p>3. Client #3's record was reviewed on 8/18/15 at 11:08 AM. Client #3's POF dated 7/23/15 indicated client #3 received Zoloft 50 milligrams daily (depression). Client #3's record did not indicate documentation of a plan of reduction/active treatment program regarding client #3's use of Zoloft for behavior management.</p> <p>AD (Area Director) #1 was interviewed on 8/19/15 at 2:00 PM. AD #1 indicated psychotropic medications used for behavior management should have a plan of reduction to reduce or eliminate the need for the use of the medication.</p> <p>9-3-5(a)</p> <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. Based on record review and interview for 1 of 4 sampled clients (#1) plus 3 additional clients (#5, #6 and #7), the facility failed to ensure clients #1, #5, #6</p>	W 0368	All staff at this group home will be retrained on medication administration according to the Indiana MENTOR policy and procedures for medication	09/26/2015	

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	<p>and #7 received their medications as ordered by the physician.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 8/18/15 at 9:29 AM. The review indicated the following:</p> <p>-BDDS report dated 4/9/15 indicated, "[Client #1] missed his Bentrophine (sic) (psychotropic medication side effects management) 1 milligram not give in the AM (on) April 7, 2015."</p> <p>-BDDS report dated 4/23/15 indicated, "Received a report from the home manager that [client #5] did not get her fiber supplement on April 21 and 22, 2015."</p> <p>-BDDS report dated 4/9/15 indicated, "[Client #6] did not receive her birth control pill for five days."</p> <p>-BDDS report dated 5/26/15 indicated, "[Nurse #1] reported that [client #7] did not receive his full dosage of Depakote (psychosis) for 5 days."</p> <p>1. Client #1's record was reviewed on 8/18/15 at 10:30 AM. Client #1's Physician's Orders Form (POF) dated</p>		<p>administration.</p> <p>For the first four weeks, the Program Coordinator, Program Director, and/or Program Nurse will complete three (3) weekly medication administration observations to ensure that the medication goals are being completed with each client as specified for four (4) weeks. These will then be reviewed by the Program Director ensuring that there are no further training needs.</p> <p>After the initial four (4) weeks, the Home Manager and/or Program Director will complete two (2) weekly medication administration observations for four (4) additional weeks, and will ensure that all needed retrainings will be completed.</p> <p>After the additional four (4) weeks, the Home Manager and/or Program Director will complete weekly medication administration observations ongoing, and will ensure that all needed retrainings will be completed.</p> <p>Ongoing, all staff will complete medication administration according to the Indiana MENTOR policy and procedures.</p>	

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	<p>7/25/15 indicated, "Benzotropine Mesylate 0.5 milligrams. Cogentin (generic) 0.5 milligrams tablet. Take one table by mouth twice daily for EPS (Extrapyramidal Symptoms)/side effects."</p> <p>2. Client #5's POF dated 8/1/15 was reviewed on 8/24/15 at 11:18 AM. Client #5's POF dated 8/1/15 indicated, "Natural Fiber Therapy Powder/Metamucil Powder (constipation). Give one tablespoon in four ounces of water two times a day for constipation."</p> <p>3. Client #6's POF dated 8/1/15 was reviewed on 8/24/15 at 11:21 AM. Client #6's POF dated 8/1/15 indicated, "Nortrel 1-0.35 tablet. Take one tablet by mouth daily as directed for menses regulation (birth control)."</p> <p>4. Client #7's POF dated 8/1/15 was reviewed on 8/24/15 at 11:32 AM. Client #7's POF dated 8/1/15 indicated, "Divalproex Sodium ER (Extended Release) 250 milligrams/Depakote ER 250 milligrams tablets. Take three tablets (1500 milligrams) with one 250 tablet by mouth at bedtime (1750 milligram dose)."</p> <p>Nurse #1 was interviewed on 8/19/15 at 2:13 PM. Nurse #1 indicated clients #1,</p>			

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W 0440 Bldg. 00	<p>#5, #6 and #7's medications should be administered as prescribed by their physician's orders.</p> <p>9-3-6(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) plus 4 additional clients (#5, #6, #7 and #8), the facility failed to conduct fire drills for each quarter of each shift of personnel.</p> <p>Findings include:</p> <p>The facility's fire evacuation log book was reviewed on 8/18/15 at 1:32 PM. The review did not indicate documentation of fire evacuation drills being conducted for the following shifts and quarters for clients #1, #2, #3, #4, #5, #6, #7 and #8:</p> <p>-day shift, second quarter of 2015 (April, May, June) -evening shift, third quarter of 2014, (June, July, August) -evening shift, fourth quarter of 2014, (October, November, December) -overnight shift, fourth quarter of 2014,</p>	W 0440	<p>All Direct Support Professionals will receive a retraining every other month to ensure that they understand the importance of completing the monthly fire drills. The retraining will include reviewing a copy of the Fire Drill Schedule. Ongoing, the Direct Support Professionals will complete one fire drill per month (or more as needed) according to the schedule to ensure that the health and safety of the client's needs are met. Ongoing, all completed fire drill reports will be turned in to and reviewed by Quality Assurance for accuracy and thoroughness of each drill.</p>	09/26/2015

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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222
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W 0488 Bldg. 00	<p>(October, November, December)</p> <p>AD (Area Director) #1 was interviewed on 8/19/15 at 2:00 PM. AD #1 indicated there was not additional documentation available for review regarding fire evacuation drills for the home. AD #1 indicated fire evacuation drills should be conducted one time per quarter per shift of personnel.</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 1 of 4 sampled clients (#2) plus 3 additional clients #5, #6 and #7, the facility failed to ensure staff provided training in meal preparation when formal and informal training opportunities existed for clients #2, #5, #6 and #7.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/17/15 from 4:51 PM through 6:20 PM. From 4:51 PM through 6:08 PM, staff #1 and staff #2 were in the home's kitchen area preparing the evening meal. Staff #1 prepared and</p>	W 0488	The Direct Support Professionals will be retrained on completing formal and informal active treatment opportunities for each client at any given teaching moment. This training will include but not limited to the meal preparation times. The Program Director and/or Home Manager will complete 2 weekly active treatment observations for 4 weeks, and then 1 per week afterwards to ensure that all formal and informal training opportunities are being completed as expected. Ongoing, the Area Director will complete quarterly pop in visits to ensure that all policies and procedures are being followed.	09/26/2015

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W 9999  Bldg. 00	<p>cooked broccoli on the stove top, prepared pasta, tossed salad and prepared serving pitchers of water and koolaid. Clients #2, #5, #6 and #7 were present in the home during the meal preparation. No clients were encouraged to assist in the preparation of the evening meal.</p> <p>AD (Area Director) #1 was interviewed on 8/19/15 at 2:00 PM. AD #1 indicated clients #2, #5, #6 and #7 should be encouraged to participate in the preparation of the home's evening meal.</p> <p>9-3-8(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division: (6.) A service delivery site with a structural or</p>	W 9999	<p>The Program Director (QIDP) will be retrained on BDDS reportable incidents. This training will include the 24 hour timeline for the incidents to be reported.</p> <p>The Program Director (QIDP) will complete all incidents within the 24 hour timeline and if unable to do so, he/she will initiate conversations with the Area Director/Administrator to assist. Ongoing, the Program Director will complete the all future incidents within the 24 hour timeline.</p>	09/26/2015

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	<p>environmental problem that jeopardizes or compromises the health or welfare of an individual."</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 1 incidents of electrical power outages reviewed, the facility failed to immediately notify the BDDS (Bureau of Developmental Disabilities Services) regarding an incident of electrical power outage for clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>Findings include:</p> <p>The facility's BDDS reports were reviewed on 8/18/15 at 9:29 AM. The review indicated the following BDDS reports:</p> <p>-BDDS report dated 7/23/15 indicated, "This report is late due to management over site and error. During the incliment (sic) weather on 7/13/15, the [group home] lost power at 10:00 PM. [Utility provider] was called and the fire watch policy was put into place due to lack of electricity. [Utility provider] reported that there were a lot of outages in the area and they were working as much as they could on it. The electricity was repaired on</p>			

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	<p>7/15/15 at 9:00 PM." The 7/23/15 BDDS report indicated the group home was without electricity from 10:00 PM on 7/13/15 through 9:00 PM on 7/15/15 and reported to BDDS on 7/23/15 for clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>AD (Area Director) #1 was interviewed on 8/19/15 at 2:00 PM. AD #1 indicated the power outage should have been reported to BDDS within 24 hours of the incident.</p> <p>9-3-1(b)(6)</p>				