

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G719	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/20/2014
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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1406 W TARKINGTON DR GREENSBURG, IN 47240
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W000000	<p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: February 17, 18, 19 and 20, 2014.</p> <p>Surveyor: Dotty Walton, QIDP.</p> <p>Facility Number: 004375 AIM Number: 200510170 Provider Number: 15G719</p> <p>The following federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/27/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 1 of 2 sampled clients (#1) and 1 additional client (#3), the facility's governing body failed to exercise general operating direction over the facility to ensure proper/complete snow removal from fire exits was accomplished.</p>	W000104	<p>Area Director will review contract with current snow removal company to ensure that they are aware of need to ensure that all exits are cleared following snow/ice storm. Home Manager will confirm with direct care staff following ice/snow storm to ensure that snow removal company has removed snow/ice</p>	03/22/2014

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>During observations at the facility on 2/18/14 from 3:10 PM until 7:00 PM and on 2/19/14 from 5:35 AM until 7:50 AM clients #1 and #3 were observed to use wheelchairs for mobility. Client #3 was observed to pivot transfer with the help of one staff from his bed to his wheelchair. Client #3 could propel his wheelchair with his feet or was assisted by facility staff. Client #1 transferred from her bed to her wheelchair with the total assistance of two staff. Client #1 required assistance from staff for mobilizing her wheelchair as she could not propel herself; staff assisted client #1 with mobility in her wheelchair. Clients #1 and #3's bedrooms had exit doors to outside of the facility on the northern side. The northern sidewalk was snow covered to a depth which effectively blocked the bedroom exits of the clients using their beds or wheelchairs for mobility during times of evacuation.</p> <p>Review of the facility fire evacuation drill book on 2/19/14 at 2:00 PM indicated sleeptime drills were conducted with one staff supervising clients #1, #2, #3, and #4 during the overnight weekday hours from 9:00 PM</p>		<p>from all exits and that are exits are clear.</p>	
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	<p>or 12:00 AM until 5:00 AM when a dayshift staff came on duty. The review indicated one staff conducted sleeptime fire evacuations drills with the clients on 12/8/13 at 3:15 AM, 9/10/13 at 3:04 AM, 6/8/13 and 3/30/13 at 1:20 AM. Staff #5 had conducted the evacuation with clients on 3/30/13 at 1:20 AM and indicated on the drill form client #1 was challenging to maneuver alone (she was a two person lift). The Qualified Intellectual disabilities Professional/QIDP #1 responded that client #1 could be transferred to the outside of the facility in her bed in times of emergency; thereby making a transfer to her wheelchair unnecessary. The review of the fire drill book indicated a 12/11/13 memo by QIDP #1 which contained a protocol for 1 staff to follow when conducting fire evacuation drills alone.</p> <p>Interview with QIDP #1 and House Manager #3 on 2/19/14 at 2:15 PM indicated the contractor should have removed the snow from the northern sidewalk of the facility in a prompt manner after the initial snowfall.</p> <p>9-3-1(a)</p>						

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 6 investigations reviewed (clients #2 and #3), the facility failed to implement corrective action in regards to program revision for staff supervision of clients after an incident of client aggression.</p> <p>Findings include:</p> <p>Facility reportable incidents and investigations were reviewed on 2/17/14 at 4:30 PM. The review indicated a reportable incident/investigation dated 10/18/13 regarding an incident on 10/18/13 at 7:10 AM. Client #3 sustained injuries (red mark to back of head, evaluated at local emergency room) when client #2 stated he "pushed him (client #3) on the floor." Staff #4 filled out the facility incident report/IR dated 10/18/13 at 7:15 AM which indicated "[Client #2] pushed [client #3] over in his wheelchair." The IR summary of client to client abuse indicated the incident happened (unwitnessed by staff) in the facility's living area while the two staff on duty were doing a two person transfer in the bathing area (the opposite end of the house) with another client. The</p>	W000157	<p>Program Director will review client #2 risk plan and behavior support plan to ensure that the necessary protocols for the safety of others is included in all plans in regard to client #2 having history of physical aggression. Program Director will review all other risk plans and BSP's to ensure that no other clients are affected by this deficient practice. Program Director will retrain all staff on updated risk plan and behavior plan. Supervisory staff will complete observations 3x a week for 4 weeks to ensure that all plans are being implemented properly. Home Manager and Program Director will complete monthly observations as an ongoing effort to ensure that plan continues to be implemented appropriately.</p>	03/22/2014			

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	<p>investigation determined client #2 did push client #3 over in his wheelchair. The Interdisciplinary team (IDT) was to meet and discuss remedies for the situation. A follow-up report dated 11/11/13 to the 10/18/13 incident indicated client #3 did receive "a bump and a bruise in the area (head) that was hit from his fall." The follow-up report indicated the IDT had discussed the continued suitability of the placement for client #2 and other agencies were going to be contacted regarding his placement. At the time of the survey, clients #2 and #3 continued to reside together.</p> <p>Review on 2/19/14 at 10:15 AM of client #2's record indicated a Behavior Support Plan dated 8/20/13. The BSP had not been revised to include any method of monitoring clients #2 and #3 to prevent another episode of client to client aggression.</p> <p>Interview (2/19/14 1:00 PM) with QIDP (Qualified Intellectual Disabilities Professional) #1 indicated client #2 had stated the facility "is my home." He had indicated he wanted to continue living at the facility and he considered the other clients his family like a "brother." Client #2 had expressed genuine remorse after the incident and no</p>			

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W000240	<p>alternate placement option for him had been identified by outside agencies. The interview indicated increased supervision of clients #2 and #3 had addressed the situation but this had not been added to client #2's or #3's programs.</p> <p>Interview with Administrative staff #1 on 2/20/14 at 1:09 PM indicated client #2's BSP should have been revised in regards to staff supervision to ensure client to client aggression did not reoccur.</p> <p>9-3-2(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 1 of 2 sampled clients (#2), the facility failed to include methodology to address client #2's bathing protocol as related to seizure safety in the client's ISP/Individual Program Plan.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 2/19/14 at 10:00 AM. Client #2's</p>	W000240	<p>Program Director and Nurse will review client #2 seizure management protocol and update to ensure that clients safety needs are being met. Program Director will review all protocols for all clients to ensure that no other client was affected by this deficient practice. Program Director will obtain HRC approval for the use of a monitor while client is in shower to assist with monitoring for seizure activity and to ensure clients</p>	03/22/2014

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	<p>diagnosis included, but was not limited to, Convulsive Epilepsy. Client #2's record review indicated a 6/13/13 "Seizure Protocol" risk plan developed by the facility's RN. The plan indicated: "Water safety precautions (such as 1:1 (one to one staffing ratio) continual observation in pool/tub, wear life jacket, use shower only-no baths, etc). Precautions must be considered when bathing swimming if there's been a seizure (sic) meds (medication for seizures) have been changed w/in (within) the last 6 month: Bathe on trolley or shower chair." The risk plan did not indicate how staff were to monitor client #2 for safety if they were in the living area of the facility while he was in the opposite side of the house showering alone.</p> <p>Interview with Qualified Intellectual Disabilities Professional/QIDP #1 on 2/19/14 at 1:30 PM indicated client #2 showered after the evening meal in the bathroom farthest from the living area. Sometimes client #2 was in the shower for an hour. The interview indicated staff did not supervise client #2 inside the shower room but assisted with his supplies and periodically checked on him. The interview indicated client #2 had a history of "drop" type seizures which happened suddenly and could</p>		<p>safety. Supervisory staff will complete observations 3x a week for 4 weeks to ensure that all plans are being implemented properly. Home Manager and Program Director will complete monthly observations as an ongoing effort to ensure that plan continues to be implemented appropriately</p>	

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W000368	<p>cause injury. The interview indicated the 6/13/13 "Seizure Protocol" did not specifically indicate how client #2 was to be kept safe while showering alone.</p> <p>9-3-4(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 2 sampled clients (#2) and 2 additional clients (#3 and #4), the facility failed to ensure the clients received medications according to the physicians' orders.</p> <p>Findings include:</p> <p>Facility reportable incidents and investigations were reviewed on 2/17/14 at 4:30 PM.</p> <p>The review indicated the following medication errors:</p> <p>1. An incident report/IR dated 10/16/13 at 7:00 AM indicated staff had found client #2's medications which had not been administered the night before. Client #2 had missed his bedtime dosages of Klonopin (for anxiety), Docusate Sodium (for constipation) and</p>	W000368	<p>Nurse will retrain staff on medication administration. All clients were affected by this deficient practice so staff will be trained on each clients protocol for washing pill crushers.</p> <p>Supervisory staff will complete medication observations 3x a week for 4 weeks to ensure that medication is being administered properly with no errors. Supervisory staff will complete monthly observations as an ongoing effort to ensure that plan continues to be implemented appropriately</p>	03/22/2014

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	<p>Maalox (antacid).</p> <p>2. IR dated 9/27/13 indicated client #3 had received a "double dose of Lasix (diuretic)" on 9/26/13 at 8:00 PM.</p> <p>3. IR dated 9/9/13 at 7:00 PM indicated client #4's morning medications for 9/9/13 at 7:00 AM were still in her medication caddy but staff had signed the Medication Administration Record for 7:00 AM as if they had been given.</p> <p>4. IR dated 9/7/13 indicated client #2 did not receive his 7:00 PM dosage of topiramate 100 milligrams/mg. (seizures) on 9/6/13.</p> <p>Interview (2/19/14 1:10 PM) with QIDP (Qualified Intellectual Disabilities Professional) #1 indicated the medication errors had warranted the retraining of all facility staff in the medication administration curriculum. The interview indicated medication errors should not happen.</p> <p>9-3-6(a)</p>				