

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/24/2013
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220		
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey. This visit included the investigation of complaint #IN00125302.</p> <p>Complaint #IN00125302: Unsubstantiated, due to lack of evidence.</p> <p>Dates of Survey: 5/13/13, 5/14/13, 5/15/13, 5/17/13, 5/22/13, 5/23/13 and 5/24/13</p> <p>Facility Number: 001020 Provider Number: 15G506 AIMS Number: 100244980</p> <p>Surveyor: Keith Briner- QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/31/13 by Ruth Shackelford, QIDP.</p>	W000000			

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

TITLE

(X6) DATE

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

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W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#2), the facility failed to secure a surrogate to assist client #2 with making informed choices and decisions.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 5/14/13 at 10:23 AM. Client #2's ISP (Individual Support Plan) dated 11/30/12 indicated client #2 was an emancipated adult. Client #2's ISP dated 11/30/12 indicated, "Working on getting a state appointed guardian. [Client #2] has limited problem solving skills and is not assessed as being able to give informed consent in any areas." Client #2's Risk Management form dated 11/30/12 indicated, "[Client #2] is unable to manage his own finances, due to lack of comprehension of his finances, it is unlikely that he would recognize if they were being mismanaged." Client #2's Physicians Order form dated 4/10/13 indicated client #2's diagnoses included: Schizophrenia, Intermittent explosive disorder, Seizure Disorder, Moderate Mental Retardation and Diabetes. Client #2's IDE (Interdisciplinary Diagnostic and Evaluation) form dated 9/25/12 indicated, "[Client #2] may benefit from</p>	W000125	<p>The paperwork has been submitted to obtain a state appointed guardian for Client #2 to assist him in making informed choices and decisions.</p> <p>Program Director will receive retraining that includes the need to ensure that all consumers that are assessed as needing assistance with having someone to oversee their care and assist with making decisions on their behalf are provided with a responsible person as soon as possible after the need has been identified.</p> <p>The Area Director will review the guardianship status of all consumers at admission to determine if there is a need for a person to assist consumers in making informed choices and decisions and assist with the process of obtaining a guardian or Health Care Representative for any consumers with an identified need as soon as possible.</p> <p>Ongoing, the Program Director will ensure that all consumers that are assessed as needing</p>	06/23/2013			

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	<p>assistance and supervision to ensure his health, safety and personal needs are met. [Client #2] would benefit from having a responsible person to oversee his care and assist with making decisions on his behalf." Client #2's Psychological Evaluation Report dated 9/25/12 indicated, "[Client #2] needs assistance to obtain a responsible party to oversee his care and assist with making decisions on his behalf."</p> <p>AS #1 (Administrative Staff) was interviewed on 5/15/13 at 3:30 PM. AS #1 indicated client #2 was assessed as needing a guardian to assist him make informed choices and decisions. AS #1 indicated the facility was in the process of identifying a potential guardian. AS #1 indicated guardianship proceedings had not been scheduled or finalized.</p> <p>9-3-2(a)</p>		<p>assistance with having someone to oversee their care and assist with making decisions on their behalf are provided with a responsible person as soon as possible after the need has been identified.</p> <p>Responsible Staff: Program Director, Area Director</p>		

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W000126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#1 and #3), the facility failed to ensure clients were allowed access to their money and/or taught to manage their money.</p> <p>Findings include:</p> <p>1. Client #1's financial record was reviewed on 5/14/13 at 7:15 AM. Client #1's financial record indicated client #1's available petty cash balance from April 1, 2013 through May 14, 2013 was \$0.88. Client #1's April 1, 2013 through May 14, 2013 petty cash ledger indicated client #1 had no withdrawals or deposits to her petty cash ledger through the review period.</p> <p>Client #1's FCAR (Financial Cluster Account Report) dated 2/28/13 through 5/14/13 indicated the following transactions:</p> <p>-2/28/13, deposit, \$62.21 with an available balance of \$61.21 -2/28/13, deposit, \$87.92 with an available balance of \$150.13</p>	W000126	<p>Home manager will receive retraining on the need to ensure that all consumers have petty cash funds readily available to access when needed. When the consumers petty cash has been used the Home Manager will request funds from the consumers' cluster account to replenish the petty cash as needed.</p> <p>Ongoing the Home Manager will make withdrawals from the consumers cluster account or personal bank account as needed to replenish consumers' petty cash accounts so that petty cash funds are readily available to access when needed.</p> <p>A money management goal has been developed for Client #1. All Direct Support staff will receive retraining on Client #1 Money management goal and how to implement and document it.</p> <p>The Program Director will receive retraining to include the need to ensure that all consumers have money management goals developed and implemented based on their individual abilities.</p>	06/23/2013			

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	<p>-2/28/13, deposit, \$26.07 with an available balance of \$176.20</p> <p>-3/1/13, deposit, \$425.00 with an available balance of \$601.20</p> <p>-3/8/13, deposit, \$745.00 with an available balance of \$1,346.20</p> <p>-3/13/13, withdrawal, \$1,118.00 with an available balance of \$228.20</p> <p>-4/3/13, deposit, \$425.00 with an available balance of \$653.20</p> <p>Client #1's FCAR dated 2/28/13 through 5/14/13 indicated facility staff had not made petty cash withdrawals from client #1's facility operated cluster account to allow client #1 access to her funds.</p> <p>Client #1's record was reviewed on 5/15/13 at 9:32 AM. Client #1's RMF (Risk Management Form) dated 3/20/13 indicated, "[Client #1] can carry up to \$1.00 for purchases at work." Client #1's ISP (Individual Support Plan) dated 3/20/13 indicated client #1 required assistance with money management. Client #1's ISP dated 3/20/13 did not include formal or informal training objectives to assist client #1 increase her financial management skills. Client #1's record did not indicate documentation of client #1 having access to her personal petty cash.</p> <p>2. Client #3's financial record was</p>		<p>Ongoing, the Program Director will ensure that all consumers have money management goals developed and implemented based on their individual abilities. The Area Director will review the next 3 ISPs submitted by this Program Director to ensure that all consumers have money management goals developed and implemented based on their individual abilities.</p> <p>Responsible Staff: Home Manager, Program Director, Area Director</p>				

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	<p>reviewed on 5/14/13 at 7:20 AM. Client #3's financial record indicated client #3's available petty cash balance from April 1, 2013 through May 14, 2013 was \$0.77. Client #3's April 1, 2013 through May 14, 2013 petty cash ledger indicated client #3 had no withdrawals or deposits to her petty cash ledger through the review period.</p> <p>Client #3's FCAR dated 2/28/13 through 5/14/13 indicated the following transactions:</p> <ul style="list-style-type: none"> -2/28/13, deposit, \$0.33 with an available balance of \$0.33 -2/28/13, deposit, \$80.10 with an available balance of \$80.43 -3/1/13, deposit, \$921.00 with an available balance of \$1,001.43 -3/13/13, withdrawal, \$869.00 with an available balance of \$132.43 -4/3/13, deposit, \$921.00 with an available balance of \$1,053.43 <p>Client #3's FCAR dated 2/28/13 through 5/14/13 indicated facility staff had not made weekly or bi-weekly petty cash withdrawals from client #3's facility operated cluster account to allow client #3 access to her funds.</p> <p>Client #3's record was reviewed on 5/14/13 at 8:21 AM. Client #3's RMF</p>			

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	<p>dated 3/25/13 indicated, "[Client #3] is able to carry up to \$0.50 to purchase a soda at work." Client #3's record did not indicate documentation of client #3 having access to her personal petty cash.</p> <p>HM (Home Manager) #1 was interviewed on 5/14/13 at 7:30 AM. HM #1 indicated she was responsible for requesting petty cash funds for the clients from the facility operated cluster account. HM #1 indicated she had not withdrawn money from the clients' cluster accounts since March 2013. HM #1 indicated clients #1 and #3 could have petty cash to take to their day programs' when the funds were made available.</p> <p>AS #1 (Administrative Staff) was interviewed on 5/15/13 at 11:00 AM. AS #1 stated, "We have had an issue with the finance department. The finance department would not release additional funds to the clients whose petty cash ledgers had not been correctly reconciled. The HM's stopped making petty cash requests because they kept being denied. We told the HM's to continue to make requests for clients to receive petty cash. We can override the finance department's denial and get the clients the requested funds. The HM's should be requesting funds so the clients can have access to their petty cash." AS #1 indicated client</p>				

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	#1 should have money management training to increase her financial independence. 9-3-2(a)			

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W000148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. Based on record review and interview for 1 of 4 sampled clients (#4), the facility failed to notify client #4's guardian of two separate emergency room visits. The facility failed to notify client #4's guardian of a fall with injury.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 5/13/13 at 1:30 PM. The review indicated the following:</p> <p>-BDDS report dated 1/14/13 indicated, "[Client #4] was taken to the emergency room because he fell and hit his head. [Client #4] has a very unsteady gait and he was not walking with his walker. There were no injuries noted from [client #4's] fall." The 1/14/13 BDDS report did not indicate documentation of client #4's guardian being notified of the emergency room visit.</p>	W000148	<p>Home Manager and Program Director will be retrained on the need to ensure that all consumers' parents and/or guardians are notified within 24 hours of any significant incidents or changes in consumers' conditions, including anytime there are injuries, falls or emergency room visits.</p> <p>Ongoing, HM and/or PD will notify all consumers' parents and/or guardians within 24 hours of any significant incidents or changes in consumers' condition. When completing paperwork for consumer incidents, the Program Director will work with the Home Manager to ensure that they have notified guardians of significant incidents or changes in the consumers' condition and if the HM has not done this, the Program Director will ensure it is completed. The Area Director will review all incident reports to ensure that documentation of guardian notification is listed as needed.</p> <p>Responsible party: Home Manager, Program Director, Area</p>	06/23/2013	

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	<p>-BDDS report dated 1/22/13 indicated, "At 1:40 AM, the on call nurse called the program director to report that the overnight staff reported to her that [client #4] had gone into the bathroom and when he came out, he had a cut on the top of his head. The staff did not know what happened while [client #4] was in the bathroom. 911 was called and an ambulance transported [client #4] to the [hospital]. The on call house manager met them at the hospital and [client #4] received 5 staples in his head." The 1/22/13 BDDS report did not indicate documentation of client #4's guardian being notified of the injury or emergency room visit.</p> <p>-BDDS report dated 5/13/13 indicated, "[Client #4] was being prepared to be transferred onto van when [client #4] tried to sit down on the lift gate bottom, he fell over and hit his nose. Resulting in scraping the side of his nose and his nose began to bleed. House Nurse came to observed [client #4] and clean up wound." The 5/13/13 BDDS report did not indicate documentation of client #4's guardian being notified of the his fall with injury.</p> <p>Client #4's record was reviewed on 5/15/13 at 11:18 AM. Client #4's ISP (Individual Support Plan) dated 8/19/12 indicated client #4 had a legal guardian.</p>		Director	

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	<p>AS #1 (Administrative Staff) was interviewed on 5/15/13 at 12:31 PM. AS #1 indicated client #4 had a legal guardian. AS #1 indicated documentation of guardian notification should be included in BDDS reports. AS #1 indicated there was no additional documentation of client #4's guardian being notified of the 1/14/13 emergency room visit, 1/22/13 emergency room visit or the 5/13/13 fall with injury. AS #1 indicated client #4's guardian should be notified of BDDS reportable incidents.</p> <p>9-3-2(a)</p>			

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 2 of 4 sampled clients (#1 and #4), the facility failed to implement its policy and procedure to ensure the facility conducted an investigation regarding an injury of unknown origin for client #4. The facility failed to implement its policy and procedure to ensure the facility developed and implemented preventive measures regarding client #4's ambulation/falls. The facility failed to implement its policy and procedure to ensure the facility conducted a thorough investigation regarding an allegation of sexual assault for client #1.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 5/13/13 from 5:05 PM through 6:15 PM. Client #4 was observed in the home throughout the observation period. At 5:15 PM client #4 entered the group home office area using a rolling walker. DSP #1 (Direct Support Professional) walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked. At 5:30 PM client #4 used a rolling walker to walk from the office area to the group home</p>	W000149	<p>1. a. The Program Director will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>b. A PT/OT assessment has been scheduled for Client #4 to evaluate the need for additional supports related to the increase in frequency of falls and regressing ambulation. Once the assessment is complete, and IDT will be held to discuss</p>	06/23/2013			

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	<p>dining area for the evening meal. DSP #4 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked. At 6:00 PM client #4 finished eating his evening meal and began to walk from the dining area back to the group home office area. DSP #3 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked.</p> <p>Observations were conducted at the group home on 5/14/13 from 6:05 AM through 8:30 AM. Client #4 was observed in the group home throughout the observation period. At 6:47 AM client #4 used a rolling walker to walk to the group home medication administration room. DSP #4 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked. At 6:55 AM client #4 used a rolling walker to walk to the group home medication administration room. DSP #4 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked.</p> <p>DSP #4 was interviewed on 5/14/13 at 6:40 AM. Staff #3 indicated client #4 should use his rolling walker to ambulate. When asked why staff was holding client #4's pant belt loops while he walked, DSP #4 stated, "[Client #4] is just so unsteady. He's had some falls. We have to do that or</p>		<p>recommendations and evaluate the need for additional supports for Client #4.</p> <p>The Program Director and Program Nurse will receive retraining on the need to ensure that assessments are scheduled and completed to assess need for additional supports if a pattern is noticed regarding regression of ambulation for consumers.</p> <p>Ongoing the Program Director and Program Nurse will work together to evaluate the need for additional supports and/or additional assessments if a pattern of falls or regression in ambulation is noted to determine if additional supports are safeguards are needed to prevent further falls.</p> <p>c. Program Director will receive retraining on the need to ensure Interdisciplinary Team meetings are held for consumers to discuss the need for further evaluation or additional assessments if a pattern of regression of ambulation for consumers is noted.</p> <p>Ongoing, the Program Director will ensure that Interdisciplinary Team meetings are held as needed when a pattern of</p>				

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	<p>he falls down." When asked if client #4 had a gait belt available for use, DSP #4 stated, "I don't think so. I'm really not sure. I think he has one at day program but I'm not sure. I think [client #4] used to have one here but not anymore."</p> <p>Observations were conducted at the facility's day service program on 5/17/13 from 9:10 AM through 10:10 AM. At 10:00 AM client #4 was seated in a wheelchair with a gait belt around his waist. Day service staff #1 pushed client #4 in a wheelchair to the restroom in the day service program area.</p> <p>DSM #1 (Day Service Manager) was interviewed on 5/17/13 at 10:00 AM. When asked if client #4 was using a wheelchair, DSM #1 stated, "We use a wheelchair here; it's not his, it belongs to us. We use it because he is so unsteady on his feet. He has the walker but he just can't stay up unless we hold him up. [Client #4] doesn't have an order for it but he just can't stand up to use the walker."</p> <p>The facility's BDDS reports and investigations regarding client #4 were reviewed on 5/13/13 at 1:30 PM. The review indicated the following:</p> <p>-BDDS report dated 1/14/13 indicated, "[Client #4] was taken to the emergency</p>		<p>incidents, including falls is noted to determine if further evaluation or additional assessments are needed.</p> <p>d. Client #4 Fall Risk Protocol will be updated to assess the need for additional supports due to increase in falls and regression in ambulation.</p> <p>Program Nurse will receive retraining to evaluate the need to review and update consumers Fall Risk Protocol after any falls to evaluate the need for additional supports or assessments and communicate any recommendations to the Program Director to implement.</p> <p>Ongoing, the Program Nurse will ensure that all consumers Fall Risk Protocols are reviewed and updated after an incident occurs to determine if any additional supports or safeguards need to be put into place. The Area Director will complete a review of medical protocols a minimum of quarterly to ensure that protocols are being updated as needed.</p> <p>2. a. The Program Director will receive retraining on completing thorough investigations including ensuring that all parties related to the incident are interviewed, designating who staff reported</p>		

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	<p>room because he fell and hit his head. [Client #4] has a very unsteady gait and he was not walking with his walker. There were no injuries noted from [client #4's] fall."</p> <p>-BDDS report dated 1/22/13 indicated, "At 1:40 AM, the on call nurse called the program director to report that the overnight staff reported to her that [client #4] had gone into the bathroom and when he came out, he had a cut on the top of his head. The staff did not know what happened while [client #4] was in the bathroom. 911 was called and an ambulance transported [client #4] to the [hospital]. The on call house manager met them at the hospital and [client #4] received 5 staples in his head."</p> <p>The review did not indicate documentation of an investigation regarding the 1/22/13 BDDS report for client #4's injury of unknown origin.</p> <p>-BDDS report dated 5/13/13 indicated, "[Client #4] was being prepared to be transferred onto van when [client #4] tried to sit down on the lift gate bottom, he fell over and hit his nose. Resulting in scraping the side of his nose and his nose began to bleed. House Nurse came to observe [client #4] and clean up wound."</p>		<p>injuries and/or allegations to and ensuring all relevant documents, including risk plan, behavior support plans, medical reports, daily support records, etc. are reviewed so that a thorough investigation can be completed.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>b. The Program Nurse will receive retraining on the need to ensure that any consumers are assessed to determine if additional assessments/evaluations for sexual assault are needed after an allegation of sexual assault is made.</p> <p>Ongoing, the Program Nurse or On call Nurse will assess any individuals to determine if additional assessments/evaluations for</p>		

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	<p>Client #4's record was reviewed on 5/15/13 at 11:18 AM. Client #4's HCCR (Health Care Coordination Review) forms indicated the following:</p> <p>-March 2013, "Unsteady gait." -February 2013, "Unsteady gait." -January 2013, "Unsteady gait." -December 2012, "Unsteady gait." -November 2012, "11/29/12: [client #4] for evaluation of gait abnormality, gait training and wheeled walker."</p> <p>Client #4's record indicated client #4 had an 11/29/12 PT (Physical Therapy) recommendation for use of a rolling walker. Client #4's Fall Risk plan dated 4/9/12 did not indicate documentation of review or revisions following the 11/29/12 PT recommendations for use of rolling walker, or the 1/14/13, 1/22/13 or 5/13/13 falls. Client #4's record did not indicate documentation of IDT (Interdisciplinary Team) meetings to assess if client #4 was regressing with ambulation, should be assessed for wheelchair use, should be assessed for gait belt use or how to prevent additional falls.</p>		<p>sexual assault are needed after an allegation of sexual assault is made. The Area Director will communicate with the program nurse to ensure that an assessment is completed after any allegation of sexual assault is made.</p> <p>Responsible party: Home manager, Program Director, Area Director, Program Nurse, Quality Assurance Specialist</p>				

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	<p>RN #1 (Registered Nurse) was interviewed on 5/15/13 at 11:00 AM. RN #1 indicated she had been assigned to this group home for less than 2 weeks. RN #1 indicated the previous nurse for this group home had retired. RN #1 indicated there was no documentation of client #4 being assessed by nursing staff to determine if client #4 needed additional supports for ambulation such as a wheelchair or gait belt. RN #1 indicated client #4's fall risk plan had not been revised or updated since 4/9/12. RN #1 indicated client #4's fall risk plan should have been assessed to determine if additional supports and safeguards were needed after client #4's falls and continued unsteady gait.</p> <p>AS #1 was interviewed on 5/15/13 at 11:15 AM. AS #1 indicated the facility had not convened an IDT to assess client #4's ambulation needs. AS #1 indicated the IDT should have met to determine if client #4 needed additional supports to prevent additional falls. AS #1 indicated client #4's 1/22/13 injury was not witnessed. AS #1 indicated client #4's 1/22/13 injury of unknown origin should have been investigated.</p> <p>2. The facility's BDDS reports and investigations regarding client #1 were reviewed on 5/13/13 at 1:30 PM. The review indicated the following:</p>			
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	<p>-BDDS report dated 3/1/13 indicated, "[Client #1] reported to staff that [client #6] has been coming in her room, climbing on top of her and puts his penis in her. [Client #1] and [client #6] were boyfriend and girlfriend which ended. After the break up, [client #1] started making the accusations against [client #6]."</p> <p>-Investigation dated 3/5/13 regarding the 3/1/13 BDDS report for client #1's allegation against client #6 indicated DSP #5 received the allegation from client #1 during the transport from the group home to the day service provider on the morning of, time unspecified, 2/28/13. The 3/5/13 investigation report did not indicate who DSP #5 reported client #1's allegation to. The 3/5/13 investigation report did not indicate if DSP #5 completed an incident report. The 3/5/13 investigation report did not indicate if the facility nurse was notified regarding client #1's allegation of sexual assault. The 3/5/13 investigation report did not indicate if any other staff were present on the van during the morning transport who also heard client #1's allegation. The 3/5/13 investigation indicated HM (Home Manager) #1 was interviewed. The 3/5/13 investigation did not indicate documentation of an interview with HM</p>						

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	<p>#1. The 3/5/13 investigation did not indicate documentation of a review of client #1's Risk Management Plan to determine her level of vulnerability to sexual assault. The 3/5/13 investigation did not indicate documentation of review of client #6, the alleged perpetrator's, BSP (Behavior Support Plan) to determine if he had a history of sexual behaviors. The 3/5/13 investigation did not indicate documentation of clients #1 or #6's sexual consents/awareness assessments.</p> <p>HM #1 was interviewed on 5/15/13 at 11:40 AM. When asked when and how she first became aware of client #1's allegation against client #6, HM #1 stated, "I'm not sure. I think [DSP #5] reported it to me after the morning transport. I don't remember for sure but I think I came to the house that night after they got back from the workshop to talk to [client #1]. " When asked if the facility nurse had been notified of the allegation, HM #1 stated, "I can't remember." When asked if the facility nurse should be notified of sexual assault allegations, HM #1 stated, "Yes." HM #1 indicated she had conducted interviews and assisted completion of the 3/5/13 investigation. HM #1 indicated client #1's sexual consents/awareness assessment had not been reviewed during the investigation.</p>						

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	<p>RN #1 was interviewed on 5/15/13 at 11:00 AM. RN #1 indicated the facility nurse should have been informed of the allegation of sexual assault to determine if client #1 needed to be evaluated for rape or injury/trauma to her genital areas. RN #1 indicated she had been assigned this group home for less than 2 weeks. RN #1 indicated the previous nurse for this group home had retired. RN #1 indicated there was no documentation of client #1 being assessed by nursing staff to determine if additional assessment/evaluation for sexual assault was needed.</p> <p>AS #1 was interviewed on 5/15/13 at 11:15 AM. AS #1 indicated the 3/5/13 investigation report should include information regarding who and when DSP #5 reported client #1's allegation. AS #1 indicated the 3/5/13 investigation report should indicate if DSP #5 completed an incident report. AS #1 indicated the 3/5/13 investigation report should indicate if the facility nurse was notified regarding client #1's allegation of sexual assault. AS #1 indicated the 3/5/13 investigation report should indicate if any other staff were present on the van during the morning transport who also heard client #1's allegation. AS #1 indicated the 3/5/13 investigation should include documentation of an interview with HM #1. AS #1 indicated the 3/5/13</p>			

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	<p>investigation should indicate documentation of a review of client #1's Risk Management Plan to determine her level of vulnerability to sexual assault. AS #1 indicated the 3/5/13 investigation should include documentation of review of client #6, the alleged perpetrator's, BSP to determine if he had a history of sexual behaviors. AS #1 indicated the 3/5/13 investigation should indicate documentation of clients #1 or #6's sexual consents/awareness assessments. When asked if the 3/5/13 investigation regarding client #1's 2/28/13 sexual assault allegation against client #6 was thorough, AS #1 stated, "No." AS #1 indicated client #1's allegation was not substantiated. When asked if the facility's abuse, neglect, exploitation and mistreatment policy should be implemented, AS #1 stated, "Yes." AS #1 indicated recommendations to prevent reoccurrence of falls and/or injuries of unknown origin should be developed from the investigation process and reviewed by the facility quality assurance team.</p> <p>The facility's policy and procedures were reviewed on 5/23/13 at 12:38 PM. The 4/2011 facility's policy entitled Quality and Risk Management indicated:</p> <p>"C. Indiana Mentor is committed to</p>			

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	<p>completing a thorough investigation for any event out of the ordinary which jeopardized the health and safety of any individual served or other employee.</p> <p>1. Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident."</p> <p>9-3-2(a)</p>			

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 11 allegations of abuse, neglect, exploitation, mistreatment and/ or injuries of unknown origin reviewed, the facility failed to conduct an investigation regarding an injury of unknown origin for client #4. The facility failed to conduct a thorough investigation regarding an allegation of sexual assault for client #1.</p> <p>Findings include:</p> <p>1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations regarding client #4 were reviewed on 5/13/13 at 1:30 PM. The review indicated the following:</p> <p>-BDDS report dated 1/22/13 indicated, "At 1:40 AM, the on call nurse called the program director to report that the overnight staff reported to her that [client #4] had gone into the bathroom and when he came out, he had a cut on the top of his head. The staff did not know what happened while [client #4] was in the bathroom. 911 was called and an ambulance transported [client #4] to the [hospital]. The on call house manager met them at the hospital and [client #4]</p>	W000154	<p>The Program Director will receive retraining on completing thorough investigations including ensuring that all parties related to the incident are interviewed, designating who staff reported injuries and/or allegations to and ensuring all relevant documents, including risk plan, behavior support plans, medical reports, daily support records, etc. are reviewed so that a thorough investigation can be completed.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</p>	06/23/2013	

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	<p>received 5 staples in his head."</p> <p>The review did not indicate documentation of an investigation regarding the 1/22/13 BDDS report for client #4's injury of unknown origin.</p> <p>AS (Administrative Staff) #1 was interviewed on 5/15/13 at 11:15 AM. AS #1 indicated client #4's 1/22/13 injury was not witnessed. AS #1 indicated client #4's 1/22/13 injury of unknown origin should have been investigated.</p> <p>2. The facility's BDDS reports and investigations regarding client #1 were reviewed on 5/13/13 at 1:30 PM. The review indicated the following:</p> <p>-BDDS report dated 3/1/13 indicated, "[Client #1] reported to staff that [client #6] has been coming in her room climbing on top of her and puts his penis in her. [Client #1] and [client #6] were boyfriend and girlfriend which ended. After the break up, [client #1] started making the accusations against him."</p> <p>-Investigation dated 3/5/13 regarding the 3/1/13 BDDS report for client #1's allegation against client #6 indicated DSP #5 (Direct Support Professional) received the allegation from client #1 during the transport from the group home to the day</p>			

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	<p>service provider on 2/28/13. The 3/5/13 investigation report did not indicate who DSP #5 reported client #1's allegation to. The 3/5/13 investigation report did not indicate if DSP #5 completed an incident report. The 3/5/13 investigation report did not indicate if the facility nurse was notified regarding client #1's allegation of sexual assault. The 3/5/13 investigation report did not indicate if any other staff were present on the van during the morning transport who also heard client #1's allegation. The 3/5/13 investigation indicated HM #1 was interviewed. The 3/5/13 investigation did not indicate documentation of an interview with HM #1. The 3/5/13 investigation did not indicate documentation of a review of client #1's Risk Management Plan to determine her level of vulnerability to sexual assault. The 3/5/13 investigation did not indicate documentation of review of client #6, the alleged perpetrator's, BSP (Behavior Support Plan) to determine if he had a history of sexual behaviors. The 3/5/13 investigation did not indicate documentation of clients #1 or #6's sexual consents/awareness assessments.</p> <p>HM (Home Manager) #1 was interviewed on 5/15/13 at 11:40 AM. When asked when and how she first became aware of client #1's allegation against client #6, HM #1 stated, "I'm not sure. I think [DSP</p>			

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	<p>#5] reported it to me after the morning transport. I don't remember for sure but I think I came to the house that night after they got back from the workshop to talk to [client #1]. " When asked if the facility nurse had been notified of the allegation, HM #1 stated, "I can't remember." When asked if the facility nurse should be notified of sexual assault allegations, HM #1 stated, "Yes." HM #1 indicated she had conducted interviews and assisted completion of the 3/5/13 investigation. HM #1 indicated client #1's sexual consents/awareness assessment had not been reviewed during the investigation.</p> <p>RN #1 was interviewed on 5/15/13 at 11:00 AM. RN #1 indicated the facility nurse should have been informed of the allegation of sexual assault to determine if client #1 needed to be evaluated for rape or injury/trauma to her genital areas. RN #1 indicated she had been assigned this group home for less than 2 weeks. RN #1 indicated the previous nurse for this group home had retired. RN #1 indicated there was no documentation of client #1 being assessed by nursing staff to determine if additional assessment/evaluation for sexual assault was needed.</p> <p>AS #1 was interviewed on 5/15/13 at 11:15 AM. AS #1 indicated the 3/5/13 investigation report should include</p>			

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	<p>information regarding who and when DSP #5 reported client #1's allegation. AS #1 indicated the 3/5/13 investigation report should indicate if DSP #5 completed an incident report. AS #1 indicated the 3/5/13 investigation report should indicate if the facility nurse was notified regarding client #1's allegation of sexual assault. AS #1 indicated the 3/5/13 investigation report should indicate if any other staff were present on the van during the morning transport who also heard client #1's allegation. AS #1 indicated the 3/5/13 investigation should include documentation of an interview with HM #1. AS #1 indicated the 3/5/13 investigation should indicate documentation of a review of client #1's Risk Management Plan to determine her level of vulnerability to sexual assault. AS #1 indicated the 3/5/13 investigation should include documentation of review of client #6, the alleged perpetrator's, BSP to determine if he had a history of sexual behaviors. AS #1 indicated the 3/5/13 investigation should indicate documentation of clients #1 or #6's sexual consents/awareness assessments. When asked if the 3/5/13 investigation regarding client #1's 2/28/13 sexual assault allegation against client #6 was thorough, AS #1 stated, "No."</p> <p>9-3-2(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 observation, record review and interview for 1 of 11 allegations of abuse, neglect, exploitation, mistreatment and/or injuries of unknown origin reviewed, the facility failed to develop and implement preventive measures regarding client #4's ambulation/falls.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 5/13/13 from 5:05 PM through 6:15 PM. Client #4 was observed in the home throughout the observation period. At 5:15 PM entered the group home office area using a rolling walker. Staff #1 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked. At 5:30 PM client #4 used a rolling walker to walk from the office area to the group home dining area for the evening meal. Staff #4 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked. At 6:00 PM client #4 finished eating his evening meal and began to walk from the dining area back to the group home office area. Staff #3 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked.</p>	W000157	<p>A PT/OT assessment has been scheduled for Client #4 to evaluate the need for additional supports related to the increase in frequency of falls and regressing ambulation. Once the assessment is complete, and IDT will be held to discuss recommendations and evaluate the need for additional supports for Client #4.</p> <p>The Program Director and Program Nurse will receive retraining on the need to ensure that assessments are scheduled and completed to assess need for additional supports if a pattern is noticed regarding regression of ambulation for consumers.</p> <p>Ongoing the Program Director and Program Nurse will work together to evaluate the need for additional supports and/or additional assessments if a pattern of falls or regression in ambulation is noted to determine if additional supports are safeguards are needed to prevent further falls.</p> <p>The Program Director will receive retraining on the need to ensure Interdisciplinary Team meetings are held for consumers to discuss the need for further evaluation or additional assessments if a</p>	06/23/2013			

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	<p>Observations were conducted at the group home on 5/14/13 from 6:05 AM through 8:30 AM. Client #4 was observed in the group home throughout the observation period. At 6:47 AM client #4 used a rolling walker to walk to the group home medication administration room. Staff #4 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked. At 6:55 AM client #4 used a rolling walker to walk to the group home medication administration room. Staff #4 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked.</p> <p>Staff #4 was interviewed on 5/14/13 at 6:40 AM. Staff #4 indicated client #4 should use his rolling walker to ambulate. When asked why staff were holding client #4's pant belt loops while he walked, staff #4 stated, "[Client #4] is just so unsteady. He's had some falls. We have to do that or he falls down." When asked if client #4 had a gait belt available for use, staff #4 stated, "I don't think so. I'm really not sure. I think he has one at day program but I'm not sure. I think [client #4] used to have one here but not anymore."</p> <p>Observations were conducted at the facility's day service program on 5/17/13 from 9:10 AM through 10:10 AM. At 10:00 AM client #4 was seated in a</p>		<p>pattern of regression of ambulation for consumers is noted.</p> <p>Ongoing, the Program Director will ensure that Interdisciplinary Team meetings are held as needed when a pattern of incidents, including falls is noted to determine if further evaluation or additional assessments are needed.</p> <p>Client #4 Fall Risk Protocol will be updated to assess the need for additional supports due to increase in falls and regression in ambulation.</p> <p>Program Nurse will receive retraining to evaluate the need to review and update consumers Fall Risk Protocol after any falls to evaluate the need for additional supports or assessments and communicate any recommendations to the Program Director to implement.</p> <p>Ongoing, the Program Nurse will ensure that all consumers Fall Risk Protocols are reviewed and updated after an incident occurs to determine if any additional supports or safeguards need to be put into place. The Area Director will complete a review of medical protocols a minimum of quarterly to ensure that protocols are being updated as needed.</p>				

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	<p>wheelchair with a gait belt around his waist. Day service staff #1 pushed client #4 in a wheelchair to the restroom in the day service program area.</p> <p>DSM #1 (Day Service Manager) was interviewed on 5/17/13 at 10:00 AM. When asked if client #4 was using a wheelchair, DSM #1 stated, "We use a wheelchair here; it's not his, it belongs to us. We use it because he is so unsteady on his feet. He has the walker but he just can't stay up unless we hold him up. [Client #4] doesn't have an order for it but he just can't stand up to use the walker."</p> <p>The facility's BDDS reports and investigations regarding client #4 were reviewed on 5/13/13 at 1:30 PM. The review indicated the following:</p> <p>-BDDS report dated 1/14/13 indicated, "[Client #4] was taken to the emergency room because he fell and hit his head. [Client #4] has a very unsteady gait and he was not walking with his walker. There were no injuries noted from [client #4's] fall."</p> <p>-BDDS report dated 1/22/13 indicated, "At 1:40 AM, the on call nurse called the program director to report that the overnight staff reported to her that [client #4] had gone into the bathroom and when</p>			

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	<p>he came out, he had a cut on the top of his head. The staff did not know what happened while [client #4] was in the bathroom. 911 was called and an ambulance transported [client #4] to the [hospital]. The on call house manager met them at the hospital and [client #4] received 5 staples in his head."</p> <p>-BDDS report dated 5/13/13 indicated, "[Client #4] was being prepared to be transferred onto van when [client #4] tried to sit down on the lift gate bottom, he fell over and hit his nose. Resulting in scraping the side of his nose and his nose began to bleed. House Nurse came to observed [client #4] and clean up wound."</p> <p>Client #4's record was reviewed on 5/15/13 at 11:18 AM. Client #4's HCCR (Health Care Coordination Review) forms indicated the following:</p> <p>-March 2013, "Unsteady gait."</p> <p>-February 2013, "Unsteady gait."</p> <p>-January 2013, "Unsteady gait."</p> <p>-December 2012, "Unsteady gait."</p> <p>-November 2012, "11/29/12: [client #4] for evaluation of gait abnormality, gait training and wheeled walker."</p>				

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	<p>Client #4's record indicated client #4 had an 11/29/12 PT (Physical Therapy) recommendation for use of a rolling walker. Client #4's Fall Risk plan dated 4/9/12 did not indicate documentation of review or revisions following the 11/29/12 recommendations for use of rolling walker, or the 1/14/13, 1/22/13 or 5/13/13 falls. Client #4's record did not indicate documentation of IDT (Interdisciplinary Team) meetings to assess if client #4 was regressing with ambulation, should be assessed for wheelchair use, should be assessed for gait belt use or how to prevent additional falls.</p> <p>RN #1 (Registered Nurse) was interviewed on 5/15/13 at 11:00 AM. RN #1 indicated she had been assigned to this group home for less than 2 weeks. RN #1 indicated the previous nurse for this group home had retired. RN #1 indicated there was no documentation of client #4 being assessed by nursing staff to determine if client #4 needed additional supports for ambulation such as a wheelchair or gait belt. RN #1 indicated client #4's fall risk plan had not been revised or updated since 4/9/12. RN #1 indicated client #4's fall risk plan should have been assessed to determine if additional supports and safeguards were needed after client #4's</p>			

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	<p>falls and continued unsteady gait.</p> <p>AS (Administrative Staff) #1 was interviewed on 5/15/13 at 11:15 AM. AS #1 indicated the facility had not convened and IDT to assess client #4's ambulation needs. AS #1 indicated the IDT should have met to determine if client #4 needed additional supports to prevent additional falls. AS #1 indicated recommendations to prevent reoccurrence of falls and/or injuries of unknown origin should be developed from the investigation process and reviewed by the facility quality assurance team.</p> <p>9-3-2(a)</p>			

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 1 of 4 sampled clients (#4), the QIDP (Qualified Intellectual Disabilities Professional) failed to ensure client #4's medication training objective was monitored and revised on a routine basis.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 5/15/13 at 11:18 AM. Client #4's ISP (Individual Support Plan) dated 8/19/12 indicated, "[Client #4] is totally dependent on staff for administering his medications. [Client #4] is also dependant on staff to schedule his medical appointments." Client #4's ISP dated 8/19/12 indicated, "[Client #4] will increase medication administration skills through a formal goal: at medication time will get his water to take his medicine with." Client #4's PSMS (Participant Monthly Summaries) indicated the following:</p> <p>-March 2013: no documentation of medication goal tracking/review.</p> <p>-February 2013: no documentation of</p>	W000159	<p>An audit has been completed on all clients, including Client #4, Individual Service Plans and Program Goals/Objectives to ensure that the clients' most current program objectives are being implemented by staff.</p> <p>Updated goal tracking sheets have been provided to staff as needed and staff will be retrained on implementing any new program goals.</p> <p>Program Director will be retrained on QMRP responsibilities including up to date and accurate goal tracking sheets being provided to the staff monthly and ensuring that updated program plan objectives are make available to staff as soon as possible after the ISP is completed/updated.</p> <p>Ongoing, when completing monthly reviews, the Program Director will review the client's goals/objectives to ensure that the objectives from the most recent program plans are being tracked.</p> <p>Responsible Party: Program Director, Area Director.</p>	06/23/2013	

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	<p>medication goal tracking/review.</p> <p>-January 2013, will state the name of his dilantin (seizures) with one verbal prompt or less at 75% of trials. The January 2013 PSMS indicated, "No data available."</p> <p>-December 2012: no documentation of medication goal tracking/review.</p> <p>Client #4's record did not indicate documentation of tracking/review of client #4's daily medication administration goal.</p> <p>AS #1 (Administrative Staff) was interviewed on 5/15/13 at 11:15 AM. AS #1 indicated client #4's goals and training objectives should be monitored on a monthly basis for progress and regression.</p> <p>9-3-3(a)</p>			

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W000210	<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>Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1's sexual consent/awareness assessment was complete.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations regarding client #1 were reviewed on 5/13/13 at 1:30 PM. The review indicated the following:</p> <p>-BDDS report dated 3/1/13 indicated, "[Client #1] reported to staff that [client #6] has been coming in her room climbing on top of her and puts his penis in her. [Client #1] and [client #6] were boyfriend and girlfriend which ended. After the break up, [client #1] started making the accusations against him."</p> <p>Client #1's record was reviewed on 5/15/13 at 9:32 AM. Client #1's sexual consent/awareness assessment form dated 4/7/12 did not indicate a summary or outcome of the assessment and/or</p>	W000210	<p>Sexual Awareness assessments will be completed for all consumers including Client #1 and include a summary or outcome of the assessment and/or recommendations.</p> <p>Program Director will receive retraining on ensuring that all assessments, including Sexual Awareness assessments are completed for each consumer within 30 days of admission and reviewed and updated a minimum of annually on an ongoing basis. Program Director will also be retrained in the need to ensure that the sexual consent/awareness assessment is reviewed and updated as needed after a sexual allegation is made.</p> <p>Ongoing, the Program Director will ensure that Sexual Awareness assessments are completed for each consumer within 30 days of admission and a minimum of annually on an ongoing basis. The Area Director will communicate with the Program Director to ensure sexual consents/awareness assessments are reviewed and updated as needed following any</p>	06/23/2013			

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	<p>recommendations. Client #1's ISP (Individual Support Plan) dated 3/20/13 indicated client #1's DOA (Date of Admission) was 3/4/05.</p> <p>AS #1 (Administrative Staff) was interviewed on 5/15/13 at 11:15 AM. AS #1 indicated client #1's sexual assessment should be completed and reviewed annually for necessary revisions. AS #1 indicated client #1's sexual consent/awareness assessment should have been reviewed in regard to her 3/1/13 sexual allegation.</p> <p>9-3-4(a)</p>		<p>sexual allegations.</p> <p>Responsible Party: Program Director, Area Director, Quality Assurance Specialist</p>		

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W000218	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review and interview for 1 of 4 sampled clients (#4) plus one additional client (#5), the facility failed to ensure a current/accurate SA (Sensorimotor Assessment had been completed to meet the clients' needs.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 5/13/13 from 5:05 PM through 6:15 PM. Client #4 was observed in the home throughout the observation period. At 5:15 PM client #4 entered the group home office area using a rolling walker. Staff #1 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked. At 5:30 PM client #4 used a rolling walker to walk from the office area to the group home dining area for the evening meal. Staff #4 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked. At 6:00 PM client #4 finished eating his evening meal and began to walk from the dining area back to the group home office area. Staff #3 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked.</p>	W000218	<p>Appointments will be scheduled for Client #4 for an OT/PT assessment to evaluate his mobility needs and potential need for additional supports in regard to his unsteady gait and for Client #5 regarding his dining needs. Once evaluations are completed IDT meetings will be held to review recommendations and make any necessary changes and/or modifications based on Client #3 and Client #5 needs.</p> <p>Program Director and Home Manager will receive retraining that includes the need to ensure that all consumers receive appropriate assessments to evaluate the need for any adaptive equipment and/or modifications as needed.</p> <p>The Area Director will review the next 3 ISPs submitted by this Program Director to ensure that all necessary assessments have been completed and/or scheduled to evaluate each client's abilities as needed.</p> <p>Ongoing, the Program Director will ensure that all consumers receive appropriate assessments to evaluate the need for any adaptive equipment and/or modifications as needed.</p>	06/23/2013	

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	<p>Observations were conducted at the group home on 5/14/13 from 6:05 AM through 8:30 AM. Client #4 was observed in the group home throughout the observation period. At 6:47 AM client #4 used a rolling walker to walk to the group home medication administration room. Staff #4 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked. At 6:55 AM client #4 used a rolling walker to walk to the group home medication administration room. Staff #4 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked.</p> <p>Staff #4 was interviewed on 5/14/13 at 6:40 AM. Staff #4 indicated client #4 should use his rolling walker to ambulate. When asked why staff were holding client #4's pant belt loops while he walked, staff #4 stated, "[Client #4] is just so unsteady. He's had some falls. We have to do that or he falls down." When asked if client #4 had a gait belt available for use, staff #4 stated, "I don't think so. I'm really not sure. I think he has one at day program but I'm not sure. I think [client #4] used to have one here but not anymore."</p> <p>Observations were conducted at the facility's day service program on 5/17/13 from 9:10 AM through 10:10 AM. At 10:00 AM client #4 was seated in a</p>		Responsible Staff: Home Manager, Program Director, Area Director				

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	<p>wheelchair with a gait belt around his waist. Day service staff #1 pushed client #4 in a wheelchair to the restroom in the day service program area.</p> <p>DSM #1 (Day Service Manager) was interviewed on 5/17/13 at 10:00 AM. When asked if client #4 was using a wheelchair, DSM #1 stated, "We use a wheelchair here; it's not his, it belongs to us. We use it because he is so unsteady on his feet. He has the walker but he just can't stay up unless we hold him up. [Client #4] doesn't have an order for it but he just can't stand up to use the walker."</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations regarding client #4 were reviewed on 5/13/13 at 1:30 PM. The review indicated the following:</p> <p>-BDDS report dated 1/14/13 indicated, "[Client #4] was taken to the emergency room because he fell and hit his head. [Client #4] has a very unsteady gait and he was not walking with his walker. There were no injuries noted from [client #4's] fall."</p> <p>-BDDS report dated 1/22/13 indicated, "At 1:40 AM, the on call nurse called the program director to report that the overnight staff reported to her that [client</p>			

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	<p>#4] had gone into the bathroom and when he came out, he had a cut on the top of his head. The staff did not know what happened while [client #4] was in the bathroom. 911 was called and an ambulance transported [client #4] to the [hospital]. The on call house manager met them at the hospital and [client #4] received 5 staples in his head."</p> <p>-BDDS report dated 5/13/13 indicated, "[Client #4] was being prepared to be transferred onto van when [client #4] tried to sit down on the lift gate bottom, he fell over and hit his nose. Resulting in scraping the side of his nose and his nose began to bleed. House Nurse came to observed [client #4] and clean up wound."</p> <p>Client #4's record was reviewed on 5/15/13 at 11:18 AM. Client #4's HCCR (Health Care Coordination Review) forms indicated the following:</p> <p>-March 2013, "Unsteady gait."</p> <p>-February 2013, "Unsteady gait."</p> <p>-January 2013, "Unsteady gait."</p> <p>-December 2012, "Unsteady gait."</p> <p>-November 2012, "11/29/12: [client #4] for evaluation of gait abnormality, gait</p>						

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	<p>training and wheeled walker."</p> <p>Client #4's record indicated client #4 had an 11/29/12 PT (Physical Therapy) recommendation for use of a rolling walker. Client #4's Fall Risk plan dated 4/9/12 did not indicate documentation of review or revisions following the 11/29/12 recommendations for use of rolling walker, or the 1/14/13, 1/22/13 or 5/13/13 falls. Client #4's record did not indicate documentation of IDT (Interdisciplinary Team) meetings to assess if client #4 was regressing with ambulation, should be assessed for wheelchair use, should be assessed for gait belt use or how to prevent additional falls.</p> <p>RN #1 (Registered Nurse) was interviewed on 5/15/13 at 11:00 AM. RN #1 indicated she had been assigned this group home for less than 2 weeks. RN #1 indicated the previous nurse for this group home had retired. RN #1 indicated there was no documentation of client #4 being assessed by nursing staff to determine if client #4 needed additional supports for ambulation such as a wheelchair or gait belt. RN #1 indicated client #4's fall risk plan had not been revised or updated since 4/9/12. RN #1 indicated client #4's fall risk plan should have been assessed to determine if additional supports and</p>						

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	<p>safeguards were needed after client #4's falls and continued unsteady gait.</p> <p>AS #1 (Administrative Staff) was interviewed on 5/15/13 at 11:15 AM. AS #1 indicated the facility had not convened and IDT to assess client #4's ambulation needs. AS #1 indicated the IDT should have met to determine if client #4 needed additional supports to prevent additional falls.</p> <p>2. Observations were conducted at the group home on 5/13/13 from 5:05 PM through 6:15 PM. Client #5 was observed in the home throughout the observation period. Client #5 was visually impaired in that he had no left eye and cataracts in his remaining right eye. At 5:30 PM client #5 was participating in the group home's family style dining for the evening meal. Client #5 had a pork chop, cooked carrots, baked potatoes and a side salad. Client #5 used a standard dining plate with a fork. Client #5 consumed his meal by placing his face next to his plate and then used his fork to scoop the food from the plate to his mouth. Client #5 positioned his mouth against the edge of the plate before scooping the food into his mouth.</p> <p>Client #5's record was reviewed on 5/15/13 at 3:44 PM. Client #5's ISP (Individual Support Plan) dated 3/30/13</p>						

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	<p>indicated, "[Client #5] requires no special utensils (sic) or other adaptive equipment for meals. [Client #5] is independently ambulatory however (sic) [client #5's] eyesight is failing." Client #5's record did not contain documentation of a SA (Sensorimotor Assessment) regarding his mealtime needs.</p> <p>HM (Home Manager) #1 was interviewed on 5/15/13 at 11:40 AM. HM #1 indicated client #5 was visually impaired. HM #1 stated, "[Client #5] is going blind. [Client #5] has one eye and it has cataracts that are getting worse. [Client #5] can't see to eat his food. He sticks his face to his plate so he can eat."</p> <p>AS #1 (Administrative Staff) was interviewed on 5/15/13 at 11:15 AM. AS #1 indicated client #5 should be assessed for dining supports.</p> <p>9-3-4(a)</p>			
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W000242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#4), the client's ISP (Individual Support Plan) failed to address the client's basic training needs in regards to oral hygiene.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 5/15/13 at 11:18 AM. Client #4's Quarterly Nutrition Assessment dated 4/13 indicated, "Assist with brushing teeth. Poor oral hygiene." Client #4's Quarterly Nursing Assessment dated through 2/13 indicated, "Poor oral hygiene. Needs help brushing." Client #4's Health Care Coordination Monthly Reviews indicated the following:</p> <p>-March 2013, "Staff assist with brushing teeth."</p> <p>-February 2013, "Staff assist with brushing teeth."</p>	W000242	<p>An oral hygiene goal will be developed for Client #4. All Direct Support staff will receive retraining on Client #4 Oral Hygiene goal and how to implement and document it.</p> <p>The Program Director will receive retraining to include the need to ensure that all consumers have Oral Hygiene goals developed and implemented based on their individual abilities.</p> <p>Ongoing, the Program Director will ensure that all consumers have Oral Hygiene goals developed and implemented based on their individual abilities. The Area Director will review the next 3 ISPs submitted by this Program Director to ensure that all consumers have Oral Hygiene goals developed and implemented based on their individual abilities.</p> <p>Responsible Staff: Program Director, Area Director</p>	06/23/2013	

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	<p>-January 2013, "Staff assist with brushing teeth."</p> <p>Client #4's Physicians Order form dated 3/26/13 indicated client #4's diagnosis included severe periodontal disease. Client #4's ISP dated 8/9/12 did not indicate documentation of training/goals or supports for client #4's dental hygiene.</p> <p>AS #1 (Administrative Staff) was interviewed on 5/15/13 at 11:15 AM. AS #1 indicated client #4's ISP should address his basic needs including dental hygiene.</p> <p>9-3-4(a)</p>				

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observations, record review and interview for 2 of 4 sampled clients (#3 and #4), the facility failed to ensure nursing services met the needs of client #3 in regard to a urology follow up appointment. The facility failed to ensure nursing services met the needs of client #4 in regard to updating a care plan for falls and ambulation.</p> <p>Findings include:</p> <p>1. Client #3's record was reviewed on 5/14/13 at 8:21 AM. Client #3's Physicians Order form dated 3/26/13 indicated client #3's diagnosis included urinary incontinence. Client #3's Physicians Order form dated 3/26/13 indicated client #3 received Oxybutynin (bladder control) 10 milligram table once a day. Client #3's Urologist record of appointment form dated 3/20/13 indicated an prescription for Oxybutynin 10 milligram tablet for urinary incontinence. Client #3's 3/20/12 urologist record of appointment form indicated the recommendation for a follow up appointment in one year. Client #3's Appointment List form dated 2012 through 2013 indicated client #3 had been scheduled for a 3/20/13 urologist follow</p>	W000331	<p>1. A follow up appointment will be scheduled for Client #3 per the recommendations from her urologist. Staff and Home Manager will receive retraining to include ensuring the Program Nurse is notified of any medical appointments and their outcome or missed medical appointments and the reason for them being missed. The Home Manager will work with the Program Nurse to ensure all appointments are kept and documentation of all appointments is forwarded to the Program Nurse for review.</p> <p>2.A PT/OT assessment has been scheduled for Client #4 to evaluate the need for additional supports related to the increase in frequency of falls and regressing ambulation. Once the assessment is complete, and IDT will be held to discuss recommendations and evaluate the need for additional supports for Client #4.</p> <p>The Program Director and Program Nurse will receive retraining on the need to ensure that assessments are scheduled and completed to assess need for additional supports if a pattern is noticed regarding regression of</p>	06/23/2013	

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	<p>up appointment but had not gone. Client #3's record did not indicate documentation of a urologist follow up since the 3/20/13 examination.</p> <p>RN #1 (Registered Nurse) was interviewed on 5/15/13 at 11:00 AM. RN #1 indicated client #3 should have attended her 3/20/13 urologist appointment or been rescheduled. RN #1 indicated there was no documentation of a scheduled urology appointment for client #3.</p> <p>2. Observations were conducted at the group home on 5/13/13 from 5:05 PM through 6:15 PM. Client #4 was observed in the home throughout the observation period. At 5:15 PM client #4 entered the group home office area using a rolling walker. Staff #1 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked. At 5:30 PM client #4 used a rolling walker to walk from the office area to the group home dining area for the evening meal. Staff #4 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked. At 6:00 PM client #4 finished eating his evening meal and began to walk from the dining area back to the group home office area. Staff #3 walked behind client #4 and used client #4's belt loops on his pants to hold him up</p>		<p>ambulation for consumers.</p> <p>Ongoing the Program Director and Program Nurse will work together to evaluate the need for additional supports and/or additional assessments if a pattern of falls or regression in ambulation is noted to determine if additional supports are safeguards are needed to prevent further falls.</p> <p>Responsible Party: Home Manager, Program Director, Program Nurse</p>		

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	<p>as he walked.</p> <p>Observations were conducted at the group home on 5/14/13 from 6:05 AM through 8:30 AM. Client #4 was observed in the group home throughout the observation period. At 6:47 AM client #4 used a rolling walker to walk to the group home medication administration room. Staff #4 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked. At 6:55 AM client #4 used a rolling walker to walk to the group home medication administration room. Staff #4 walked behind client #4 and used client #4's belt loops on his pants to hold him up as he walked.</p> <p>Staff #4 was interviewed on 5/14/13 at 6:40 AM. Staff #3 indicated client #4 should use his rolling walker to ambulate. When asked why staff were holding client #4's pant belt loops while he walked, staff #4 stated, "[Client #4] is just so unsteady. He's had some falls. We have to do that or he falls down." When asked if client #4 had a gait belt available for use, staff #4 stated, "I don't think so. I'm really not sure. I think he has one at day program but I'm not sure. I think [client #4] used to have one here but not anymore."</p> <p>Observations were conducted at the facility's day service program on 5/17/13</p>						

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	<p>from 9:10 AM through 10:10 AM. At 10:00 AM client #4 was seated in a wheelchair with a gait belt around his waist. Day service staff #1 pushed client #4 in a wheelchair to the restroom in the day service program area.</p> <p>DSM #1 (Day Service Manager) was interviewed on 5/17/13 at 10:00 AM. When asked if client #4 was using a wheelchair, DSM #1 stated, "We use a wheelchair here; it's not his, it belongs to us. We use it because he is so unsteady on his feet. He has the walker but he just can't stay up unless we hold him up. [Client #4] doesn't have an order for it but he just can't stand up to use the walker."</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations regarding client #4 were reviewed on 5/13/13 at 1:30 PM. The review indicated the following:</p> <p>-BDDS report dated 1/14/13 indicated, "[Client #4] was taken to the emergency room because he fell and hit his head. [Client #4] has a very unsteady gait and he was not walking with his walker. There were no injuries noted from [client #4's] fall."</p> <p>-BDDS report dated 1/22/13 indicated, "At 1:40 AM, the on call nurse called the</p>				

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	<p>program director to report that the overnight staff reported to her that [client #4] had gone into the bathroom and when he came out, he had a cut on the top of his head. The staff did not know what happened while [client #4] was in the bathroom. 911 was called and an ambulance transported [client #4] to the [hospital]. The on call house manager met them at the hospital and [client #4] received 5 staples in his head."</p> <p>-BDDS report dated 5/13/13 indicated, "[Client #4] was being prepared to be transferred onto van when [client #4] tried to sit down on the lift gate bottom, he fell over and hit his nose. Resulting in scraping the side of his nose and his nose began to bleed. House Nurse came to observed [client #4] and clean up wound."</p> <p>Client #4's record was reviewed on 5/15/13 at 11:18 AM. Client #4's HCCR (Health Care Coordination Review) forms indicated the following:</p> <p>-March 2013, "Unsteady gait."</p> <p>-February 2013, "Unsteady gait."</p> <p>-January 2013, "Unsteady gait."</p> <p>-December 2012, "Unsteady gait."</p>						

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	<p>-November 2012, "11/29/12: [client #4] for evaluation of gait abnormality, gait training and wheeled walker."</p> <p>Client #4's Fall Risk plan dated 4/9/12 did not indicate documentation of review or revisions following the 11/29/12 recommendations for use of rolling walker or the 1/14/13, 1/22/13 or 5/13/13 falls. Client #4's record did not indicate documentation of nursing measures and/or assessments to determine if client #4 was regressing with ambulation, should be assessed for wheelchair use, should be assessed for gait belt use or how to prevent additional falls.</p> <p>RN #1 (Registered Nurse) was interviewed on 5/15/13 at 11:00 AM. RN #1 indicated she had been assigned this group home for less than 2 weeks. RN #1 indicated the previous nurse for this group home had retired. RN #1 indicated there was no documentation of client #4 being assessed by nursing staff to determine if client #4 needed additional supports for ambulation such as a wheelchair or gait belt. RN #1 indicated client #4's fall risk plan had not been revised or updated since 4/9/12. RN #1 indicated client #4's fall risk plan should have been assessed to determine if additional supports and safeguards were needed after client #4's falls and continued unsteady gait.</p>			

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W000371	<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 record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure the client had medication administration training.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 5/14/13 at 8:21 AM. Client #3's ISP (Individual Support Plan) dated 3/25/13 indicated, "[Client #3] is dependent on staff for all aspects of monitoring her health. [Client #3] does not independently take her medications, she needs assistance to schedule and attend all medical appointments." Client #3's Physicians Orders dated 3/26/13 indicated client #3 received the following medications:</p> <ul style="list-style-type: none"> -Abilify tablet 15 milligram (bipolar) -Aspirin-Low tablet 81 milligrams (heart) -Bupropion 150 milligram tablet (mood) -Divalproex 250 milligram tablet (bipolar) 	W000371	<p>A Medication Administration goal has been developed for Client #3. All Direct Support staff will receive retraining on Client #3 Medication Administration goal and how to implement and document it.</p> <p>The Program Director will receive retraining to include the need to ensure that all consumers have Medication Administration goals developed and implemented based on their individual abilities.</p> <p>Ongoing, the Program Director will ensure that all consumers have Medication Administration goals developed and implemented based on their individual abilities. The Area Director will review the next 3 ISPs submitted by this Program Director to ensure that all consumers have Medication Administration goals developed and implemented based on their individual abilities.</p> <p>Responsible Staff: Program Director, Area Director</p>	06/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/24/2013
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220		
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	<p>-Glyburide 5 milligram tablet (diabetes)</p> <p>-Oxybutynin 10 milligram tablet (incontinence)</p> <p>Client #3's PSMS (Participant Status Monthly Summaries) were reviewed from March 2013 through November 2012. Client #3's PSMS's did not indicate documentation of medication administration training objectives.</p> <p>AS (Administrative Staff) #1 was interviewed on 5/15/13 at 11:15 AM. AS #1 stated, "[Client #3] should have medication training anytime she had medications."</p> <p>9-3-6(a)</p>				

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W000440	<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 evacuation drills for each quarter on each shift.</p> <p>Findings include:</p> <p>The facility's evacuation drills record was reviewed on 5/13/13 at 3:38 PM. The review indicated the facility failed to conduct an evacuation drill for 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7 and #8) for the 3rd quarter, July through September 2012 for the 7:00 AM through 3:00 PM shift.</p> <p>AS #1 (Administrative Staff) was interviewed on 5/13/13 at 3:40 PM. AS #1 indicated there were no additional fire/evacuation drills.</p> <p>9-3-7(a)</p>	W000440	<p>All Direct Support Professionals will receive a retraining at least every other month to ensure that they understand the importance of completing the monthly fire drills. The training will include reviewing a copy of the fire drill schedule.</p> <p>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.</p> <p>Ongoing, the completed fire drill reports will be turned in to and reviewed by Quality Assurance for accuracy and thoroughness of each drill.</p> <p>Responsible Staff: Home Manager, Program Director, Quality Assurance</p>	06/23/2013	