

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G418	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/13/2011
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN46254
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W0000	<p>This visit was for investigation of complaint #IN00096573.</p> <p>Complaint #IN00096573 - Substantiated, Federal and state deficiencies related to the allegation(s) were cited at W149 and W159.</p> <p>Survey Dates: October 4, 5, 6 and 13, 2011</p> <p>Facility Number: 000932 Provider Number: 15G418 Aim Number: 100244560</p> <p>Surveyor: Jo Anna Scott, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/9/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0149	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 4 sampled clients (client A), the facility failed to implement their Abuse</p>	W0149	All staff were retrained on the need to ensure that contact information of the house as well as the contact information for the	11/21/2011

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>and Neglect Policy and neglected to provide supervision for client A when he was released from the hospital to return to the group home.</p> <p>Findings include:</p> <p>The Bureau of Developmental Disabilities Services (BDDS) reports were reviewed on 10/5/11 at 10:59 AM. The BDDS report dated 8/27/11 indicated client A had an altercation with a peer and had called the police himself. The report indicated the police had come to the house and felt that it was not safe to leave him in the home. The report indicated the police took client A to a local hospital. The report indicated the hospital did not admit client A because he calmed and he was released back to the home. The report indicated client A was "released via taxi back to the group home at 1:30 AM."</p> <p>Interview with staff #1, Area Manager, on 10/5/11 at 2:00 PM indicated she had not gone to the hospital with client A and was not contacted by the hospital that he was going to be released. Staff #1, Area Manager, indicated she did not know if client A would be admitted to the hospital when the police removed him from the home.</p> <p>Interview with staff #2, Home Manager</p>		<p>Home Manager and Program Director are provided to both the police and the hospital where clients are being transported to allow for open communication regarding the clients' status. (See attachment)A procedure was developed for staff, Home Manager and Program Director to refer to when a consumer is being transported by police or ambulance for a psychiatric evaluation. (See attachment) The procedure includes who determines if staff need to accompany a consumer to the hospital, how often communication with the hospital regarding the status of the consumer should take place and that the Area Director will be notified of any incidents that require the police or ambulance to transport a client for evaluation. All Direct Support staff, Home Manager and Program Director received retraining on this procedure. (See attachment) Ongoing, the Area Director will review all incident reports of clients being transported by the police or ambulance to the hospital for psychiatric evaluation to ensure that the procedure has been followed as outlined to ensure that clients are not left without required supervision. Responsible Party: Home Manager, ProgramDirector, Area Director</p>		

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	<p>(HM) on 10/5/11 at 2:00 PM indicated client A was not supposed to be unsupervised. Staff #2, HM, indicated client A arrived home by cab at around 1:45 AM.</p> <p>The facility abuse and neglect policy dated June 2007 was reviewed on 10/5/11 at 10:00 AM. The policy indicated the facility "promotes a high quality of service and seeks to protect individuals receiving (provider) services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed."</p> <p>This federal tag relates to complaint #IN00096573.</p> <p>9-3-2(a)</p>				

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W0159	<p>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 (client A), the Qualified Mental Retardation Professional (QMRP) failed to ensure communication with the work shop that they were provided with the information of client A's elopement from the group home.</p> <p>Findings include:</p> <p>The Bureau of Developmental Disability Services (BDDS) reports were reviewed on 10/5/11 at 10:59 AM. The BDDS report dated 9/8/11 indicated "[Client A] eloped from the group home at approximately 8:45 PM on 9/8/11. [Client A] was located by the police department at 9:00 PM on [name of street]. [Client A] was transported to [hospital name] on the morning of 9/9/11." The BDDS report dated 9/10/11 indicated "[Client A] was at [name of workshop], his residential staff arrived to pick him up and [workshop] could not locate [client A]. [Client A] was found by police around 7:00 PM at [name of street]. [Client A] was unharmed and police brought him back to his group home." The report included additional information on Monday 9/12/11 from the [workshop staff #2] and was added to the</p>	W0159	<p>The Home Manager and Program Director were retrained on the need to ensure that Day Service programs received either a copy of BDDS reports or verbal notification of any incidents, including elopements that may affect the consumers behaviors while at day placement. (see attachment) If the BDDS report has not been submitted for an incident such as elopement before the client reports to their next scheduled program at the Day Service the Home Manager and/or Program Director will be responsible for verbally notifying the Day Service program prior to the consumer returning or attending Day Services on the next scheduled day. Ongoing, the Area Director will contact the Day Service providers a minimum of quarterly to ensure that this requirement is being met. Responsible Party: Home Manager, Program Director, Area Director</p>	11/21/2011			

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	<p>incident report. The additional information indicated "In the morning [client A] reported that he wanted to talk to his residential staff and he seemed very agitated. [Workshop] staff called and [Provider] arranged for either a pickup or phone call from staff to address his concerns. [Client A] related that he had some difficulties the previous evening and ended up in the psychiatric unit. At 1:00 PM his residential staff arrived to pick him up and he was paged. [Workshop] staff saw him get up from his seat and leave the area. A few minutes later he had not reported to residential staff and he was paged again. Staff began to search the building and could not locate him. The grounds were searched and he was not found. After a search of the immediate area police were called to report."</p> <p>Interview with client A on 10/5/11 at 1:40 PM stated he ran away because "his mind was telling him to run." Client A indicated he was upset about the incident the night before when the police took him to the psychiatric unit.</p> <p>Interview with staff #2, Home Manager (HM), on 10/5/11 at 2:00 PM stated client A did not have elopement in his behavior plan at the time of the elopement but it had been added. Staff #2, HM, indicated they did not communicate with the</p>				

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	<p>workshop that client A had tried to elope the night before and had been taken to the hospital.</p> <p>Interview with workshop staff #2 on 10/6/11 at 9:15 AM. Staff #2 stated client A was having a "weird" day on the day of the elopement and kept saying he needed to talk to his residential staff. Staff #2 indicated they had not been made aware that morning that client A had eloped the night before and had spent the night in the psychiatric unit.</p> <p>This federal tag relates to complaint #IN00096573.</p> <p>9-3-3(a)</p>				