

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 01/13/2012
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000C	<p>This visit was for a post certification revisit (PCR) to complaint #IN00096573 investigated on 10/13/11.</p> <p>This visit was in conjunction with the recertification and state licensure survey.</p> <p>Complaint #IN00096573: Not Corrected.</p> <p>Survey Dates: January 9, 10, 11, 13, 2012</p> <p>Facility number: 000932 Provider number: 15G418 Aim number: 100244560</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 1/23/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			

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.

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 01/13/2012	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>implement policy and procedures in regard to immediately reporting allegations of abuse to the administrator.</p> <p>Findings include:</p> <p>Record review of facility incident reports was done on 1/9/12 at 1:38p.m. The following allegation of suspected/alleged abuse was not immediately reported to the facility administrator: An incident report dated 1/4/12 indicated client #4 had informed a direct care staff on 1/2/12 that client #1 had inappropriately touched him (hugged and kissed him) on 1/2/12. The incident report indicated the program director/administrator wasn't notified until 1/3/12 of the allegation.</p> <p>Record review was done on 1/11/12 at 2:20p.m. of the facility's policy and procedures. The facility's policy titled "Report of Abuse/Neglect/Exploitation Received" (dated 5/5/06) indicated: "Staff will immediately contact the program director or on-call supervisor."</p> <p>Interview on 1/11/12 at 2:40p.m. of staff #1 (program director) indicated the facility had not followed its policy and procedures to report suspected client abuse immediately to the administrator. Staff #1 indicated facility direct care staff were aware on 1/2/12 of an inappropriate</p>						

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 01/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>touch allegation by client #4 regarding client #1. Staff #1 indicated they were not informed of the allegation until 1/3/12. Staff #1 indicated they should have been immediately informed of the allegation on 1/2/12. 9-3-2(a) This deficiency was cited on 10/13/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>			
--	--	--	--	--