

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032		
(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	
W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: June 19, 20, 21, 26, 27, and July 1, 2013.</p> <p>Facility Number: 001045 Provider Number: 15G531 AIMS Number: 100244990</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed July 9, 2013 by Dotty Walton, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032			
(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			
W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review, and interview, for 4 of 4 clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8) who lived in the group home, the governing body failed to exercise operating direction over the facility to complete maintenance and repairs at the group home.</p> <p>Findings include:</p> <p>During observations on 6/19/13 from 3:20pm until 6:20pm and on 6/20/13 from 5:35am until 8:05am, at the group home, clients #1, #2, #3, #4, #5, #6, #7, and #8 were at the group home and the following was observed with the RM (Residential Manager), Group Home Staff (GHS) #1, and GHS #2.</p> <p>-On 6/19/13 at 3:50pm, the RM indicated the living room wall had a ten feet by two feet (10' x 2') plaster repair patch that needed repainted.</p> <p>-On 6/19/13 at 3:50pm, the RM indicated three of three (3/3) hallway closet doors' finish was worn, unclean, and needed repainted.</p>	W000104	<p>The Program Director will submit requests for the following maintenance items to be completed: for the plaster repair patch in the living room to be repainted, for the hallway closet doors to be cleaned and repainted, for the hallway bathroom ceiling finish to be repaired, for the hallway bathroom walls to be repainted, for the hallway bathroom ceiling light cover to be replaced and for the wallpaper in Client #4 and #8 shared bedroom to be repaired/replaced. The Program Director will work with maintenance staff to obtain a date for the completion of the all requested items.</p> <p>The Home Manager will provide the Program Director with a daily report on the progress of all of the repairs starting on the estimated date of completion.</p> <p>If the repairs are not completed within 3 days of the estimated date of completion the Program Director will inform the Area Director.</p> <p>The Area Director will ensure</p>	07/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032		
(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>-On 6/19/13 at 3:50pm, the RM indicated hallway bathroom #1 had a three feet by one foot (3' x 1') popcorn ceiling finish inside the shower peeling away from the plaster and falling into the shower below.</p> <p>-On 6/19/13 at 3:50pm, the RM stated the top of client #8's bedroom dresser "was covered with toothpaste" and had dried to form a substance "like playdough."</p> <p>-On 6/19/13 at 3:50pm, the RM indicated hallway bathroom #2 had one of two (1/2) ceiling light covers missing and the bare light bulbs were exposed. The RM indicated two of four (2/4) bathroom walls had a discoloration stain covering a three feet by three feet (3' x 3') area of the two walls.</p> <p>-On 6/19/13 at 3:50pm, the RM indicated client #4 and #8's shared bedroom had one of four (1/4) walls with wallpaper peeling the length of the seam from above the floor to the ceiling.</p> <p>On 6/19/13 at 3:50pm and on 6/21/13 at 7:45am, the facility's maintenance items to be repaired and/or replaced was requested from the PD (Program Director) and none were available for review.</p> <p>An interview with the Site Director (SD) was conducted on 6/21/13 at 11:00am.</p>		<p>other arrangements are made to have all requested repairs completed by 7-31-13.</p> <p>In the future the Home Manager will electronically inform the Program Director of maintenance needs in the home. The Program Director will ensure a maintenance request is submitted properly. The Home Manager will be responsible for keeping the PD informed of the progress on maintenance requests on a weekly basis. The PD will contact the Maintenance staff supervisor if the request has not been completed within 2 weeks of the request.</p> <p>Staff Responsible: Home Manager, program Director, Maintenance Staff, Office Manager</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/01/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032		
(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	
	The SD indicated no maintenance items had identified maintenance needs for needed repairs.  9-3-1(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032			
(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			
W000130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, for 3 of 4 sampled clients (client #1, #2, and #3) and two additional clients (clients #5 and #8), the facility failed to provide privacy during medical monitoring, medication administration, and client #2's morning routine.</p> <p>Findings include:</p> <p>1. On 6/19/13 at 4:30pm, Group Home Staff (GHS) #2 requested client #1 come to the medication area in the center hallway and sat down in a chair in view of the living room open door. Clients #2, #3, #5, #6, #7, and #8 walked throughout the group home, sat in the living room, and general conversations/interactions were overheard and observed in the medication area. GHS #2 requested client #1 to pull up his shirt and make ready his G-tube for feeding. Client #1 complied, exposed his abdominal area, the tube into his stomach, and GHS #2 administered client #1's two cans of nutritional supplement (8 ounces each), client #1's medications, and flushed the tube in full view of the living room and hallway areas. Client #8 walked through the</p>	W000130	<p>All staff will be retrained on client dignity especially ensuring that all clients have privacy when they are assisting them medication administration. All staff will be retrained to encourage consumers to wear robes when they are walking to and from the bathroom and their bedrooms.</p> <p>Ongoing, the Home Manager and/or Program Director will complete active treatment observations twice per week for four weeks to observe if staff are maintaining consumers' dignity when they are assisting clients with medication administration and encouraging them to wear robes when they are walking around the common areas of the home. After four weeks the Home Manager and/or PD will complete active treatment observations once per week to observe if staff are maintaining consumers' dignity when they are assisting clients with medication administration and encouraging them to wear robes when they are walking around the common areas of the home.</p> <p>Responsible Party: Home Manager, Program Director, Area Director</p>	07/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032		
(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>medication area twice and interacted verbally with GHS #2 during client #1's procedures. No privacy was encouraged or offered.</p> <p>2. On 6/19/13 at 4:50pm, GHS #2 requested client #5 come to the medication area in the center hallway and client #5 sat down on a chair in view of the living room open door and hallways. GHS #2 named client #5's medications, side effects, took client #5's blood pressure in his left arm, and administered client #5's oral medications in view of other clients and staff in the living room and hallway areas. No privacy was encouraged or offered.</p> <p>3. On 6/19/13 at 5:00pm, GHS #2 requested client #3 come to the medication area in the center hallway and client #3 sat down on a chair in view of the living room open door and hallways. GHS #2 named client #3's medications, side effects, and administered client #3's oral medications in view of other clients and staff in the living room and hallway areas. No privacy was encouraged or offered.</p> <p>4. On 6/19/13 at 4:50pm, GHS #2 requested client #8 come to the medication area in the center hallway and in view of the living room open door and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032			
(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>hallways. GHS #2 named client #8's medications, side effects, and administered client #8's oral medications in view of other clients and staff in the living room and hallway areas. No privacy was encouraged or offered.</p> <p>5. On 6/20/13 at 5:45am, client #2 walked independently from her bedroom in a short night gown with a low cut neck line, exposed the tops of her breasts, and the hem of the night gown was above her knees. Client #2 used her cane due to blindness, navigated into the living room, and sat down in the living room with male clients #1, #4, #6, and male group home staff. Client #2 was not redirected to wear a robe and no personal privacy was taught. At 6am, GHS #2 stated he was unsure if client #2 "owned a robe."</p> <p>On 6/21/13 at 11:15am, an interview with the Site Director (SD) was conducted. The SD indicated clients should have privacy ensured by facility staff during medication administration and medical monitoring. The SD indicated client #2 should have had personal privacy encouraged and the SD was unsure if client #2 owned a robe.</p> <p>9-3-2(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032		
(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	
W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, for 1 of 1 unreported controlled medication discrepancy count (client #1), the facility nurse failed to report to the facility administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law client #1's discrepancy for controlled medication investigation for his Klonopin (for behaviors), an anti convulsant benzodiazepine Schedule IV medication.</p> <p>Findings include:</p> <p>On 6/19/13 at 11:15am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 06/2012 through 06/19/13 and did not indicate client #1's discrepancy for controlled medication had been reported to BDDS or to the facility's administrator.</p> <p>On 6/21/13 at 9:10am, client #1's record was reviewed. Client #1's 12/23/12 "Consultant Pharmacist's Medication Regimen Review" indicated</p>	W000153	<p>The Program Nurse that made the entry into Client #1 medical record is no longer employed by the agency. All direct care staff and the new Program Nurse will be retrained on incident reporting including reporting to the supervisor immediately when incidents of medication errors, missing medications, reporting timelines, and DSP, Program Nurse and Home Manager role in reporting incidents.</p> <p>The PD will be retrained on the requirement for the completion of investigations and the development of recommendations based on the factual findings of the investigation to include but not be limited to corrective action for staff, retraining of staff, client plan changes, etc.</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 Quality Assurance</p>	07/31/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032		
(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>"Recommendation...Please investigate: Control count sheet for Klonopin does not match with on hand count. Control Inventory sheet indicates 11 tablets have been used, however there are 15 tablets remaining in card." Documented in a handwritten entry from the former agency nurse indicated "Count was off due to extra med (medication) from November (2012) card was given. Count 12/2012 correct when I checked it. Jan. (January) 2012 (sic) card correct also" signed by the Licensed Practical Nurse.</p> <p>On 6/21/13 at 11:15am, an interview with the Site Director (SD) was conducted. The SD indicated she was not aware of the Pharmacists' entry or the request for an investigation. The SD indicated client #1's Klonopin medication was not formally reported by the nurse and was not investigated by the agency. The SD indicated the agency nurse, who made the entry into client #1's record, was no longer employed by the agency, and no further information regarding the medication count discrepancy was available for review. The SD indicated client #1's Klonopin count discrepancy should have been reported and was not.</p> <p>9-3-2(a)</p>		<p>Specialist. If the investigations are not thorough enough the Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Staff: Home Manager, Program Nurse, Program Director, Area Director</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032			
(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			
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 1 of 1 controlled medication Klonopin (for behaviors) count discrepancy (client #1), the facility failed to thoroughly investigate a discrepancy in the number of Klonopin pills versus the number of pills recorded.</p> <p>Findings include:</p> <p>On 6/19/13 at 11:15am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 06/2012 through 06/19/13 and did not include an investigation of client #1's discrepancy of controlled medication (Klonopin).</p> <p>On 6/21/13 at 9:10am, client #1's record was reviewed. Client #1's 12/23/12 "Consultant Pharmacist's Medication Regimen Review" indicated "Recommendation...Please investigate: Control count sheet for Klonopin does not match with on hand count. Control Inventory sheet indicates 11 tablets have been used, however there are 15 tablets remaining in card." Documented in a handwritten entry from the former agency nurse indicated "Count was off due to</p>	W000154	<p>The Program Director will receive retraining on investigations including ensuring that all reports of medication errors or missing medications for consumes are investigated, investigations are completed thoroughly and accurately and all investigations are reported to the administrator or designee the results within 5 work days.</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 Quality Assurance Specialist. If the investigations are not thorough enough the Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Program Director, Quality Assurance Specialist, Area Director</p>	07/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032			
(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>extra med (medication) from November (2012) card was given. Count 12/2012 correct when I checked it. Jan. (January) 2012 (sic) card correct also" signed by the Licensed Practical Nurse. No investigation results, no investigative documents, and no investigative process was available for review.</p> <p>On 6/21/13 at 11:15am, an interview with the Site Director (SD) was conducted. The SD indicated she was not aware of the Pharmacists' entry or the request for an investigation. The SD indicated client #1's Klonopin medication was not formally reported by the nurse and was not investigated by the agency. The SD indicated the agency nurse who made the entry into client #1's record was no longer employed by the agency and no further information was available for review. The SD indicated client #1's Klonopin discrepancy in his count should have been thoroughly investigated and was not.</p> <p>9-3-2(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032			
(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			
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 sample clients (client #2), the facility failed to assess client #2's functional ability related to her blindness.</p> <p>Findings include:</p> <p>During observations on 6/19/13 from 3:20pm until 6:20pm and on 6/20/13 from 5:35am until 8:05am, at the group home, client #2 walked with her cane throughout the group home catching her feet on throw rugs on the floors in the living room, bathrooms, and her bedroom. Client #2 walked through doorways independently, dressed with the assistance of staff, independently washed dishes, and fed herself with her fingers supper and breakfast. On 6/19/13 at 5:19pm, GHS (Group Home Staff) #1, the RM (Residential Manager), and the QIDP (Qualified Intellectual Disabilities Professional) served client #2 her hamburger hand over hand, set her items of onion slice, tomato slice, and ketchup onto client #2's hamburger bun on client #2's plate. Client #2 indicated she wanted a lettuce salad, the QIDP served client #2 a lettuce salad, and the QIDP poured client #2's selected dressing onto her salad custodially. From 5:19pm until 5:30pm,</p>	W000218	<p>An appointment will be scheduled for Client #2 for an assessment to evaluate her mobility needs and potential need for additional supports in regard to her blindness. Once an evaluation is completed, an IDT meeting will be held to review recommendations and make any necessary changes and/or modifications based on Client #2 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> <p>Responsible Staff: Home Manager, Program Director, Area</p>	07/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032			
(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>client #2 fed herself the meal with her fingers. No redirection was provided by staff and no tactile aid was provided to client #2.</p> <p>A review of client #2's record was conducted on 6/21/13 at 12:00noon. Client #2's 10/30/12 ISP (Individual Support Plan) did not indicate a goal/objective for her safely walking throughout the group home and did not indicate environmental factors to consider. Client #2's 3/21/11 visual assessment indicated her ocular health was stable and client #2 was legally blind. Client #2's 5/30/13 "Physician's Order" indicated client #2's diagnosis included, but was not limited to: Blindness. Client #2's 10/30/12 Risk Assessment indicated client #2 was blind and at risk for falls. Review of the record did not indicate a sensorimotor assessment to assist client #2 in functioning with her visual limitations.</p> <p>An interview with the QIDP (Qualified Intellectual Disabilities Professional) was completed on 6/21/13 at 12:15pm. When asked if client #2 was assessed to address her functional skills related to her blindness, the QIDP stated "No." The QIDP indicated client #2 used her cane to walk and had no functional skill assessment completed.</p>		Director				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032
---	---

(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
	9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032			
(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			
W000386	<p>483.460(l)(4) DRUG STORAGE AND RECORDKEEPING The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq., as implemented by 21 CFR Part 308). Based on record review and interview, for 1 of 1 controlled medication discrepancy count (client #1), the facility nurse failed to ensure the facility staff reconciled client #1's controlled medication count of his Klonopin (for behaviors).</p> <p>Findings include:</p> <p>On 6/19/13 at 11:15am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 06/2012 through 06/19/13 and did not indicate client #1's controlled medication Klonopin had been counted, recorded, and any discrepancies reconciled.</p> <p>On 6/21/13 at 9:10am, client #1's record was reviewed. Client #1's 12/23/12 "Consultant Pharmacist's Medication Regimen Review" indicated "Recommendation...Please investigate: Control count sheet for Klonopin does not match with on hand count. Control Inventory sheet indicates 11 tablets have been used, however there are 15 tablets</p>	W000386	<p>The Program Nurse that made the entry into Client #1 medical record is no longer employed by the agency and no further information is available for review regarding this situation. All direct care staff and the new Program Nurse will be retrained on ensuring that all medications, especially controlled medications, are counted, recorded and any discrepancies reconciled.</p> <p>The Program Nurse will review the Pharmacy Consultation Notes as soon as possible after they are completed and report any discrepancies to the Program Director and Area Director so that any necessary reports can be made and investigations completed.</p> <p>Ongoing, the Home Manager, Program Director and/or Program Nurse will complete medication administration observations twice per week for four weeks to observe if staff are counting and recording controlled substance counts when they are assisting clients with medication administration and reporting any</p>	07/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032			
(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>remaining in card." Documented in a handwritten entry from the former agency nurse indicated "Count was off due to extra med (medication) from November (2012) card was given. Count 12/2012 correct when I checked it. Jan. (January) 2012 (sic) card correct also" signed by the Licensed Practical Nurse. No documented controlled count process was available for review to determine if or when client #1's controlled medication of Klonopin was accounted for.</p> <p>On 6/21/13 at 11:15am, an interview with the Site Director (SD) was conducted. The SD indicated she was not aware of the Pharmacists' entry or the request for an investigation. The SD indicated the agency nurse who made the entry into client #1's record was no longer employed by the agency and no further information was available for review. The SD indicated client #1's Klonopin count discrepancy should have been reported and in an effort to reconcile the pill count; thoroughly investigated. The SD indicated controlled medications should be accounted for by each shift of personnel who are dispensing medications.</p> <p>9-3-6(a)</p>		<p>discrepancies to the Program Director and Area Director so that they can be investigated and reconciled as needed. After four weeks the Home Manager, Program Nurse and/or PD will complete medication administration observations once per week to observe if staff are counting and recording controlled substance counts when they are assisting clients with medication administration and reporting any discrepancies to the Program Director and Area Director so that they can be investigated and reconciled as needed.</p> <p>Responsible Staff: Program Nurse, Home Manager, Program Director, Area Director</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032			
(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			
W000454	<p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (client #1) who lived in the group home, the facility staff failed to ensure client #1's pill crusher was clean.</p> <p>Findings include:</p> <p>On 6/19/13 at 4:30pm, Group Home Staff (GHS) #2 requested client #1 come to the medication area in the center hallway. GHS #2 requested client #1 pull up his shirt and make ready his G-tube for feeding. Client #1 complied. GHS #2 selected a blue pill crusher from the drawer labeled for client #1. GHS #2 opened the dusty pill crusher and indicated the dust was inside the pill crusher. GHS #2 indicated the dust left inside the pill crusher was from client #1's morning medication being crushed. GHS #2 indicated client #1's pill crusher was washed once a day. GHS #2 crushed client #1's tablets inside the pill crusher. GHS #2 administered client #1's two cans of nutritional supplement (8 ounces each), client #1's crushed medications, and flushed client #1's tube with water. GHS #2 replaced the cap on the soiled pill crusher and placed it back into client #1's</p>	W000454	<p>All direct care staff will be retrained on the need to ensure that Client #1 pill crusher is cleaned after each medication pass.</p> <p>Ongoing, the Home Manager, Program Director and/or Program Nurse will complete medication administration observations twice per week for four weeks to observe if staff are cleaning Client #1 pill crusher after each medication pass. After four weeks the Home Manager, Program Nurse and/or PD will complete medication administration observations once per week to observe if staff are cleaning Client #1 pill crusher after each medication pass.</p> <p>Responsible Party: Home Manager, Program Director, Program Nurse</p>	07/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3107 HENSEL DR CARMEL, IN 46032		
(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>medication drawer.</p> <p>On 6/20/13 at 5:45am, GHS #4 was asked about client #1's pill crusher. GHS #4 retrieved the same blue dusty pill crusher from client #1's medication drawer and indicated the dusty pill crusher was washed daily on day shift.</p> <p>An interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 6/21/13 at 7:45am. The QIDP indicated staff should have washed client #1's pill crusher daily. The QIDP indicated no cleaning schedule was available to determine who was responsible for cleaning client #1's blue pill crusher or when the pill crusher was last cleaned.</p> <p>9-3-7(a)</p>				