

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/29/2012
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3705 E 116TH ST CARMEL, IN 46032		
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: June 25, 26, 27, 28, and 29, 2012</p> <p>Surveyor: Kathy Craig, Medical Surveyor</p> <p>Facility Number: 001174 Provider Number: 15G625 AIMS Number: 100235590</p> <p>These deficiencies also reflect state findings under 460 IAC 9.</p> <p>Quality Review was completed on 7/6/12 by Tim Shebel, 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.

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the governing body failed to exercise general maintenance over the facility for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) by not ensuring the carpet was stain-free, not replacing two torn chairs, not taking care of a urine smell in the hallway, not replacing a client's stained bedspread, and not replacing a client's closet door.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 6/25/12 from 3:55 PM to 6:30 PM, and on 6/26/12 from 6:30 AM to 7:40 AM, where clients #1, #2, #3, #4, #5, #6, #7, and #8 reside. Client #2's bedroom closet did not have a door on it. The hallway had a urine odor. There were dark stains on the light brown carpet all throughout the home, too numerous to count. There were two tan colored vinyl chairs in the family room. One chair's arms had tears up and down them. The other chair had 6 tears on the seat cushion. Client #1's bedspread had 20 circular brown stains on it.</p> <p>Interview on 6/27/12 at 12:25 PM with</p>	W0104	<p>The House Manager and Program Director will work with the maintenance crew to ensure that the stained carpet is cleaned professionally. This will be completed throughout the house to ensure that any urine smells will be removed.</p> <p>The Maintenance Crew removed the torn chairs from the living area. The Home Manager will purchase new ones.</p> <p>The Home Manager purchased a new bedspread for client #1.</p> <p>The Home Manager and Program Director will be retrained on ensuring that all maintenance issues are addressed in a timely manner and followed up on, if remaining incomplete.</p> <p>Ongoing, the Program Director will complete a monthly walk thru of the group home to ensure that no issues are noted.</p> <p>Ongoing, the Area Director will ensure that a quarterly walk-thru is completed to ensure that all maintenance issues are taken care of in a timely matter and do not remain incomplete.</p> <p>Completion Date: 7-29-2012 Responsible Party: Home Manager and Program Director, and Area Director</p>	07/29/2012			

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	<p>the house manager and the Area Director (AD) was conducted. The house manager indicated if there are maintenance issues they call the maintenance man. The AD indicated the carpet is cleaned by a professional cleaner.</p> <p>9-3-1(a)</p>			

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W0252	<p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #1) by not ensuring data for client #1's individual support plan objectives was being documented on a regular basis.</p> <p>Findings include:</p> <p>Review on 6/26/12 at 11:35 AM of client #1's records was conducted. Review of client #1's monthly reviews from 1/12 to 4/12 of his program plan objectives from 1/12 to 4/12 no data was collected for the following objectives during the indicated months. The following monthly reviews indicated on the objectives listed "There was no data collected for this objective this month." and "It is unknown why there was no data available for this month."</p> <p>1. January, 2012: Three times a week will wash his armpits; and twice a week, client #1 will count his petty cash.</p> <p>2. February, 2012: Three times a week will wash his armpits; and twice a week, client #1 will count his petty cash.</p> <p>3. March, 2012: Three times a week will</p>	W0252	<p>All staff will be retrained on completing and properly documenting all goals. The Home Manager will complete two weekly observations to ensure that all staff are completing the objectives correctly with the clients. The Home Manager will be retrained on completing documentation reviews weekly. Along with the observations, the Home Manager will also complete weekly random documentation reviews to ensure that all staff are completing the documentation to record the completion of the objectives. The Program Director will review all documentation reviews and completed observations to ensure that they are being completed correctly by both the staff and the Home Manager. Ongoing, the Area Director will complete random quarterly audits to ensure that all documentation is being completed and correctly. Completion Date: 7-29-2012 Responsible Party: Home Manager , Program Director, and Area Director</p>	07/29/2012	

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	<p>wash his armpits; and twice a week, client #1 will count his petty cash.</p> <p>4. April, 2012: Three times a week will wash his armpits; and twice a week, client #1 will count his petty cash.</p> <p>Interview on 6/20/12 at 2:38 PM with the AD (Area Director) was conducted. She indicated staff should always record the data when running a goal formally.</p> <p>9-3-4(a)</p>				

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W0262	<p>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on record review and interview, the facility failed for 3 of 4 sampled clients (clients #2, #3, and #4) by not ensuring HRC (Human Rights Committee) reviewed and approved clients' restrictive programs.</p> <p>Findings include:</p> <p>Review on 6/26/12 at 12:00 PM of client #2's records included his BDP (Behavior Development Program) dated 6/2/11. His BDP indicated he was on the following behavior medications: Oripiprazole- 15 mgs (milligrams) and Noritriptyline-40 mgs for depression. Client #2's BDP did not have the approval of the HRC.</p> <p>Review on 6/26/12 at 12:15 PM of client #3's records included his BDP dated 6/6/11. His BDP indicated he was on the following behavior medications: 40 mg (milligrams) Propranolol, 3 mg Alprazolam, 40 mg paroxetine; all for extreme irritability. Client #3's BDP did not have the approval of the HRC.</p>	W0262	<p>The new Program Director will be trained on the correct process for retrieving the appropriate approvals for the Behavior Support Plans. Ongoing, the new Program Director will correctly retrieve the approvals for all future Behavior Support Plans from the Guardian/Health Care Representative first, then once received, will get the appropriate approval from the Human Rights Committee, before implementing. Ongoing, the Area Director will complete random quarterly audits to ensure that all of the proper approvals are in place from the IDTs. Completion Date: 7-29-2012 Responsible Party: Home Manager, Program Director, and Area Director</p>	07/29/2012			

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	<p>Review on 6/26/12 at 12:30 PM of client #4's records included his BDP dared 10/31/11. His BDP indicated he was on the following behavior medications: 50 mg (milligrams) Naltrexone, 20 mg paroxetine, .25 mg Halcion, and 10 mg Diazepam, for anxiety. Client #4's BDP did not have the approval of the HRC.</p> <p>Interview on 6/27/12 at 2:10 PM with the AD (Area Director) was conducted. The AD indicated she couldn't find the approvals for clients #2, #3, and #4's BDPs.</p> <p>9-3-4(a)</p>			

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W0263	<p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (clients #1 and #2) by not obtaining the written informed consent of the guardian or healthcare representative before the HRC (Human Rights Committee) approved clients' restrictive programs; or didn't obtain the written informed consent of the guardian.</p> <p>Findings include:</p> <p>Review on 6/26/12 at 11:35 AM of client #1's records included his BDP (Behavior Development Program) dated 10/31/11. His BDP indicated he was on the following behavior medications: 40 mg (milligrams) Fluoxetine, 20 mg Loxapine, and 20 mg Olanzapine. Client #1's guardian gave written consent on 2/5/12. The HRC approved it before the guardian gave written consent on 1/18/12.</p> <p>Review on 6/26/12 at 12:00 PM of client #2's records included his BDP dated 6/2/11. His BDP indicated he was on the following behavior medications: 15 mgs (milligrams) Oripiprazole, and 40 mgs Nortriptyline, and 2 mg for depression.</p>	W0263	<p>The new Program Director will be trained on the correct process for retrieving the appropriate approvals for the Behavior Support Plans. Ongoing, the new Program Director will correctly retrieve the approvals for all future Behavior Support Plans from the Guardian/Health Care Representative first, then once received, will get the appropriate approval from the Human Rights Committee, before implementing. Ongoing, the Area Director will complete random quarterly audits to ensure that all of the proper approvals are in place from the IDTs. Completion Date: 7-29-2012 Responsible Party: Home Manager , Program Director, and Area Director</p>	07/29/2012			

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	<p>Client #2's BDP did not have written guardian consent.</p> <p>Interview on 6/27/12 at 2:10 PM with the AD (Area Director) was conducted. The AD indicated she didn't have written consent from clients #1 and #2's guardians.</p> <p>9-3-4(a)</p>						

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W0268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation and interview, the facility failed for 3 of 4 sampled clients (clients #1, #2, and #3) by not maintaining their dignity by not keeping their nails trimmed, and for not ensuring client #2 had proper fitting pants on at day program.</p> <p>Findings include:</p> <p>Observations were conducted at Day Program #1 (DP#1) from 9:10 AM to 9:40 AM, where client #2 attended. Upon entering DP#1, client #2 grabbed this surveyor's right hand and dug his fingernails into it. Client #2's fingernails were sharp and were 1/2 inch long. Client #2's jeans were baggy and were held up by a belt.</p> <p>Interview on 6/26/12 at 9:25 AM with DP#1 supervisor was conducted. The supervisor stated client #2's clothes were "ill-fitting." The supervisor indicated if the group home cuts their clients' nails, it is once a month.</p> <p>Observations were conducted at Day Program #2 (DP#2) from 10:25 AM to 10:45 AM, where client #3 attended.</p>	W0268	<p>The Direct Care Staff will be retrained on dignity needs of the clients, specifically in regards to hygiene and appearance. The retraining will also include documentation of the correct hygiene for the clients, specifically the monthly healthcare checklist. Ongoing, the Home Manager will complete weekly observations to ensure that the client's dignity is respected and that the staff are appropriately monitoring the client's appearance and hygiene needs, specifically the cutting of fingernails. All observations will be reviewed by a supervisor after completed. Ongoing, the Area Director will complete random observations to ensure that the staff are appropriately monitoring the client's appearance and hygiene needs. Completion Date: 7-29-2012 Responsible Party: Home Manager, Program Director, and Area Director.</p>	07/29/2012			

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	<p>Client #3's fingernails were long, approximately 1/2 inches.</p> <p>Interview on 6/26/12 at 10:35 AM with DP#2 direct care staff was conducted. The direct care staff indicated client #3's nails are a problem and indicated the day program staff are not allowed to cut clients' nails.</p> <p>Observations were conducted at Day Program #3 (DP#3) from 10:55 AM to 11:25 AM, where client #1 attended. Client #1's fingernails were long, approximately 1/2 inches, with the middle one on right hand curling under.</p> <p>Interview on 6/26/12 at 11:10 AM with DP#3's director was conducted. The director indicated client #1's nails was one of the biggest issues and she has talked to the nurse about it. The director indicated DP#3 has sent home notes in the past about client #1's nails needing clipped. The director stated it was "grooming altogether-shaving, hair, nails" with client #1.</p> <p>Interview on 6/27/12 at 12:25 PM with the house manager of the group home was conducted. The house manager indicated staff trim clients' nails and they were supposed to check them once every 2 weeks.</p>						

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	<p>Interview on 6/27/12 at 1:25 PM with the Program Director (PD) was conducted. The PD indicated the clients' nails should have been trimmed on a regular basis.</p> <p>9-3-5(a)</p>				

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W0322	<p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #4) to provide preventive and general care as indicated by his health status.</p> <p>Findings include:</p> <p>During Record Review on 6/26/12 at 12:30 PM no PSA (prostate lab exam) was provided for client #4. Review on 6/25/12 at 1:45 PM of the Community Residential Facility Surveyor Worksheet dated 6/25/12 indicated client #4 was over the age of 50 years old. During the same record review the Preventative Screening Guidelines (not dated) indicated beginning at age 50 (male) Clients would receive the PSA and had written by it "N/A." There were no deliberations in the Individual Support Plan or in any other portion of the clients' charts indicating client #4 did not have a PSA test administered at age 50 and beyond.</p> <p>Interview on 6/27/12 at 12:05 PM with</p>	W0322	<p>The Director of Nursing will retrain the Program Nurse on the appropriate testing to be completed on all male clients over the age of 50 and also, if this PSA test cannot be completed, then the documentation of why and where this will be located in the permanent files. Ongoing, the Director of Nursing will complete random quarterly audits to ensure that all proper medical care is followed up on and documented correctly. Completion Date: 7-29-2012 Responsible Party: Program Nurse and Director of Program Nursing</p>	07/29/2012			

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	<p>the AD (Area Director) was conducted.</p> <p>The AD indicated she did not find anything on client #4's PSA.</p> <p>9-3-6(a)</p>				

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W0369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview, the facility failed to administer without error one medication out of one for 1 of 4 additional clients (client #8).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 6/26/12 from 6:10 AM to 7:40 AM. At 6:35 AM, client #8 was administered one 50 mcg (micrograms) Levothyroxine tablet (for thyroid) by staff #1. The pill packet indicated it was to be taken 30 minutes before a meal. Client #8 started eating breakfast at 6:40 AM, 5 minutes after taking his Levothyroxine.</p> <p>Review on 6/26/12 at 12:40 PM of client #8's Physician's Order dated 5/30/12 indicated client #8 was to take one Levothyroxine, 50 mcg tablet by mouth 30 minutes before a meal. Client #8's MAR (Medication Administration Record) dated 6/26/12 indicated Levothyroxine was to be taken 30 minutes before a meal.</p> <p>Interview on 6/27/12 at 12:25 PM with the house manager was conducted. The</p>	W0369	<p>The Direct Support Professionals will be retrained on medication administration. This training will include the times that medication administration is completed, which must be according to the Med Sheets.</p> <p>After the retraining occurs, the Home Manager will complete two (2) weekly medication administration observations to ensure that the administration is being completed according to Indiana MENTOR policy and procedures for four (4) weeks. These will then be reviewed by the Program Director ensuring that there are no further training needs. After the initial four (4) weeks, the Home Manager and/or Program Director will complete weekly medication administration observations ongoing, and will ensure that all needed future retrainings will be completed. Ongoing each DSP will complete Medication Administration as expected by Indiana MENTOR's policy and procedures. Completion Date: 7-29-2012 Responsible Party: Home Manager and Program Director</p>	07/29/2012

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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3705 E 116TH ST CARMEL, IN 46032		
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	house manager indicated the physician's order should be followed when administering medications to clients.  9-3-6(a)				

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W0440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based on record review and interview, the facility failed for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who resided in the group home by not conducting evacuation drills at least one per shift per quarter, or every 90 days, in the past year.</p> <p>Findings include:</p> <p>Review on 6/26/12 at 7:00 AM of the facility's evacuation drills was conducted for the period of 7/1/11 to 6/26/12. During third shift (10:00 PM to 6:00 AM), there were no evacuation drills run between 9/7/11 and 3/9/12.</p> <p>Interview on 6/27/12 at 12:25 PM with the house manager was conducted. The house manager indicated evacuation drills were to be run every month and rotate shifts.</p> <p>9-3-7(a)</p>	W0440	<p>All Direct Support Professionals will receive a retraining every other month to ensure that they understand the importance of completing the monthly fire drills. The retraining will include reviewing a copy of the Fire Drill Schedule. 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. Ongoing, all completed fire drill reports will be turned in to and reviewed by Quality Assurance for accuracy and thoroughness of each drill.</p> <p>Completion Date: 7-29-2012 Responsible Party: Home Manager</p>	07/29/2012			

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W9999	<p>State Findings:</p> <p>This Community Residential Facilities Rule for persons with developmental disabilities was not met: 460 IAC 9-3-3 Facility Staffing (e) Prior to assuming residential job duties and annuall thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest X-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered.</p> <p>Based on record review and interview, the facility failed for 1 of 1 newest staff person reviewed (staff #1) by not ensuring staff #1's tuberculosis (TB) test had been read at least annually.</p> <p>Findings include:</p> <p>Review on 6/27/12 at 12:40 PM of staff #1's personnel records was completed. Staff #1's hire date was 9/12/11 and there was no evidence staff #1 had a TB test taken.</p> <p>Interview on 6/29/12 at 9:35 AM with the</p>			W9999	<p>All staff are given reminders as to when their annual training requirements are due to expire. Those that fail to keep them up to date receive suspension until completed. Ongoing, the Administrative Assistant, with the help of HR, will keep the Home Manager and Direct Care staff up to date with the staff annual training expiration dates. Completion Date: 7-29-2012 Responsible Party: Home Manager</p>		07/29/2012

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	Area Director (AD) indicated there was no documentation staff #1 had a TB test available for review.  9-3-3(e)				