

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G319	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 3RD ST PERU, IN 46970
---	---

(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
W0000	<p>This visit was for a pre-determined full annual recertification and state licensure survey.</p> <p>This visit was in conjunction with the post-certification revisit (PCR) to the investigation of complaint #IN00105070 completed on 03/22/12.</p> <p>This visit was in conjunction with the PCR to the PCR completed on 3/22/12 to the investigation of complaint #IN00098512 completed on 10/21/11.</p> <p>Dates of survey: April 24, 25, 26 and 30, 2012.</p> <p>Facility Number: 000837 Provider Number: 15G319 AIMS Number: 100243970</p> <p>Surveyor: Claudia Ramirez, RN/Public Health Nurse Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on May 4, 2012 by Dotty Walton, 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:  15G319	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/30/2012
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 3RD ST PERU, IN 46970		
(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	
W0126	<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 observation, record review and interview, the facility failed for 2 of 4 sampled clients (client #1 and #3), to encourage clients to exercise their rights, and to teach clients money values with actual U.S. currency instead of using play money.</p> <p>Findings include:</p> <p>Observations were conducted on 04/24/12 from 3:20 PM until 5:35 PM at the group home. At 4:05 PM staff #1 obtained a plastic drawer which contained replica coins and currency. Staff #1 was observed to ask client #1 to use the coins to make the total amount of \$1.00. Staff #1 finished with client #1 and went to client #3. Staff #1 presented client #3 with 4 coins and asked her to identify the penny.</p> <p>An interview was conducted on 04/24/12 at 4:20 PM with staff #1. Staff #1 stated they used the play money to run the money goals with the clients.</p> <p>Client #1's records were reviewed on</p>	W0126	<p><b>W126:</b> The facility ensures the right of all clients. The facility allows and encourages each individual to exercise their rights as clients and citizens including the right to file complaints and the right to due process. The facility trained all supervisors to obtain the approval of the guardian, health care representative or family member prior to implementation of any action that would restrict client rights. The staff have been trained to use actual coins when implementing the financial goals of all clients. The Home Manager has been retrained to consider the rights of the clients at all times including using actual money when counting goal is completed. In the future, the Program Director will ensure client rights are being respected. Weekly, home manager will monitor the goals/ home to ensure client rights are protected. The Program Director will monitor the home monthly to ensure client rights are protected and approvals are obtained as necessary.</p> <p>Person Responsible: Program Director</p>	05/30/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G319	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/30/2012
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 3RD ST PERU, IN 46970		
(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>04/25/12 at 10:42 AM. Client #1's Individual Support Plan (ISP) dated 03/28/11 indicated client #1's goal was to make \$1.00 given a variety of coins.</p> <p>Client #3's records were reviewed on 04/25/12 at 12:46 PM. Client #3's ISP dated 01/19/12 indicated client #3's goal was to identify the penny when presented with 4 coins.</p> <p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 04/26/12 at 12:30 PM. The QMRP indicated the play replica money was not the same as using U.S. bills and coins. The QMRP indicated U.S. coins and bills would be used in the community and not the play replicas.</p> <p>9-3-2(a)</p>		Completion Date: 5/30/12		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G319		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/30/2012	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 3RD ST PERU, IN 46970			
(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			
W0312	<p><b>483.450(e)(2) DRUG USAGE</b></p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on record review and interview, the facility failed for 1 of 4 clients (client #1) on behavioral medications, to ensure a Behavior Support Plan (BSP) was completed.</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 04/25/12 at 10:42 AM. The record indicated client #1 was admitted on 03/07/12. Client #1's intake record indicated client #1 was admitted on the medication, "Risperidone 4 mg (milligram) tablet give 1 tablet by mouth once a day for psychotic disorder." "Sertraline 100 mg tablet take 1 tablet by mouth at bedtime for psychotic disorder." The intake record indicated client #1's behaviors included, but were not limited to verbal aggression, refusals, disruptive behavior and auditory hallucinations. Client #1's ISP (Individual Support Plan) dated 03/28/12 did not include the medications or a titration plan/BSP for client #1.</p>	W0312	<p><b>W312:</b> The facility currently employs a practice to ensure all clients with psychotropic medication to control medication have a behavioral support plan to attempt to reduce said behaviors. Each client behavioral support plan with a titration plan included to ensure the gradual withdrawal of client psychotropic medication taken for inappropriate behavior at least annually in conjunction with the team.</p> <p>The team has been performing a baseline of behaviors since her recent admission to the home to track behaviors. The behavior specialist has been contacted to develop a behavior support plan for client 1. The plan will include a titration plan for client #1 medication to address inappropriate behavior due to diagnosis.</p> <p>The Program Director will monitor the behavior data monthly to ensure the guidelines are followed to decrease client behaviors and monitor the need of current medication dosage as indicated per titration plan criteria. The facility will ensure a behavioral support plan is obtained within 30 days of the</p>	05/30/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G319	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/30/2012
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 3RD ST PERU, IN 46970		
(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 Qualified Mental Retardation Professional (QMRP) was interviewed on 04/26/12 at 12:30 PM. The QMRP indicated the ISP did not contain the behavioral medications or a titration plan.  9-3-5(a)		arrival of a new client in need of one in the future.  Person Responsible: Area Director Completion Date: 5/30/12		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G319	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/30/2012
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 3RD ST PERU, IN 46970		
(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	
W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview for 2 of 23 medication doses administered at the AM medication administration, the facility failed to ensure staff administered client medication at a time to ensure nursing followed pharmacy drug considerations for specific medications for 2 of 4 sampled clients (clients #1 and #4).</p> <p>Findings include:</p> <p>1. Observations were conducted in the group home on 04/25/12 from 6:22 AM until 8:03 AM. On 04/25/12 at 6:56 AM staff #2 was observed to administer client #3's AM medications to her. Client #1 received a total of 13 oral medications which included calcium. Client #1's medications included the medication Levothyroxine tablet 25 mcg (microgram) (for Hypothyroidism). On 04/25/12 at 7:30 PM a review of the 2010 Nursing Spectrum Drug Handbook indicated nursing considerations for this drug include taking the medication on an empty stomach, with plenty of water, take as single dose 30 minutes to 1 hour before breakfast and no antacids, calcium or iron</p>	W0331	<p><b>W331:</b> The facility provides nursing services for the clients in the group home on a daily basis to ensure medical needs of the clients are being met. The facility nurse trains staff upon hire and as needed on medical treatments and procedures necessary to ensure the client medical needs are being met. . The direct support staff have been re-trained to implement medical procedures and protocols as written. The staff have been specifically trained on following doctor's order for medications to be given 30-60 minutes prior to a meal for Client 1 and 2. In the future, the medication administration will be monitored for one month period by the home manager on a weekly basis. The home manager will check the MAR documentation on a daily basis on going to ensure all medical practices are being carried out correctly and documented as per doctor's orders.</p> <p>Responsible Person: Program Director Completion Date: 5/30/12</p>	05/30/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G319		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/30/2012	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 3RD ST PERU, IN 46970			
(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>within 4 hours. Client #3 was observed to be take all her medications at one time and was at the kitchen table eating breakfast at 7:16 AM.</p> <p>Client #1's records were reviewed on 04/25/12 at 10:42 AM. Client #1's April 2012 Physician's Orders and April 2012 Medication Administration Record (MAR) indicated the order for the medication, "Levothyroxine tablet 25 mcg; give 1 tablet orally once a day."</p> <p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 04/26/12 at 12:30 PM and the LPN (Licensed Practical Nurse) was not available for interview. The QMRP indicated there were nursing considerations for certain medications and they should be followed. She further indicated the thyroid medication was set up to be given by itself at 6:00 AM but the staff gave it with the 7:00 AM meds and should not have.</p> <p>2. Observations were conducted in the group home on 04/25/12 from 6:22 AM until 8:03 AM. On 04/25/12 at 7:33 AM staff #2 was observed to administer client #4's AM medications to him. Client #4 medications included the medication Omeprazole 20 mg (milligram) give 1 tablet by mouth twice a day for GERD</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G319		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/30/2012	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 3RD ST PERU, IN 46970			
(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>(Gastroesophageal Reflux Disease). On 04/25/12 at 7:30 PM a review of the 2010 Nursing Spectrum Drug Handbook indicated nursing considerations for this drug include taking the medication 30 to 60 minutes before a meal. Client #4 took the medication at 7:27 AM and was eating breakfast at 7:33 AM.</p> <p>Client #4's records were reviewed on 04/25/12 at 1:20 AM. Client #1's April 2012 Physician's Orders and April 2012 Medication Administration Record (MAR) indicated the order for the medication, "Omeprazole tablet 20 mg; give 1 tablet by mouth twice a day."</p> <p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 04/26/12 at 12:30 PM and the LPN (Licensed Practical Nurse) was not available for interview. The QMRP indicated there were nursing considerations for certain medications and they should be followed.</p> <p>9-3-6(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G319		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/30/2012	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 3RD ST PERU, IN 46970			
(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			
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 home, by not ensuring an evacuation drill was conducted at least every 90 days on the night shift.</p> <p>Findings include:</p> <p>On 04/26/12 at 11:41 AM, record reviews were completed of the facility's evacuation drills for the period of 05/01/11 through 04/14/12. The review of the evacuation drill records included evacuation drills which were conducted for personnel and clients #1, #2, #3, #4, #5, #6, #7 and #8. A night shift drill was conducted on 09/10/11 and there were no documented night drills until 03/10/12.</p> <p>On 04/26/12 at 12:30 PM an interview with the Qualified Mental Retardation Professional (QMRP) was conducted. The QMRP indicated there were no additional documents for review.</p> <p>9-3-7(a)</p>	W0440	<p><b>W440:</b> A fire drill schedule has been developed to inform Home Managers as to when drills are to be completed. This schedule allows for a drill to be completed for each shift of work every quarter as well as to allow for a barricade drill to be completed at least every quarter.</p> <p>The Home Manager has been trained of the responsibility and necessity of ensuring that the drills has been completed as scheduled on a monthly basis.</p> <p>In the future, the Home Manager will adhere to the calendar of drills to ensure the group home staff have completed a evacuation drill at the designated time and date to meet safety guidelines. The Program Director will review the evacuation drills monthly to ensure completion and follow up as needed.</p> <p>Person Responsible: Program Director, Completion Date: 5/30/12</p>	05/30/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G319	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/30/2012
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 3RD ST PERU, IN 46970		
(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	
W9999	<p>STATE FINDING(S)</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p> <p>460 IAC 9-3-6 Health care services (b) All personnel who administer medication to residents or observe residents self-administering medications shall have received and successfully completed training using materials supported by the council.</p> <p>This State Rule was not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure staff followed training in health care for 2 of 4 sampled clients (clients #2 and #4) and 1 additional client (client #6) who received medications at the 7:00 AM medication pass for proper medication administration.</p> <p>Findings include:</p> <p>On 04/25/12 from 6:30 AM until 7:45 AM staff #2 was observed to prepare client #2, #4 and #6's medications for administration. Staff #2 was observed to</p>	W9999	<p><b>W999:</b> The facility will ensure the staff are trained upon hire to utilize the medication administration system to administer medication without error.</p> <p>The staff will be retrained to properly administer medication per doctor's order and document as such. The training will include reading and following label directions, giving medication to client then signing off on MAR as given.</p> <p>The Home manager will monitor the staff weekly for one month to ensure that the medication is administered as directed. The home manager will review the MAR daily to ensure medications are given to clients as ordered. The Program Director will continue to ensure that all staff are trained prior to passing medication as per facility policy.</p> <p>Person responsible: Program Director Completion Date: 5/30/12</p>	05/30/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G319	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 3RD ST PERU, IN 46970
---	---

(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>initial the MAR (Medication Administration Record) before the medications were administered to clients #2, #4 and #6.</p> <p>On 04/25/12 at 7:30 PM, the Living in the Community: Medication Administration Manual, dated 2004, was reviewed. The manual indicated, "<b><u>Never chart until after you have given the medication.</u></b>"</p> <p>On 04/26/12 at 12:30 PM, an interview with the Qualified Mental Retardation Professional (QMRP) was completed. The QMRP indicated staff #2 should not have signed the MAR before administering the medications.</p> <p>9-3-6(b)</p>			