

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947
---	---

(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 pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: June 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, and 17, 2013.</p> <p>Provider Number: 15G498 Facility Number: 001012 AIM Number: 100239780</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed June 24, 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:  15G498		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947			
(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			
W000157	<p><b>483.420(d)(4)</b> <b>STAFF TREATMENT OF CLIENTS</b> If the alleged violation is verified, appropriate corrective action must be taken. Based on record review, and interview, the facility failed to take effective corrective action for 1 of 6 clients (client #3) after repeated medication errors.</p> <p>Findings include:</p> <p>On 6/3/13 at 12:50pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 6/2012 through 6/3/13 and indicated the following for client #3:</p> <p>-A 5/17/13 BDDS report for a medication error on 5/16/13 at 8pm, indicated client #3's Melatonin medication (for sleep) was found in applesauce and was not administered to client #3.</p> <p>-A 3/16/13 BDDS report for a medication error on 3/15/13 at 8pm, indicated client #3's Melatonin medication was found in applesauce and was not administered to client #3.</p> <p>-A 1/31/13 BDDS report for a medication error on 1/30/13 at 7pm, indicated client #3 was not given 1 of his prescribed 2 capsules of Depakote medication (for seizures).</p>	W000157	<p><b>W157:</b> The facility currently has policy and procedures in place regarding the mistreatment, neglect or abuse of a client and the reporting thereof. All new employees are trained upon hire and annually thereafter on the policy and the procedure for reporting injury of the clients to the proper authorities within and outside the agency. Upon hire all staff are trained and certified in medication administration in guidance with state standards through Core A and B. All staff must successfully pass Core A and B prior to doing medication administration. Staff goes through annual reviews thereafter on medication administration. Staffs are trained on checking medication to orders, ensuring the right medications are given at the right time and proper documentation for medications. The facility addresses medication errors by the policy of corrective action in addition to retraining on medication administration. All staff was trained on medication administration. In the future, the home manager will review the Medication Administration Record on a daily basis to ensure no errors are present. Management will conduct</p>	07/03/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/17/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947			
(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>-A 11/19/12 BDDS report for a medication error on 11/19/12 at 12:00 noon, indicated client #3 was administered two (2) extra doses of insulin (for diabetes) and no ill effects were documented.</p> <p>-A 9/2/12 BDDS report for a medication error on 9/1/12 at 7am, indicated client #3 was not administered his new 7:00am prescribed medications. No medications were listed on the report.</p> <p>-A 7/29/12 BDDS report for a medication error on 7/18/12 at 7:00pm, indicated client #3 was not administered his Keppra 750mg medication (for seizures) because staff missed the physician's order.</p> <p>Client #3's record was reviewed on 6/7/13 at 1:00pm and on 6/10/13 at 5:30pm. Client #3's diagnoses included, but were not limited to: Diabetes Mellitus and Seizure Disorder. Client #3's 4/1/13 Physician's Orders included "Novolog Flexpen Syringe, Inject Sub Q (injected by a needle under the skin) per sliding scale...Novolog Flexpen Syringe, inject 5 units sub Q daily at 11:00 am for Diabetes...Melatonin 1mg (milligrams) give 1 tablet by mouth at bedtime for sleep...." Client #3's 3/26/13 "Annual Healthcare Assessment" signed by the physician and agency nurse indicated</p>		<p>medication observations 4x a month for a period of 6 months to ensure medication administration is completed as directed. Responsible Party: Program Director/Area Director Completion Date: 7/3/2013</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/17/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947			
(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>"Levemir Flexpen...Novolog Flexpen...Keppra 750mg (in the) AM (morning) + (and) 1000mg in PM (at night) for seizures...Melatonin 1mg q HS (at night) for sleep apnea...."</p> <p>On 6/4/13 at 9:10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the Agency Nurse was on vacation at this time. The QIDP indicated the agency retrained staff after the medication errors for the staff person involved in the error. The QIDP indicated client #3 was not administered his medications according to his physician's orders. The QIDP indicated the facility failed to follow the abuse/neglect policy and procedure to complete effective corrective action.</p> <p>9-3-2(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947
---	---

(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
W000242	<p><b>483.440(c)(6)(iii)</b> <b>INDIVIDUAL PROGRAM PLAN</b> The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on interview and record review, for 2 of 2 sampled clients (clients #1 and #3) who had teeth to brush, the facility failed to initiate programming in client #1 and #3's Individual Support Plans (ISPs) to address toothbrushing skills.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 6/4/13 at 12:15pm, 6/7/13 at 3:00pm, and on 6/10/13 at 5pm. Client #1's 1/5/13 ISP (Individual Support Plan) did not include a dental toothbrushing objective. Client #1's 12/7/12 Dental assessment indicated a recommendation "need help brush front lower teeth (sic)."</p> <p>Interview on 6/6/13 at 10:41am, with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #1 did not have a current dental toothbrushing goal.</p>	W000242	<p><b>W242</b> The facility develops and utilizes the client ISP and teaming input to develop programming goals to ensure the client is provided with continuous Active Treatment in sufficient number and frequency to support the achievement of the objectives identified. This includes reviewing personnel skills and identifying areas of need.</p> <p>The toothbrushing goal for clients 1 and 3 were added on 6/17/2013 by the QMRP.</p> <p>The QMRP reviewed the goals for all the individuals to ensure all personal needs were identified as indicated in the client Individual Support Plan. In the future the QMRP will review the ISP to ensure the goals listed continue to identify all the individual's needs and are aimed at increasing the personal skills. These ISP's will be reviewed by the team prior to goal implementation.</p> <p>Responsible Party: Program Director/Area Director Completion Date: 7/3/2013</p>	07/03/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPOORT, IN 46947
---	--

(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>2. Client #3's record was reviewed on 6/7/13 at 1:00pm and on 6/10/13 at 5:30pm. Client #3's 4/20/13 ISP did not include a dental toothbrushing objective.</p> <p>Interview on 6/13/13 at 9:45am with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #3 did not have a current dental toothbrushing goal.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947
---	---

(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
W000250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on observation, interview and record review for 3 of 3 sampled clients (clients #1, #2, and #3), the facility failed to develop a facility own day services active treatment schedule which included what staff were to do with the clients during the day and/or indicated what training was to occur with the clients.</p> <p>Findings include:</p> <p>On 6/5/13 from 8:55am until 10:25am, observation at the facility own day services site was completed. From 8:55am until 10:25am, clients #1, #2, and #3 walked throughout the day service site, sat at a table, completed puzzles, sat in the living room area with the television set on, and colored on paper at a table. At 9:40am, an interview with the Site Manager (SM) was conducted. The SM stated "no specific written individual schedule" for clients #1, #2, or #3 were available for review. The SM provided a list of activities the staff at the day services were to pick from for activities and community outings each day.</p> <p>Client #1's record was reviewed on 6/4/13</p>	W000250	<p><b>W250</b> The facility has policies that outline active treatment for individuals, including treatment schedules that are made with team input. These schedules are designed to meet individual's needs and interests. The program director implemented new schedules for clients 1, 2, and 3 and posted them in the program . In the future, the program director will compile and post the new schedules on a weekly basis and turn these schedules into the Area director at the end of the month. Responsible Party: Program Director/Area Director Completion Date: 7/5/2013</p>	07/05/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947			
(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>at 12:15pm, 6/7/13 at 3:00pm, and on 6/10/13 at 5pm. Client #1's 1/5/13 ISP (Individual Support Plan) indicated an active treatment schedule for outside day services from 9am until 3pm daily Monday through Friday. No client specific activities were listed on the schedule from 9:00am until 3:00pm.</p> <p>Client #2's record was reviewed on 6/4/13 at 1:30pm. Client #2's 1/19/13 ISP indicated an active treatment schedule for day services from 9am until 3pm daily Monday through Friday. No client specific activities on the schedule were listed from 9:00am until 3:00pm.</p> <p>Client #3's record was reviewed on 6/7/13 at 1:00pm and on 6/10/13 at 5:30pm. Client #3's 4/20/13 ISP indicated an active treatment schedule for day services from 9am until 3pm daily Monday through Friday. No client specific activities were listed on the schedule from 9:00am until 3:00pm.</p> <p>On 6/6/13 at 10:40am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated clients #1, #2, and #3 did not have an active treatment schedule available with activities listed specific for clients #1, #2, and #3 while at the facility owned day services site.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/17/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947
---	---

(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:  15G498	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947		
(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	
W000312	<p><b>483.450(e)(2) DRUG USAGE</b> 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. Based on record review and interview, for 1 of 3 sampled clients (client #1) who used behavior controlling medications, the facility failed to have a plan to address the reason for client #1's medications and failed to ensure a plan of reduction was in place.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 6/4/13 at 12:15pm, 6/7/13 at 3:00pm, and on 6/10/13 at 5pm. Client #1's diagnosis included, but was not limited to: Anxiety. Client #1's 4/9/13 "Physician's Order" and his 6/2013 MAR (Medication Administration Record) both indicated the use of "Zyprexa 2.5mg (milligrams)" twice a day for behaviors and "Ambien 5mg q HS (every night)" for sleep. Client #1's BSP of 4/2013 (Behavior Support Plan) did not include the use of client #1's Zyprexa medication and did not include the use of his Ambien medication for sleep.</p> <p>Interview on 6/7/13 at 2:58pm, with the</p>	W000312	<p><b>W312</b> Clients that have a behavioral pattern have a behavioral support plan implemented to decrease such behaviors. Staffs are trained on these plans and the facility consistently monitors client treatment on a daily basis plus thorough review of documentation on all clients. For client #1 the behavioralist has been contacted to include the client medication for behavioral control to the behavior support plan. The staff will be trained on the changes made to the new plan upon the plan approval. A reduction plan for the medication will also be added. The QMRP and Area Director will review the remaining charts to ensure all client psychotropic medications are included in client behavior plans. In the future the team will review the medication monthly to ensure all psychotropic and behavior medication are listed on the plans to ensure a plan of reduction is followed. Completion Date: 7/5/2013 Responsible Party: Program Director/Area Director</p>	07/05/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947
---	---

(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>QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP stated client #1 was on Ambien medication for sleep and client #1's sleep was a "physical issues not a behavioral, so it is not addressed in the behavior plan (sic)." The QIDP indicated client #1's Zyprexa "is not in the behavior plan yet, since it was prescribed after the plan was amended. This is currently being amended to add the Zyprexa" medication.</p> <p>9-3-5(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947		
(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	
W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review, and interview for 1 of 3 sampled clients (client #3), the facility failed to administer medications without error and as prescribed by the clients' personal physician.</p> <p>Findings include:</p> <p>On 6/3/13 at 12:50pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 6/2012 through 6/3/13 and indicated the following for client #3:</p> <p>-A 5/17/13 BDDS report for a medication error on 5/16/13 at 8pm, indicated client #3's Melatonin medication (for sleep) was found in applesauce and was not administered to client #3.</p> <p>-A 3/16/13 BDDS report for a medication error on 3/15/13 at 8pm, indicated client #3's Melatonin medication was found in applesauce and was not administered to client #3.</p> <p>-A 1/31/13 BDDS report for a medication error on 1/30/13 at 7pm, indicated client #3 was not given 1 of his prescribed 2 capsules of Depakote medication (for</p>	W000368	<p><b>W368</b> Upon hire all staff are trained and certified in medication administration in guidance with state standards through Core A and B. All staff must successfully pass Core A and B prior to doing medication administration. Staff goes through annual reviews thereafter on medication administration. Staffs are trained on checking on ensuring the right medications are given at the right time and proper documentation for medications. Staff who commit medication errors are subject to corrective and retraining on medication administration. All staff was trained on medication administration. Weekly the home manager will review the MAR to ensure no errors are present. Management will conduct medication observations 4x a month for a period of 6 months. Responsible Party: Program Director/Area Director Completion Date: 7/5/2013</p>	07/05/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947			
(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>seizures).</p> <p>-A 11/19/12 BDDS report for a medication error on 11/19/12 at 12:00 noon, indicated client #3 was administered two (2) extra doses of insulin (for diabetes).</p> <p>-A 9/2/12 BDDS report for a medication error on 9/1/12 at 7am, indicated client #3 was not administered his new 7:00am prescribed medications. No medications were listed on the report.</p> <p>-A 7/29/12 BDDS report for a medication error on 7/18/12 at 7:00pm, indicated client #3 was not administered his Keppra 750mg medication (for seizures) because staff missed the physician's order.</p> <p>Client #3's record was reviewed on 6/7/13 at 1:00pm and on 6/10/13 at 5:30pm. Client #3's diagnosis included, but was not limited to: Diabetes Mellitus and Seizure Disorder. Client #3's 4/1/13 Physician's Orders included "Novolog Flexpen Syringe, Inject Sub Q (subcutaneous-under the skin) (per sliding scale...Novolog Flexpen Syringe, inject 5 units sub Q daily at 11:00am for Diabetes...Melatonin 1mg (milligrams) give 1 tablet by mouth at bedtime for sleep...." Client #3's 3/26/13 "Annual Healthcare Assessment" signed by the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947
---	---

(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>physician and agency nurse indicated "Levemir Flexpen...Novolog Flexpen...Keppra 750mg AM (morning) + (and) 1000mg in PM (at night) for seizures...Melatonin 1mg q HS (at night) for sleep apnea...."</p> <p>On 6/4/13 at 9:10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the Agency Nurse was on vacation at this time. The QIDP indicated the agency retrained staff after the medication errors for the staff person involved in the error. The QIDP indicated client #3 was not administered his medications according to his physician's orders. The QIDP indicated client #3's physician orders were not followed when facility staff did not administer his medications according to the physician's order.</p> <p>On 6/7/13 at 2:56pm, a record review was completed of the undated facility's policy and procedures indicated facility staff should follow physician's orders to administer medications to clients who lived in the group home.</p> <p>On 6/7/13 at 2:56pm, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/17/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPOORT, IN 46947
---	--

(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
	and procedure indicated the facility should follow physician orders.  9-3-6(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947			
(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			
W000369	<p><b>483.460(k)(2)</b> <b>DRUG ADMINISTRATION</b> 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 for 2 of 6 doses (clients #2 and #4) administered at the evening medication administration, the facility failed to administer medications without error.</p> <p>Findings include:</p> <p>1. On 6/3/13 at 4:17pm, Group Home Staff (GHS) #5 administered client #2's "Calcium 600mg/w vit D (milligrams with vitamin D), 1 tab w/meals (with meals) for osteoporosis." Client #2 took the medication in a teaspoon of applesauce and drank two ounces of water.</p> <p>At 4:17pm, client #2's 6/2013 MAR (Medication Administration Record) was reviewed and indicated "Calcium 600mg w/vit. D, 1 tab w/meals twice daily for Osteoporosis."</p> <p>At 5:17pm, client #2 consumed her first bite of food from the supper meal. At 5:25pm, GHS #4 indicated client #2 receives daily a 3:00pm snack at the day services site which the facility operates. GHS #4 checked with the other staff on</p>	W000369	<p><b>W369</b>The facility currently has policy and procedures in place regarding the mistreatment, neglect or abuse of a client and the reporting thereof. All new employees are trained upon hire and annually thereafter on the policy and the procedure for reporting injury of the clients to the proper authorities within and outside the agency. Upon hire all staff are trained and certified in medication administration in guidance with state standards through Core A and B. All staff must successfully pass Core A and B prior to doing medication administration. Staff goes through annual reviews thereafter on medication administration. Staffs are trained on checking medication to orders, ensuring the right medications are given at the right time and proper documentation for medications. The facility addresses medication errors by the policy of corrective action in addition to retraining on medication administration. All staff was trained on medication administration. (Attachment #1)In the future, the home manager will review the Medication Administration Record on a daily basis to ensure no errors are present. Management will conduct</p>	07/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947		
(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>duty and reviewed client #2's daily log entries from client #2's communication book and GHS #4 indicated the day services did not indicate when or if client #2 was given her snack at 3:00pm.</p> <p>Client #2's records were reviewed on 6/4/13 at 1:30pm. Client #2's 4/1/13 "Physician's Order" indicated "Calcium 600mg w/vit. D, 1 tab w/meals twice daily for Osteoporosis."</p> <p>2. On 6/3/13 at 4:10pm, Group Home Staff (GHS) #5 administered client #4's "Saline Mist 0.65%, 2 sprays into each nostril 5 times a day for moisturized" and 1 spray into each nostril was administered by GHS #5. At 4:10pm, client #4's 6/2013 MAR indicated "Saline Mist 0.65%, 2 sprays into each nostril 5 times a day for moisturizer (sic)." At 4:10pm, client #4's 4/1/13 "Physician Order" indicated "Saline Mist 0.65%, 2 sprays into each nostril 5 times a day for moisturizer."</p> <p>On 6/4/13 at 9:10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the Agency Nurse was on vacation at this time. The QIDP indicated clients #2 and #4 were not administered their medications according to physician's orders if the client #4 did</p>		<p>medication observations 4x a month for a period of 6 months to ensure medication administration is completed as directed. Weekly the home manager will review the MAR to ensure no errors are present. Responsible Party: Program Director/Area Director Completion Date: 7/5/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPOORT, IN 46947
---	--

(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
	not receive the correct dose and if client #2 did not consume the medication with the meal. The QIDP indicated clients #2's and #4's physician orders should be followed.  9-3-6(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947			
(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			
W000426	<p>483.470(d)(3) CLIENT BATHROOMS</p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>Based on observation, record review, and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2, and #3) and 3 additional clients (clients #4, #5, and #6), to ensure the temperature of the water did not exceed 110 degrees Fahrenheit.</p> <p>Findings include:</p> <p>During observations at the group home on 6/3/13 from 3:10pm until 5:40pm, and on 6/4/13 from 5:35am until 7:50am, the temperature of the water was observed to be in excess of 120 degrees Fahrenheit. On 6/3/13 at 3:40pm, the Residential Manager (RM) indicated the water temperature in the front bathroom and the kitchen sink exceeded 115.3 degrees Fahrenheit. At 3:40pm, the RM indicated clients #1, #2, #3, #4, #5, and #6 did not have the skill to mix the water temperature below 110 degrees Fahrenheit. On 6/4/13 at 5:40am, Group Home Staff (GHS) #3 took the water temperature and the kitchen sink exceeded 120 degrees Fahrenheit. GHS</p>	W000426	<p><b>W426</b> The facility completes water temperature checks which are recorded and reviewed by management. The staff are trained on risks of hot temperature and appropriate water temperatures. The agency also has maintenance on staff capable to check and adjust water heater as needed. The facility alerted maintenance of the hot water temperature on 6/4/2013. The Maintenance person adjusted the tank and retested the water to ensure it measured at a safe temperature of 110 or below. The facility will continue to test the water temperatures to ensure it remains at a safe level. If the water temperature reads past 110 degrees, the facility will adjust the valve or contact maintenance to correct issue. Responsible Party: Program Director/Area Director Completion Date: 7/5/2013</p>	07/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPOORT, IN 46947		
(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>#3 indicated clients #1, #2, #3, #4, #5, and #6 did not have the skill to mix the water temperature below 110 degrees Fahrenheit.</p> <p>On 6/4/13 at 12:45pm, the QIDP (Qualified Intellectual Disabilities Professional) was interviewed. The QDP stated clients #1, #2, #3, #4, #5, and #6 "did not recognize the risks of hot water." The QIDP indicated monitoring of the group home water temperature log was completed by the overnight staff and the water temperature was not to exceed 110 degrees Fahrenheit.</p> <p>9-3-7(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947			
(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			
W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 3 of 3 sampled clients (#1, #2, and #3) and 3 additional clients (#4, #5, and #6), by not ensuring an evacuation drill was conducted quarterly for the evening shift of personnel (2:30pm - 11:00pm) from 12/17/12 until 5/9/13 and the overnight shift (11:00pm - 8:00am) from 9/7/12 until 3/9/13.</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 6/3/13 at 3:20pm. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, #5, and #6 for the evening shift (2:30pm - 11:00pm) for the first quarter of 2013 period from 12/17/12 at 6pm, until 5/9/13 at 6pm, and on the overnight shift (11:00pm - 8:00am) for the fourth quarter of 2012 period from 9/7/12 at 3:15am, until 3/9/13 at 1:45am.</p> <p>An interviews with the QIDP (Qualified Intellectual Disabilities Professional) was completed on 6/6/13 at 10:40am. The QIDP indicated she was unable to locate any further evacuation drills for the evening shift and for overnight shift of personnel for clients #1, #2, #3, #4, #5,</p>	W000440	<p><b>W440</b> Indiana Mentor has policies in place for individuals receiving services through adherence to safety guidelines. Each home has emergency number, safety routes, and monthly drills which are documented and turned in every month. The Area Director retrained the home manager and program director on drill schedules, documentation, and guidelines. The Program Director checked the home to ensure the proper drill schedule was located for use in the home. The Program Director will review each drill ongoing upon completion and track to ensure compliance with Indiana Mentor safety procedures. Responsible Party: Program Director/Area Director Completion Date: 7/5/2013</p>	07/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPOORT, IN 46947
---	--

(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
	and #6.  9-3-7(a)			