

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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
W 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00189207.</p> <p>Complaint #IN00189207: SUBSTANTIATED, Federal and State deficiencies related to the allegation are cited at W104, W149, W192, and W331.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: 2/4, 2/5, 2/8, 2/9, 2/10, 2/11, 2/12, 2/15, 2/16, 2/17, and 2/19/2016.</p> <p>Provider Number: 15G538 Facility Number: 001052 AIM Number: 100239830</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/29/16.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview for 1 of 3 sampled clients (client A), the governing body failed to</p>	W 0104	W104: The governing body will exercise general policy, budget, and operating direction over the facility. The facility will ensure the	03/20/2016

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: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/19/2016
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>ensure the facility's policy and procedure for g-tubes (a tube inserted through the abdomen to deliver nutrition directly to the stomach) was implemented and that staff were trained by an RN (Registered Nurse) prior to administering g-tube feedings and medication for client A.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/4/16 from 5:30pm until 7:40pm. From 5:30pm until 6:20pm, client A's tube feeding syringe and water reservoir container were stored uncovered and behind the kitchen sink on the counter. At 6:20pm, GHS (Group Home Staff) #5 indicated client A was non verbal. GHS #5 prepared client A's medications of Valproic Acid 15 ml (milliliters) for seizures/aggression, a liquid medication and Lorazepam 1 mg (milligram) for anxiety tablet. GHS #5 crushed client A's tablet in a pill crusher and mixed together client A's liquid medication and crushed tablet. GHS #5 uncapped client A's g-tube, connected a syringe tip to client A's g-tube, pulled upward on the plunger, and indicated client A had no residual fluid present. GHS #5 pushed downward on the syringe plunger, and removed the syringe tip from the g-tube. GHS #5 removed the plunger from the g-tube syringe, replaced</p>		<p>staff will follow the facility policy and procedures for client g-tubes. The policy and procedures for administration of food and medication plus the training format has been updated in a new policy allowing any nurse to complete training and have oversight of the g-tube procedure. The new procedure added staff to check residual fluid/ recording of fluid prior to administering medication or food, recording problems encountered, skin problems, recording on feeding record at each feeding. The facility nurse re-trained the staff on the g-tube procedures for tube flushes, feedings and medication on 3/8/16. The training included proper storage procedures for feeding syringe and water reservoir container, additional residual fluid recording, calming the client during g-tube procedure, taking vital signs and overall documentation of such. The facility supervisor or nurse will complete observations twice weekly for one month to ensure staff follow the g-tube policy and procedures to provide care for Client A. The facility will continue to client specific train all staff prior to feeding/administration of medication in tube with client A. The Program Coordinator will check the documentation forms at least weekly to ensure the tube feeding records are</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>the syringe without the plunger into client A's g-tube, and indicated she was going to administer client A's medications.</p> <p>GHS #5 did not check and monitor client A's vital signs and listen for bowel sounds. GHS #5 measured and poured 60 cc of water into a measuring cup and set the container to the side. GHS #5 administered 15 cc water to flush client A's tube from the water container, poured the liquid and crushed medication mixture into client A's g-tube together, and GHS #5 then began to gradually pour the 8 ounce can of Pulmocare tube feeding (liquid nutrition) into the tube. Client A was sitting upright in a wheelchair, began to make noises and laugh and when client A made noises and laughed louder, the Pulmocare tube feeding material began to back up into the syringe to refill the syringe from client A's stomach tube. GHS #5 and the Residential Manager (RM) both tried to calm client A. As client A calmed to a quieter tone of noise, the gravity method of tube feeding was administered and drained from the syringe into client A's stomach. After the can of Pulmocare tube feeding was administered, GHS #5 poured the remaining water (45 cc) from the prepared water container into client A's tube, and GHS #5 recapped client A's g-tube.</p>		<p>completed by staff. Also see W331 Person responsible: Program Director Completion Date: 3/20/16</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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 6:55pm, GHS #5 and the RM both indicated client A was on a fluid restriction for his recurrent Aspiration Pneumonia. The RM stated "We don't record residual" liquid amounts "because we only record that we checked it." The RM and GHS #5 indicated client A was loud during tube feedings and client A's plans did not address client A's loud laughing, screaming, and noises which cause his stomach to constrict to force the contents back up into the syringe. The RM and GHS #5 indicated client A's fluid restrictions limit the amount of water administered and the number of times water was administered as tube flushes at the beginning of administration, between client A's medication administration and his tube feeding, and at the end of his tube feeding. The RM stated "That's how we were shown to do it" by the agency nurse and the nurse at the hospital. GHS #5 and the RM indicated the staff did not record/monitor vital signs, bowel sounds, hardness around the tube site, and the amount of residual contents of client A's stomach.</p> <p>On 2/5/16 at 11:00am, the facility's 5/2005 "Process for Initiating Curriculum G/J Tube Medication Administration" indicated "1. A written evaluation from a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>licensed health care provider i.e.. Physician, Nurse Practitioner, or Registered Nurse (RN) is completed, documenting that it is appropriate to train approved staff to administer medications via the G/J tube to this particular individual. Such determination must include an evaluation of the staffing pattern in the individual's residence...4. Specialized training in administration of medications via G/J tube must be done by an RN. 5. Any G/J tube curriculum utilized to train approved staff in the administration of medications via a G/J tube must contain the following components...Overview of different methods of tube feeding bolus, continuous...Maintenance of G/J tube. Positioning issues with G/J tubes as well as specific positioning instructions for each individual. Overview of signs and symptoms of G/J tube problems including G/J tube becoming dislodged, G/J tube occluded, diarrhea, respiratory difficulty...site is red or has drainage...6...Successfully completed individual specific training to administer medications via G/J tube done by a RN following accepted procedures for the administration of medication...." The policy did not include oversight by an LPN (Licensed Practical Nurse), did not address the specific guidelines for g-tube feedings and medication administration</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>in that the policy failed to include recording residual stomach contents prior to administering medications or feedings, equipment used i.e.. an asepto syringe, monitoring vital signs, temperature, tube placement, bowel sounds, and the amount recorded for flushing the tube at the beginning, between medications, separating medications (crushed and liquid), and flushing before and after the tube feeding nutrition.</p> <p>The 5/2005 Policy and Procedure indicated "Individual should be in bed with head of bed elevated at least 45 degrees or in a wheelchair while using tube and for one hour afterwards...Check medication book for amount of feeding, prune juice or water flushes or medications to be administered...N/A (Not Applicable) (hand written with no initials for who made the entry) Perform GT placement check at this time by checking where the number is on the G tube and making sure the number is visible and not greater than or less than 2 cm (centimeters)...Remove the g-tube plug. Put the syringe into the end of the g-tube and pour 30 cc water into syringe. Pour feeding/fluid or medications into the syringe. Allow gravity to flow fluid into stomach do not plunge....Do not add medications to the formula or container. Make sure to follow medication, formula,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>or prune juice with water flush. The g-tube needs to be clear of all fluids. Flush the tube with 30 cc of warm water before and after giving medications and feedings...Remove the syringe and put the plug back in. Verify tube placement. Allow individual to sit up after g-tube administration for one hour...."</p> <p>Client A's record was reviewed on 2/4/16 at 6:45pm and on 2/5/16 at 11:38am. Client A's 12/3/15 "Gastrostomy (G) Feeding Protocol Physician's Order" indicated at "7a+12p+5p+10p (7:00am and 12:00noon and 5:00pm and 10:00pm)...Gravity-Pulmocare 1 / 8 ounce can (or 240 cc) with 30 cc of water flushes before and after feeding...Sitting upright...If medications are in tablet form, crush or dissolve prior to administering them through the G-tube. Use a pill crusher to crush the medications into a fine powder...mix crushed medications with 10 cc of water. Prime tube with water keeping at least 10 cc of water in the syringe before adding medications. Add medications, crushed, mixed, or liquid and then add 10 cc more water. Attach feeding tube to button, open clamp so that medications go in at a rate of less than 5 minutes. Add the remaining water to clear tubing...Document...Residuals if greater than 50 cc, recheck in 1 hr. (hour), if less</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>than 50 cc give feeding, if still greater than 50 cc hold feeding. Special Instructions: Follow Behavior Management Plan for food/fluid thefts...If feedings withheld more than 24 hrs. notify supervisor."</p> <p>-Client A's 12/1/15 "Aspiration Protocol" indicated "NPO (Nothing Orally by mouth) Nutritional Supplement and meds via g-tube...Hx (history) Aspiration Pneumonia Dx (Diagnosis) of Dysphagia...."</p> <p>Client A's record indicated the following medical visits:</p> <p>-On 2/4/16 client A was seen at the hospital ER (Emergency Room) for "site of g-tube is seeping blood. Called [name of doctor] for appointment and he recommended bringing [client A] to the ER...Recommendations...Normal appearing g-tube site. No infection noted, mucus at g-tube opening. No bleeding noted." The report indicated client A had a diagnosis of "Aspiration Pneumonia."</p> <p>-On 1/15/16 client A was seen by his physician for "check of G-tube site." The report indicated client A should receive "Silver Nitrate" cream on the skin around his g-tube.</p> <p>-On 12/4/15 client A was seen at the ER for "Low grade fever 99.6 greenish</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>stomach contents from g-tube, possible aspiration...Recommendations...Observation admission by [Name of doctor] DX. Pleural Effusion." The client was discharged 12/8/15.</p> <p>-On 12/1/15 client A was discharged from the hospital after his admission for Respiratory Failure and Aspiration Pneumonia. Client A had a "g-tube" placed and "Pulmocare feedings via g-tube 1 can approximately 120 cc per feeding 4 times a day with 90 cc of water flushes before and after feeding...client had high residuals switched feedings...4 cans Pulmocare daily with 30 cc flushes before and after the feedings."</p> <p>-On 11/24/15 client A was admitted to the hospital with the following diagnoses: "Right lower lobe Pneumonia, Respiratory Failure with Hypoxia, Acute Respiratory Failure, Sepsis, and Aspiration Pneumonia."</p> <p>Client A's daily/weekly Tube feeding record indicated no specific documented record of "problems encountered, skin problems," amount of residuals, vital signs, and tube placement. Client A's daily/weekly Tube feeding record indicated the staff were to document a "B=Before, A=After, OS=Oral Stimulation, 0=None, [a check mark] =See Notes," no check marks were documented, and no notes were available</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>for review. Client A's record indicated once a week monitoring of his blood pressure and pulse, monthly vital signs, did not indicate how client A tolerated the feeding, and did not indicate client A made noises and laughing to constrict his abdominal area to force the feeding back into the syringe.</p> <p>On 2/5/16 at 9:40am and on 2/17/16 at 8:00pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 11/1/2015 through 2/17/16 and indicated the following for client A:</p> <p>-A 2/16/16 BDDS report for an incident on 2/15/16 at 5:00pm indicated client A "was starting to sound congested, raspy and was starting to cough a lot so the nurse said to take him to be seen at the Dr. (Doctor's) office...a chest X-ray and [lab work]. He said that he looked like [client A] had pneumonia so [the doctor] wanted to admit [client A] to the hospital."</p> <p>-A 2/5/16 BDDS report for an incident on 2/4/16 at 2pm indicated client A had his g-tube site checked at the local ER (Emergency Room) due to the area around the site had been bleeding.</p> <p>-A 12/5/15 BDDS report for an incident on 12/4/15 at 11:00am, indicated client A had a "low grade fever" and was admitted to the hospital. (2nd visit to ER).</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N LOGANSFORT, 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 12/5/15 BDDS report for an incident on 12/4/15 at 11:00am indicated client A was seen at the ER for Pulmonary Edema and was "now on tube feedings." (1st visit to ER).</p> <p>-A 11/24/15 BDDS report for an incident on 11/24/15 at 8:45am indicated client A was seen at the ER and admitted to the hospital for Aspiration Pneumonia. Client A was discharged from hospital to the group home on 12/1/15.</p> <p>During interview with the facility's LPN on 2/5/16 at 11:45am, the LPN: ___ Indicated client A had recurrent Aspiration Pneumonia on 12/1/15, 11/24/15, 6/8/13, and 12/2011. ___ Indicated the staff were to conduct residual checks prior to giving client A any medications and/or feedings through his g-tube. ___ Stated she "was not concerned with the amount of residual" fluids from client A's g-tube. ___ Stated the staff documented "that residuals were checked not the amount" of the residual and if the results for client A were over 50 cc then client A's tube feeding was withheld and staff were to contact their supervisor. ___ Indicated the supervisor was the non licensed Residential Manager and the RM decided when to call the LPN. ___ Indicated she could not provide</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>evidence the staff had documented any amounts regarding the amounts of the residual checks.</p> <p>__ Indicated client A's residual checks were not included on client A's MARs.</p> <p>__ Indicated the staff were to record client A's vital signs monthly, monitored client A's Blood Pressure and pulse rate weekly. The LPN indicated she was trained by the RN at the hospital regarding client A's g-tube.</p> <p>__ Stated the agency "did not have an RN" available on site at the agency and an RN did not provide oversight of client A's g-tube and staff training for client A's g-tube.</p> <p>__ Indicated she did not train staff to monitor for bowel sounds, tube placement, monitoring temperature, and to record the results.</p> <p>On 2/5/16 at 9:40am, the agency's Program Director (PD) was conducted. The PD indicated client A had recurrent aspiration pneumonia and the agency did not have an RN at the agency to oversee client A's nursing services. The PD indicated the staff were trained by RN's at the hospital and the LPN at the agency to administer client A's tube feedings and medications.</p> <p>Please refer to W331. The facility nursing services failed to ensure the staff</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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
W 0149 Bldg. 00	<p>followed the facility protocol for client A's g-tube (a tube inserted through the abdomen to deliver nutrition directly to the stomach) and to develop a nursing guideline to ensure staff monitored: signs/symptoms of infection, vital signs daily, tube placement, and bowel sounds; to ensure client A's liquid medications and crushed medications were separated during administration; and to ensure the amount of residual stomach contents was recorded prior to giving client A's medications and/or feedings for 1 of 3 sampled clients (client A).</p> <p>This federal tag relates to complaint #IN00189207.</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observations, record review, and interview for 1 of 3 sampled clients (client A), the facility neglected to ensure the implementation of it's abuse, neglect, and/or mistreatment policy and procedure to ensure client A received medical nursing oversight according to his identified needs.</p>	W 0149	W149: All new employee sare trained on the policy and the procedure for endangered adult/abuse/neglect. The facility follows a protocol including assessment of client behavioral support plans, program goals and individual support plan to ensure the client needs and protection is met. The Director of Nursing will train the Nurse to ensure the client receives no medical	03/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>Findings include:</p> <p>On 2/5/16 at 9:40am, and on 2/17/16 at 8:00pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 11/1/2015 through 2/17/16 and indicated the following for client A:</p> <p>-A 2/16/16 BDDS report for an incident on 2/15/16 at 5:00pm indicated client A "was starting to sound congested, raspy and was starting to cough a lot so the nurse said to take him to be seen at the Dr. (Doctor's) office...a chest X-ray and [lab work]. He said that he looked like [client A] had pneumonia so [the doctor] wanted to admit [client A] to the hospital."</p> <p>-A 2/5/16 BDDS report for an incident on 2/4/16 at 2pm indicated client A had his g-tube (a tube inserted through the abdomen to deliver nutrition directly to the stomach) site checked at the local ER (Emergency Room) due to the area around the site had been bleeding.</p> <p>-A 12/5/15 BDDS report for an incident on 12/4/15 at 11:00am, indicated client A had a "low grade fever" and was admitted to the hospital. (2nd visit to ER).</p> <p>-A 12/5/15 BDDS report for an incident on 12/4/15 at 11:00am indicated client A was seen at the ER for Pulmonary Edema and was "now on tube feedings." (1st visit to ER).</p>		<p>mistreatment/ neglect/ or abuse by following the correct procedures and policies for all client health and well-being. The facility nurse has trained the staff/Program Coordinator on Client A g-tube procedures and protocols on 3/8/16. See W104 for additional corrective actions. The facility supervisor or nurse will complete observations twice weekly for one month to ensure staff follow the g-tube policy and procedures to provide care for Client A. The facility will continue to client specific train all staff prior to feeding/administration of medication in tube with client A. The Program Coordinator will check the documentation forms at least weekly to ensure the tube feeding records are completed by staff. Person responsible: Program Director Completion Date: 3/20/16</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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 11/24/15 BDDS report for an incident on 11/24/15 at 8:45am indicated client A was seen at the ER and admitted to the hospital for Aspiration Pneumonia. Client A was discharged from hospital to the group home on 12/1/15.</p> <p>Observations were conducted at the group home on 2/4/16 from 5:30pm until 7:40pm. From 5:30pm until 6:20pm, client A's tube feeding syringe and water reservoir container were stored uncovered and behind the kitchen sink on the counter. At 6:20pm, GHS (Group Home Staff) #5 indicated client A was non verbal. GHS #5 prepared client A's medications of Valproic Acid 15 ml (milliliters) for seizures/aggression, a liquid medication and Lorazepam 1 mg (milligram) for anxiety tablet. GHS #5 crushed client A's tablet in a pill crusher and mixed together client A's liquid medication and crushed tablet. GHS #5 uncapped client A's g-tube, connected a syringe tip to client A's g-tube, pulled upward on the plunger, and indicated client A had no residual fluid present. GHS #5 pushed downward on the syringe plunger, and removed the syringe tip from the g-tube. GHS #5 removed the plunger from the g-tube syringe, replaced the syringe without the plunger into client A's g-tube, and indicated she was going to administer client A's medications.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>GHS #5 did not check and monitor client A's vital signs and listen for bowel sounds. GHS #5 measured and poured 60 cc of water into a measuring cup and set the container to the side. GHS #5 administered 15 cc water to flush client A's tube from the water container, poured the liquid and crushed medication mixture into client A's g-tube together. GHS #5 then began to gradually pour the 8 ounce can of Pulmocare tube feeding (liquid nutrition) into the tube. Client A was sitting upright in a wheelchair, began to make noises and laugh and when client A made noises and laughed louder, the Pulmocare tube feeding material began to back up into the syringe to refill the syringe from client A's stomach tube. GHS #5 and the Residential Manager (RM) both tried to calm client A. As client A calmed to a quieter tone of noise, the gravity method of tube feeding was administered and drained from the syringe into client A's stomach. After the can of Pulmocare tube feeding was administered, GHS #5 poured the remaining water (45 cc) from the prepared water container into client A's tube, and GHS #5 recapped client A's g-tube.</p> <p>At 6:55pm, GHS #5 and the RM both indicated client A was on a fluid</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/19/2016
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>restriction for his recurrent Aspiration Pneumonia. The RM stated "We don't record residual" liquid amounts "because we only record that we checked it." The RM and GHS #5 indicated client A was loud during tube feedings and client A's plans did not address client A's loud laughing, screaming, and noises which cause his stomach to constrict to force the contents back up into the syringe. The RM and GHS #5 indicated client A's fluid restrictions limit the amount of water administered and the number of times water was administered as tube flushes at the beginning of administration, between client A's medication administration and his tube feeding, and at the end of his tube feeding. The RM stated "That's how we were shown to do it" by the agency nurse and the nurse at the hospital. GHS #5 and the RM indicated the staff did not record/monitor vital signs, bowel sounds, hardness around the tube site, and the amount of residual contents of client A's stomach.</p> <p>On 2/5/16 at 11:00am, the facility's 5/2005 "Process for Initiating Curriculum G/J Tube Medication Administration" indicated "1. A written evaluation from a licensed health care provider i.e., Physician, Nurse Practitioner, or Registered Nurse (RN) is completed,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/19/2016
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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	
	documenting that it is appropriate to train approved staff to administer medications via the G/J tube to this particular individual. Such determination must include an evaluation of the staffing pattern in the individual's residence...4. Specialized training in administration of medications via G/J tube must be done by an RN. 5. Any G/J tube curriculum utilized to train approved staff in the administration of medications via a G/J tube must contain the following components...Overview of different methods of tube feeding bolus, continuous...Maintenance of G/J tube. Positioning issues with G/J tubes as well as specific positioning instructions for each individual. Overview of signs and symptoms of G/J tube problems including G/J tube becoming dislodged, G/J tube occluded, diarrhea, respiratory difficulty...site is red or has drainage...6...Successfully completed individual specific training to administer medications via G/J tube done by a RN following accepted procedures for the administration of medication...." The policy did not include oversight by an LPN (Licensed Practical Nurse), did not address the specific guidelines for g-tube feedings and medication administration in that the policy failed to include recording residual stomach contents prior to administering medications or feedings,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>equipment used i.e.. an asepto syringe, monitoring vital signs, temperature, tube placement, bowel sounds, and the amount recorded for flushing the tube at the beginning, between medications, separating medications (crushed and liquid), and flushing before and after the tube feeding nutrition.</p> <p>The 5/2005 Policy and Procedure indicated "Individual should be in bed with head of bed elevated at least 45 degrees or in a wheelchair while using tube and for one hour afterwards...Check medication book for amount of feeding, prune juice or water flushes or medications to be administered...N/A (Not Applicable) (hand written with no initials for who made the entry) Perform GT placement check at this time by checking where the number is on the G tube and making sure the number is visible and not greater than or less than 2 cm (centimeters)...Remove the g-tube plug. Put the syringe into the end of the g-tube and pour 30 cc water into syringe. Pour feeding/fluid or medications into the syringe. Allow gravity to flow fluid into stomach do not plunge....Do not add medications to the formula or container. Make sure to follow medication, formula, or prune juice with water flush. The g-tube needs to be clear of all fluids. Flush the tube with 30 cc of warm water</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>before and after giving medications and feedings...Remove the syringe and put the plug back in. Verify tube placement. Allow individual to sit up after g-tube administration for one hour..."</p> <p>Client A's record was reviewed on 2/4/16 at 6:45pm and on 2/5/16 at 11:38am. Client A's 12/3/15 "Gastrostomy (G) Feeding Protocol Physician's Order" indicated at "7a+12p+5p+10p (7:00am and 12:00noon and 5:00pm and 10:00pm)...Gravity-Pulmocare 1 / 8 ounce can (or 240 cc) with 30 cc of water flushes before and after feeding...Sitting upright...If medications are in tablet form, crush or dissolve prior to administering them through the G-tube. Use a pill crusher to crush the medications into a fine powder...mix crushed medications with 10 cc of water. Prime tube with water keeping at least 10 cc of water in the syringe before adding medications. Add medications, crushed, mixed, or liquid and then add 10 cc more water. Attach feeding tube to button, open clamp so that medications go in at a rate of less than 5 minutes. Add the remaining water to clear tubing...Document...Residuals if greater than 50 cc, recheck in 1 hr. (hour), if less than 50 cc give feeding, if still greater than 50 cc hold feeding. Special Instructions: Follow Behavior</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>Management Plan for food/fluid thefts...If feedings withheld more than 24 hrs. notify supervisor."</p> <p>-Client A's 12/1/15 "Aspiration Protocol" indicated "NPO (Nothing Orally by mouth) Nutritional Supplement and meds via g-tube...Hx (history) Aspiration Pneumonia Dx (Diagnosis) of Dysphagia...."</p> <p>-Client A's Nurse's Notes indicated the following: -On 1/27/16 Reviewed MARs (Medication Administration Record) weights recorded every "3 days: on 1/2 was 109lbs; on 1/5 was 108; on 1/8 was 108; on 1/11 was 109; on 1/14 was 109; on 1/17 was 113; on 1/20 was 115; on 1/23 was 114; on 1/26 was 118...."</p> <p>-On 1/27/16 client A was assessed by the agency LPN and the LPN received and reviewed the recommendations from the Dietician to "provide additional 550cc of free water dly (daily) and if fluids not increased rec. (recommend) to do [Lab work] every 3 months. to monitor weight every 3 days...."</p> <p>-On 1/27/16 "skin at tube site is red and almost blistered on the bottom part." -On 1/25/16 "assessed peg tube, site doesn't look any better yet." -On 1/22/16 Dietician recommendation "to increase his free water and if not rec.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>to check [Lab work] every 3 months to make sure he is not dehydrated." -On 1/20/16 "assessed...no lower extremity edema...Abd. (Abdominal) soft and not distended. Tube site with no red skin around the area and a scant amt. (amount) of mucous is present, yelling during the assessment and grabbing at stethoscope."</p> <p>Client A's record indicated the following medical visits: -On 2/4/16 client A was seen at the hospital ER (Emergency Room) for "site of g-tube is seeping blood. Called [name of doctor] for appointment and he recommended bringing [client A] to the ER...Recommendations...Normal appearing g-tube site. No infection noted, mucus at g-tube opening. No bleeding noted." The report indicated client A had a diagnosis of "Aspiration Pneumonia." -On 1/15/16 client A was seen by his physician for "check of G-tube site." The report indicated client A should receive "Silver Nitrate" cream on the skin around his g-tube. -On 12/4/15 client A was seen at the ER for "Low grade fever 99.6 greenish stomach contents from g-tube, possible aspiration...Recommendations...Observation admission by [Name of doctor] DX. Pleural Effusion." The client was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>discharged 12/8/15.</p> <p>-On 12/1/15 client A was discharged from the hospital after his admission for Respiratory Failure and Aspiration Pneumonia. Client A had a "g-tube" placed and "Pulmocare feedings via g-tube 1 can approximately 120 cc per feeding 4 times a day with 90 cc of water flushes before and after feeding...client had high residuals switched feedings...4 cans Pulmocare daily with 30 cc flushes before and after the feedings."</p> <p>-On 11/24/15 client A was admitted to the hospital with the following diagnoses: "Right lower lobe Pneumonia, Respiratory Failure with Hypoxia, Acute Respiratory Failure, Sepsis, and Aspiration Pneumonia."</p> <p>Client A's daily/weekly Tube feeding record indicated no specific documented record of "problems encountered, skin problems," amount of residuals, vital signs, and tube placement. Client A's daily/weekly Tube feeding record indicated the staff were to document a "B=Before, A=After, OS=Oral Stimulation, 0=None, [a check mark] =See Notes," no check marks were documented, and no notes were available for review. Client A's record indicated once a week monitoring of his blood pressure and pulse, monthly vital signs, did not indicate how client A tolerated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>the feeding, and did not indicate client A made noises and laughing to constrict his abdominal area to force the feeding back into the syringe.</p> <p>During interview with the facility's LPN on 2/5/16 at 11:45am, the LPN: ___ Indicated client A had recurrent Aspiration Pneumonia on 12/1/15, 11/24/15, 6/8/13, and 12/2011. ___ Indicated the staff were to conduct residual checks prior to giving client A any medications and/or feedings through his g-tube. ___ Stated she "was not concerned with the amount of residual" fluids from client A's g-tube. ___ Stated the staff documented "that residuals were checked not the amount" of the residual and if the results for client A were over 50 cc then client A's tube feeding was withheld and staff were to contact their supervisor. ___ Indicated the supervisor was the non licensed Residential Manager and the RM decided when to call the LPN. ___ Indicated she could not provide evidence the staff had documented the amounts any residual checks. ___ Indicated client A's residual checks were not included on client A's MARs. ___ Indicated the staff were to record client A's vital signs monthly, monitored client A's Blood Pressure and pulse rate weekly.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>The LPN indicated she was trained by the RN at the hospital regarding client A's g-tube.</p> <p>__ Stated the agency "did not have an RN" available on site at the agency and an RN did not provide oversight of client A's g-tube and staff training for client A's g-tube.</p> <p>__ Indicated she did not train staff to monitor for bowel sounds, tube placement, monitoring temperature, and to record the results.</p> <p>On 2/5/16 at 9:40am, the agency's Program Director (PD) was conducted. The PD indicated the facility followed the BDDS reporting guidelines for reportable incidents and investigations. The PD indicated client A had recurrent aspiration pneumonia and the agency did not have an RN at the agency to oversee client A's nursing services. The PD indicated the staff were trained by RN's at the hospital and the LPN at the agency to administer client A's tube feedings and medications.</p> <p>On 2/5/16 at 9:40am, the facility's policy and procedures were reviewed. The facility's 4/2011 Quality and Risk Management policy indicated "Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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
W 0192 Bldg. 00	<p>thorough oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The 4/2011 Quality and Risk Management Policy indicated failure to provide appropriate supervision, care or training was considered neglect. The 4/2011 Quality and Risk Management Policy indicated, "Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. (1.) Investigation findings will be submitted to the AD (Area Director) for review and development of further recommendations as needed within 5 days of the incident."</p> <p>This federal tag relates to complaint #IN00189207.</p> <p>9-3-2(a)</p> <p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation, record review, and interview for 1 of 3 sampled clients</p>	W 0192	W192: All new employees are trained on the company policy and the procedure s plus training	03/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/19/2016
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>(client A), the facility failed to ensure the facility staff were trained by an RN (Registered Nurse) for the implementation, identified medical services, and the care of client A's g-tube feedings (a tube inserted through the abdomen to deliver nutrition directly to the stomach) and medication administration.</p> <p>Findings include:</p> <p>On 2/5/16 at 9:40am and on 2/17/16 at 8:00pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 11/1/2015 through 2/17/16 and indicated the following for client A:</p> <p>-A 2/16/16 BDDS report for an incident on 2/15/16 at 5:00pm indicated client A "was starting to sound congested, raspy and was starting to cough a lot so the nurse said to take him to be seen at the Dr. (Doctor's) office...a chest X-ray and [lab work]. He said that he looked like [client A] had pneumonia so [the doctor] wanted to admit [client A] to the hospital."</p> <p>-A 2/5/16 BDDS report for an incident on 2/4/16 at 2pm indicated client A had his g-tube site checked at the local ER (Emergency Room) due to the area around the site had been bleeding.</p> <p>-A 12/5/15 BDDS report for an incident</p>		<p>specific to each client prior to working. The training focuses on skills and competencies toward the clients' health needs, behavioral support, program goals and individual support plan to ensure the client needs are met. The process for initiating curriculum for G/J Tube medication Administration has been updated to allow for any level of nurse to provide staff training. The facility nurse has re-trained the staff on 3/8/16 based on the updated qualification requirements. The facility will continue to ensure the nurse has the required credentials to train staff to ensure proper implementation, identified medical services and care of client A's g-tube feeding administration. Person responsible: Area Director Completion Date: 3/20/16</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>on 12/4/15 at 11:00am, indicated client A had a "low grade fever" and was admitted to the hospital. (2nd visit to ER). -A 12/5/15 BDDS report for an incident on 12/4/15 at 11:00am indicated client A was seen at the ER for Pulmonary Edema and was "now on tube feedings." (1st visit to ER). -A 11/24/15 BDDS report for an incident on 11/24/15 at 8:45am indicated client A was seen at the ER and admitted to the hospital for Aspiration Pneumonia. Client A was discharged from hospital to the group home on 12/1/15.</p> <p>Observations were conducted at the group home on 2/4/16 from 5:30pm until 7:40pm. From 5:30pm until 6:20pm, client A's tube feeding syringe and water reservoir container were stored uncovered and behind the kitchen sink on the counter. At 6:20pm, GHS (Group Home Staff) #5 indicated client A was non verbal. GHS #5 prepared client A's medications of Valproic Acid 15 ml (milliliters) for seizures/aggression, a liquid medication and Lorazepam 1 mg (milligram) for anxiety tablet. GHS #5 crushed client A's tablet in a pill crusher and mixed together client A's liquid medication and crushed tablet. GHS #5 uncapped client A's g-tube, connected a syringe tip to client A's g-tube, pulled upward on the plunger, and indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>client A had no residual fluid present. GHS #5 pushed downward on the syringe plunger, and removed the syringe tip from the g-tube. GHS #5 removed the plunger from the g-tube syringe, replaced the syringe without the plunger into client A's g-tube, and indicated she was going to administer client A's medications. GHS #5 did not check and monitor client A's vital signs and listen for bowel sounds.</p> <p>GHS #5 measured and poured 60 cc of water into a measuring cup and set the container to the side. GHS #5 administered 15 cc water to flush client A's tube from the water container, poured the liquid and crushed medication mixture into client A's g-tube together. GHS #5 then began to gradually pour the 8 ounce can of Pulmocare tube feeding (liquid nutrition) into the tube. Client A was sitting upright in a wheelchair, began to make noises and laugh and when client A made noises and laughed louder, the Pulmocare tube feeding material began to back up into the syringe to refill the syringe from client A's stomach tube. GHS #5 and the Residential Manager (RM) both tried to calm client A. As client A calmed to a quieter tone of noise, the gravity method of tube feeding was administered and drained from the syringe into client A's stomach. After the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>can of Pulmocare tube feeding was administered, GHS #5 poured the remaining water (45 cc) from the prepared water container into client A's tube, and GHS #5 recapped client A's g-tube.</p> <p>At 6:55pm, GHS #5 and the RM both indicated client A was on a fluid restriction for his recurrent Aspiration Pneumonia. The RM stated "We don't record residual" liquid amounts "because we only record that we checked it." The RM and GHS #5 indicated client A was loud during tube feedings and client A's plans did not address client A's loud laughing, screaming, and noises which cause his stomach to constrict to force the contents back up into the syringe. The RM and GHS #5 indicated client A's fluid restrictions limit the amount of water administered and the number of times water was administered as tube flushes at the beginning of administration, between client A's medication administration and his tube feeding, and at the end of his tube feeding. The RM stated "That's how we were shown to do it" by the agency nurse and the nurse at the hospital. GHS #5 and the RM indicated the staff did not record/monitor vital signs, bowel sounds, hardness around the tube site, and the amount of residual contents of client A's</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>stomach.</p> <p>On 2/5/16 at 11:00am, the facility's 5/2005 "Process for Initiating Curriculum G/J Tube Medication Administration" indicated "1. A written evaluation from a licensed health care provider i.e.. Physician, Nurse Practitioner, or Registered Nurse (RN) is completed, documenting that it is appropriate to train approved staff to administer medications via the G/J tube to this particular individual. Such determination must include an evaluation of the staffing pattern in the individual's residence...4. Specialized training in administration of medications via G/J tube must be done by an RN. 5. Any G/J tube curriculum utilized to train approved staff in the administration of medications via a G/J tube must contain the following components...Overview of different methods of tube feeding bolus, continuous...Maintenance of G/J tube. Positioning issues with G/J tubes as well as specific positioning instructions for each individual. Overview of signs and symptoms of G/J tube problems including G/J tube becoming dislodged, G/J tube occluded, diarrhea, respiratory difficulty...site is red or has drainage...6...Successfully completed individual specific training to administer medications via G/J tube done by a RN</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>following accepted procedures for the administration of medication...." The policy did not include oversight by an LPN (Licensed Practical Nurse), did not address the specific guidelines for g-tube feedings and medication administration in that the policy failed to include recording residual stomach contents prior to administering medications or feedings, equipment used i.e.. an asepto syringe, monitoring vital signs, temperature, tube placement, bowel sounds, and the amount recorded for flushing the tube at the beginning, between medications, separating medications (crushed and liquid), and flushing before and after the tube feeding nutrition.</p> <p>The 5/2005 Policy and Procedure indicated "Individual should be in bed with head of bed elevated at least 45 degrees or in a wheelchair while using tube and for one hour afterwards...Check medication book for amount of feeding, prune juice or water flushes or medications to be administered...N/A (Not Applicable) (hand written with no initials for who made the entry) Perform GT placement check at this time by checking where the number is on the G tube and making sure the number is visible and not greater than or less than 2 cm (centimeters)...Remove the g-tube plug. Put the syringe into the end of the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>g-tube and pour 30 cc water into syringe. Pour feeding/fluid or medications into the syringe. Allow gravity to flow fluid into stomach do not plunge....Do not add medications to the formula or container. Make sure to follow medication, formula, or prune juice with water flush. The g-tube needs to be clear of all fluids. Flush the tube with 30 cc of warm water before and after giving medications and feedings...Remove the syringe and put the plug back in. Verify tube placement. Allow individual to sit up after g-tube administration for one hour...."</p> <p>Client A's record was reviewed on 2/4/16 at 6:45pm and on 2/5/16 at 11:38am. Client A's 12/3/15 "Gastrostomy (G) Feeding Protocol Physician's Order" indicated at "7a+12p+5p+10p (7:00am and 12:00noon and 5:00pm and 10:00pm)...Gravity-Pulmocare 1 / 8 ounce can (or 240 cc) with 30 cc of water flushes before and after feeding...Sitting upright...If medications are in tablet form, crush or dissolve prior to administering them through the G-tube. Use a pill crusher to crush the medications into a fine powder...mix crushed medications with 10 cc of water. Prime tube with water keeping at least 10 cc of water in the syringe before adding medications. Add medications, crushed, mixed, or liquid and then add 10 cc more water.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>Attach feeding tube to button, open clamp so that medications go in at a rate of less than 5 minutes. Add the remaining water to clear tubing...Document...Residuals if greater than 50 cc, recheck in 1 hr. (hour), if less than 50 cc give feeding, if still greater than 50 cc hold feeding. Special Instructions: Follow Behavior Management Plan for food/fluid thefts...If feedings withheld more than 24 hrs. notify supervisor."</p> <p>-Client A's 12/1/15 "Aspiration Protocol" indicated "NPO (Nothing Orally by mouth) Nutritional Supplement and meds via g-tube...Hx (history) Aspiration Pneumonia Dx (Diagnosis) of Dysphagia...."</p> <p>-Client A's Nurse's Notes indicated the following: -On 1/27/16 Reviewed MARs (Medication Administration Record) weights recorded every "3 days: on 1/2 was 109lbs; on 1/5 was 108; on 1/8 was 108; on 1/11 was 109; on 1/14 was 109; on 1/17 was 113; on 1/20 was 115; on 1/23 was 114; on 1/26 was 118...." -On 1/27/16 client A was assessed by the agency LPN and the LPN received and reviewed the recommendations from the Dietician to "provide additional 550cc of free water dly (daily) and if fluids not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>increased rec. (recommend) to do [Lab work] every 3 months. to monitor weight every 3 days...."</p> <p>-On 1/27/16 "skin at tube site is red and almost blistered on the bottom part."</p> <p>-On 1/25/16 "assessed peg tube, site doesn't look any better yet."</p> <p>-On 1/22/16 Dietician recommendation "to increase his free water and if not rec. to check [Lab work] every 3 months to make sure he is not dehydrated."</p> <p>-On 1/20/16 "assessed...no lower extremity edema...Abd. (Abdominal) soft and not distended. Tube site with no red skin around the area and a scant amt. (amount) of mucous is present, yelling during the assessment and grabbing at stethoscope."</p> <p>Client A's record indicated the following medical visits:</p> <p>-On 2/4/16 client A was seen at the hospital ER (Emergency Room) for "site of g-tube is seeping blood. Called [name of doctor] for appointment and he recommended bringing [client A] to the ER...Recommendations...Normal appearing g-tube site. No infection noted, mucus at g-tube opening. No bleeding noted." The report indicated client A had a diagnosis of "Aspiration Pneumonia."</p> <p>-On 1/15/16 client A was seen by his physician for "check of G-tube site." The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>report indicated client A should receive "Silver Nitrate" cream on the skin around his g-tube.</p> <p>-On 12/4/15 client A was seen at the ER for "Low grade fever 99.6 greenish stomach contents from g-tube, possible aspiration...Recommendations...Observation admission by [Name of doctor] DX. Pleural Effusion." The client was discharged on 12/8/15.</p> <p>-On 12/1/15 client A was discharged from the hospital after his admission for Respiratory Failure and Aspiration Pneumonia. Client A had a "g-tube" placed and "Pulmocare feedings via g-tube 1 can approximately 120 cc per feeding 4 times a day with 90 cc of water flushes before and after feeding...client had high residuals switched feedings...4 cans Pulmocare daily with 30 cc flushes before and after the feedings."</p> <p>-On 11/24/15 client A was admitted to the hospital with the following diagnoses: "Right lower lobe Pneumonia, Respiratory Failure with Hypoxia, Acute Respiratory Failure, Sepsis, and Aspiration Pneumonia."</p> <p>Client A's daily/weekly Tube feeding record indicated no specific documented record of "problems encountered, skin problems," amount of residuals, vital signs, and tube placement. Client A's daily/weekly Tube feeding record</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>indicated the staff were to document a "B=Before, A=After, OS=Oral Stimulation, 0=None, [a check mark] =See Notes," no check marks were documented, and no notes were available for review. Client A's record indicated once a week monitoring of his blood pressure and pulse, monthly vital signs, did not indicate how client A tolerated the feeding, and did not indicate client A made noises and laughing to constrict his abdominal area to force the feeding back into the syringe.</p> <p>During interview with the facility's LPN on 2/5/16 at 11:45am, the LPN: ___ Indicated client A had recurrent Aspiration Pneumonia on 12/1/15, 11/24/15, 6/8/13, and 12/2011. ___ Indicated the staff were to conduct residual checks prior to giving client A any medications and/or feedings through his g-tube. ___ Stated she "was not concerned with the amount of residual" fluids from client A's g-tube. ___ Stated the staff documented "that residuals were checked not the amount" of the residual and if the results for client A were over 50 cc then client A's tube feeding was withheld and staff were to contact their supervisor. ___ Indicated the supervisor was the non licensed Residential Manager and the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>RM decided when to call the LPN.</p> <p>__ Indicated she could not provide evidence the staff had documented any amounts of the residual checks.</p> <p>__ Indicated client A's residual checks were not included on client A's MARs.</p> <p>__ Indicated the staff were to record client A's vital signs monthly, monitored client A's Blood Pressure and pulse rate weekly. The LPN indicated she was trained by the RN at the hospital regarding client A's g-tube.</p> <p>__ Stated the agency "did not have an RN" available on site at the agency and an RN did not provide oversight of client A's g-tube and staff training for client A's g-tube.</p> <p>__ Indicated she did not train staff to monitor for bowel sounds, tube placement, monitoring temperature, and to record the results.</p> <p>On 2/5/16 at 9:40am, the agency's Program Director (PD) was conducted. The PD indicated client A had recurrent aspiration pneumonia and the agency did not have an RN at the agency to oversee client A's nursing services. The PD indicated the staff were trained by RN's at the hospital and the LPN at the agency to administer client A's tube feedings and medications.</p> <p>This federal tag relates to complaint</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/19/2016	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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
W 0331 Bldg. 00	<p>#IN00189207.</p> <p>9-3-3(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview for 1 of 3 sampled clients (client A), the facility nursing services failed to ensure the staff followed the facility protocol for client A's g-tube (a tube inserted through the abdomen to deliver nutrition directly to the stomach) and to develop a nursing guideline to ensure staff monitored: signs/symptoms of infection, vital signs daily, tube placement, and bowel sounds; to ensure client A's liquid medications and crushed medications were separated during administration; and to ensure the amount of residual stomach contents was recorded prior to giving client A's medications and/or feedings.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/4/16 from 5:30pm until 7:40pm. From 5:30pm until 6:20pm, client A's tube feeding syringe and water reservoir container were stored uncovered and behind the kitchen sink on</p>			W 0331	<p>W331: 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 nurse monitors the documentation of medical orders to weekly to ensure procedures are being carried out as ordered by the doctor. The policy and procedures for administration of food and medication plus the training format has been updated in a new policy allowing any nurse to complete training and have oversight of the g-tube procedure. The new procedure added staff to check residual fluid/ recording of fluid prior to administering medication or food, recording problems encountered, skin problems, recording on feeding record at each feeding. The facility nurse re-trained the staff on the g-tube procedures for tube flushes, feedings and medication on 3/8/16. The</p>		03/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>the counter. At 6:20pm, GHS (Group Home Staff) #5 indicated client A was non verbal. GHS #5 prepared client A's medications of Valproic Acid 15 ml (milliliters) for seizures/aggression, a liquid medication and Lorazepam 1 mg (milligram) for anxiety tablet. GHS #5 crushed client A's tablet in a pill crusher and mixed together client A's liquid medication and crushed tablet. GHS #5 uncapped client A's g-tube, connected a syringe tip to client A's g-tube, pulled upward on the plunger, and indicated client A had no residual fluid present. GHS #5 pushed downward on the syringe plunger, and removed the syringe tip from the g-tube. GHS #5 removed the plunger from the g-tube syringe, replaced the syringe without the plunger into client A's g-tube, and indicated she was going to administer client A's medications.</p> <p>GHS #5 did not check and monitor client A's vital signs and listen for bowel sounds. GHS #5 measured and poured 60 cc of water into a measuring cup and set the container to the side. GHS #5 administered 15 cc water to flush client A's tube from the water container, poured the liquid and crushed medication mixture into client A's g-tube together. GHS #5 then began to gradually pour the 8 ounce can of Pulmocare tube feeding (liquid nutrition) into the tube. Client A</p>		<p>training included proper storage procedures for feeding syringe and water reservoir container, additional residual fluid recording, calming the client during g-tube procedure, taking vital signs and overall documentation of such. The facility supervisor or nurse will complete observations twice weekly for one month to ensure staff follow the g-tube policy and procedures to provide care for Client A. The facility will continue to client specific train all staff prior to feeding/administration of medication in tube with client A. The Program Coordinator will check the documentation forms at least weekly to ensure the g-tube feeding records are completed by staff. Responsible Person: Area Director Completion Date: 3/20/16</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>was sitting upright in a wheelchair, began to make noises and laugh and when client A made noises and laughed louder, the Pulmocare tube feeding material began to back up into the syringe to refill the syringe from client A's stomach tube. GHS #5 and the Residential Manager (RM) both tried to calm client A. As client A calmed to a quieter tone of noise, the gravity method of tube feeding was administered and drained from the syringe into client A's stomach. After the can of Pulmocare tube feeding was administered, GHS #5 poured the remaining water (45 cc) from the prepared water container into client A's tube, and GHS #5 recapped client A's g-tube.</p> <p>At 6:55pm, GHS #5 and the RM both indicated client A was on a fluid restriction for his recurrent Aspiration Pneumonia. The RM stated "We don't record residual" liquid amounts "because we only record that we check it." The RM and GHS #5 indicated client A was loud during tube feedings and client A's plans did not address client A's loud laughing, screaming, and noises which cause his stomach to constrict to force the contents back up into the syringe. The RM and GHS #5 indicated client A's fluid restrictions limit the amount of water administered and the number of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>times water was administered as tube flushes at the beginning of administration, between client A's medication administration and his tube feeding, and at the end of his tube feeding. The RM stated "That's how we were shown to do it" by the agency nurse and the nurse at the hospital. GHS #5 and the RM indicated they did not record/monitor vital signs, bowel sounds, hardness around the tube site, and the amount of residual contents of client A's stomach.</p> <p>On 2/5/16 at 9:40am and on 2/17/16 at 8:00pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 11/1/2015 through 2/17/16 and indicated the following for client A: -A 2/16/16 BDDS report for an incident on 2/15/16 at 5:00pm indicated client A "was starting to sound congested, raspy and was starting to cough a lot so the nurse said to take him to be seen at the Dr. (Doctor's) office...a chest X-ray and [lab work]. He said that he looked like [client A] had pneumonia so [the doctor] wanted to admit [client A] to the hospital." -A 2/5/16 BDDS report for an incident on 2/4/16 at 2pm indicated client A had his g-tube site checked at the local ER (Emergency Room) due to the area</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>around the site had been bleeding.</p> <p>-A 12/5/15 BDDS report for an incident on 12/4/15 at 11:00am, indicated client A had a "low grade fever" and was admitted to the hospital. (2nd visit to ER).</p> <p>-A 12/5/15 BDDS report for an incident on 12/4/15 at 11:00am indicated client A was seen at the ER for Pulmonary Edema and was "now on tube feedings." (1st visit to ER).</p> <p>-A 11/24/15 BDDS report for an incident on 11/24/15 at 8:45am indicated client A was seen at the ER and admitted to the hospital for Aspiration Pneumonia. Client A was discharged from hospital to the group home on 12/1/15.</p> <p>On 2/5/16 at 11:00am, the facility's 5/2005 "Process for Initiating Curriculum G/J Tube Medication Administration" indicated "1. A written evaluation from a licensed health care provider i.e.. Physician, Nurse Practitioner, or Registered Nurse (RN) is completed, documenting that it is appropriate to train approved staff to administer medications via the G/J tube to this particular individual. Such determination must include an evaluation of the staffing pattern in the individual's residence...4. Specialized training in administration of medications via G/J tube must be done by an RN. 5. Any G/J tube curriculum utilized to train approved staff in the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>administration of medications via a G/J tube must contain the following components...Overview of different methods of tube feeding bolus, continuous...Maintenance of G/J tube. Positioning issues with G/J tubes as well as specific positioning instructions for each individual. Overview of signs and symptoms of G/J tube problems including G/J tube becoming dislodged, G/J tube occluded, diarrhea, respiratory difficulty...site is red or has drainage...6...Successfully completed individual specific training to administer medications via G/J tube done by a RN following accepted procedures for the administration of medication..." The policy did not include oversight by an LPN (Licensed Practical Nurse), did not address the specific guidelines for g-tube feedings and medication administration in that the policy failed to include recording residual stomach contents prior to administering medications or feedings, equipment used i.e.. an asepto syringe, monitoring vital signs, temperature, tube placement, bowel sounds, and the amount recorded for flushing the tube at the beginning, between medications, separating medications (crushed and liquid), and flushing before and after the tube feeding nutrition.</p> <p>The 5/2005 Policy and Procedure</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>indicated "Individual should be in bed with head of bed elevated at least 45 degrees or in a wheelchair while using tube and for one hour afterwards...Check medication book for amount of feeding, prune juice or water flushes or medications to be administered...N/A (Not Applicable) (hand written with no initials for who made the entry) Perform GT placement check at this time by checking where the number is on the G tube and making sure the number is visible and not greater than or less than 2 cm (centimeters)...Remove the g-tube plug. Put the syringe into the end of the g-tube and pour 30 cc water into syringe. Pour feeding/fluid or medications into the syringe. Allow gravity to flow fluid into stomach do not plunge....Do not add medications to the formula or container. Make sure to follow medication, formula, or prune juice with water flush. The g-tube needs to be clear of all fluids. Flush the tube with 30 cc of warm water before and after giving medications and feedings...Remove the syringe and put the plug back in. Verify tube placement. Allow individual to sit up after g-tube administration for one hour...."</p> <p>Client A's record was reviewed on 2/4/16 at 6:45pm and on 2/5/16 at 11:38am. Client A's 12/3/15 "Gastrostomy (G) Feeding Protocol Physician's Order"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>indicated at "7a+12p+5p+10p (7:00am and 12:00noon and 5:00pm and 10:00pm)...Gravity-Pulmocare 1 / 8 ounce can (or 240 cc) with 30 cc of water flushes before and after feeding...Sitting upright...If medications are in tablet form, crush or dissolve prior to administering them through the G-tube. Use a pill crusher to crush the medications into a fine powder...mix crushed medications with 10 cc of water. Prime tube with water keeping at least 10 cc of water in the syringe before adding medications. Add medications, crushed, mixed, or liquid and then add 10 cc more water. Attach feeding tube to button, open clamp so that medications go in at a rate of less than 5 minutes. Add the remaining water to clear tubing...Document...Residuals if greater than 50 cc, recheck in 1 hr. (hour), if less than 50 cc give feeding, if still greater than 50 cc hold feeding. Special Instructions: Follow Behavior Management Plan for food/fluid thefts...If feedings withheld more than 24 hrs. notify supervisor."</p> <p>-Client A's 12/1/15 "Aspiration Protocol" indicated "NPO (Nothing Orally by mouth) Nutritional Supplement and meds via g-tube...Hx (history) Aspiration Pneumonia Dx (Diagnosis) of Dysphagia...."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>-Client A's Nurse's Notes indicated the following:</p> <p>-On 1/27/16 Reviewed MARs (Medication Administration Record) weights recorded every "3 days: on 1/2 was 109lbs; on 1/5 was 108; on 1/8 was 108; on 1/11 was 109; on 1/14 was 109; on 1/17 was 113; on 1/20 was 115; on 1/23 was 114; on 1/26 was 118...."</p> <p>-On 1/27/16 client A was assessed by the agency LPN and the LPN received and reviewed the recommendations from the Dietician to "provide additional 550cc of free water dly (daily) and if fluids not increased rec. (recommend) to do [Lab work] every 3 months. to monitor weight every 3 days...."</p> <p>-On 1/27/16 "skin at tube site is red and almost blistered on the bottom part."</p> <p>-On 1/25/16 "assessed peg tube, site doesn't look any better yet."</p> <p>-On 1/22/16 Dietician recommendation "to increase his free water and if not rec. to check [Lab work] every 3 months to make sure he is not dehydrated."</p> <p>-On 1/20/16 "assessed...no lower extremity edema...Abd. (Abdominal) soft and not distended. Tube site with no red skin around the area and a scant amt. (amount) of mucous is present, yelling during the assessment and grabbing at stethoscope."</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>Client A's record indicated the following medical visits:</p> <p>-On 2/4/16 client A was seen at the hospital ER (Emergency Room) for "site of g-tube is seeping blood. Called [name of doctor] for appointment and he recommended bringing [client A] to the ER...Recommendations...Normal appearing g-tube site. No infection noted, mucus at g-tube opening. No bleeding noted." The report indicated client A had a diagnosis of "Aspiration Pneumonia."</p> <p>-On 1/15/16 client A was seen by his physician for "check of G-tube site." The report indicated client A should receive "Silver Nitrate" cream on the skin around his g-tube.</p> <p>-On 12/4/15 client A was seen at the ER for "Low grade fever 99.6 greenish stomach contents from g-tube, possible aspiration...Recommendations...Observation admission by [Name of doctor] DX. Pleural Effusion." The client was discharged 12/8/15.</p> <p>-On 12/1/15 client A was discharged from the hospital after his admission for Respiratory Failure and Aspiration Pneumonia. Client A had a "g-tube" placed and "Pulmocare feedings via g-tube 1 can approximately 120 cc per feeding 4 times a day with 90 cc of water flushes before and after feeding...client had high residuals switched feedings...4</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>cans Pulmocare daily with 30 cc flushes before and after the feedings."</p> <p>-On 11/24/15 client A was admitted to the hospital with the following diagnoses: "Right lower lobe Pneumonia, Respiratory Failure with Hypoxia, Acute Respiratory Failure, Sepsis, and Aspiration Pneumonia."</p> <p>Client A's daily/weekly Tube feeding record indicated no specific documented record of "problems encountered, skin problems," amount of residuals, vital signs, and tube placement. Client A's daily/weekly Tube feeding record indicated the staff were to document a "B=Before, A=After, OS=Oral Stimulation, 0=None, [a check mark] =See Notes," no check marks were documented, and no notes were available for review. Client A's record indicated once a week monitoring of his blood pressure and pulse, monthly vital signs, did not indicate how client A tolerated the feeding, and did not indicate client A made noises and laughing to constrict his abdominal area to force the feeding back into the syringe.</p> <p>During interview with the facility's LPN on 2/5/16 at 11:45am, the LPN: __ Indicated client A had recurrent Aspiration Pneumonia on 12/1/15, 11/24/15, 6/8/13, and 12/2011.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>__ Indicated the staff were to conduct residual checks prior to giving client A any medications and/or feedings through his g-tube.</p> <p>__ Stated she "was not concerned with the amount of residual" fluids from client A's g-tube.</p> <p>__ Stated the staff documented "that residuals were check not the amount" of the residual and if the results for client A were over 50 cc then client A's tube feeding was withheld and staff were to contact their supervisor.</p> <p>__ Indicated the supervisor was the non licensed Residential Manager and the RM decided when to call the LPN.</p> <p>__ Indicated she could not provide evidence the staff had documented any amounts of the residual checks.</p> <p>__ Indicated client A's residual checks were not included on client A's MARs.</p> <p>__ Indicated the staff were to record client A's vital signs monthly, monitored client A's Blood Pressure and pulse rate weekly. The LPN indicated she was trained by the RN at the hospital regarding client A's g-tube.</p> <p>__ Stated the agency "did not have an RN" available on site at the agency and an RN did not provide oversight of client A's g-tube and staff training for client A's g-tube.</p> <p>__ Indicated she did not train staff to monitor for bowel sounds, tube</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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
W 0382 Bldg. 00	<p>placement, monitoring temperature, and to record the results.</p> <p>This federal tag relates to complaint #IN00189207.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients A, B, and C) and 2 additional clients (clients D and E), the facility failed to keep medications locked when not being administered for clients A, B, C, D, and E.</p> <p>Findings include:</p> <p>Observations and interviews were conducted at the group home on 2/4/16 from 5:30pm until 6:20pm. Clients B, C, D, and E walked throughout the group home while the medication closet was unlocked and the door was ajar to expose the light on with shelves of medications. From 6:15pm until 6:20pm, client A returned from the hospital with GHS (Group Home Staff) #5. At 6:20pm, the medication closet door was secured shut</p>	W 0382	<p>W382: The governing body will exercise general policy, budget, and operating direction over the facility. The facility will ensure the staff do follow the facility policy and procedures for medication administration including storage of medications. The staff have been retrained to properly store and lock all client medication when not being used per policy. The Program Coordinator will monitor the medication supply to ensure that the client medications are locked and stored properly in the future. The Program Coordinator/nurse will complete twice weekly observations to include medication administration for 4 weeks to ensure staff are correctly locking and storing medications. Person responsible: Program Director Completion Date: 3/20/16</p>	03/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/19/2016
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N 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>and locked.</p> <p>On 2/5/16 at 11:45am, an interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional), RM (Residential Manager), and the LPN (Licensed Practical Nurse) was conducted. The PD/QIDP and LPN both indicated medications should be kept secured when not administered. The LPN indicated the facility followed Core A/Core B Living in the Community for medication administration and medication security. The LPN indicated clients A, B, C, D, and E had access to unsecured medications inside the closet when the door was not closed and locked.</p> <p>On 2/5/16 at 11:45am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of Administering Medication" indicated medications should be secured when not administered.</p> <p>9-3-6(a)</p>				