

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 5/13/13, 5/14/13, 5/15/13, 5/16/13, 5/17/13 and 5/22/13</p> <p>Facility Number: 000892 Provider Number: 15G378 AIMS Number: 100244290</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/29/13 by Ruth Shackelford, QIDP.</p>	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/22/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254		
(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	
W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1's ISP (Individual Support Plan) included recommended sensitization training regarding his targeted behavior of theft.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 5/16/13 at 11:36 AM. Client #1's BSP (Behavior Support Plan) dated 2/25/13 indicated, "[Client #1's] ISP should include a formal program used to assure that he remains sensitive to the negative outcomes for others and for him that are associated with taking others property without their permission." Client #1's BSP dated 2/25/13 indicated, "[Client #1's] ISP should indicate outcomes such as arrest and jail. Should be a continued goal until theft/stealing is no longer a TPB (Targeted Problem Behavior)." Client #1's ISP dated 2/7/13 did not include formal or informal sensitization training or objectives regarding theft/stealing.</p>	W000227	<p>Formal training goals for Client #1 will be put into placeto address the negative outcomes of the targeted behavior of stealing. Ongoing, the Direct Support Staff will complete this formaltraining goal with Client #1 to ensure sensitizing of negative outcomes to thetarget behavior of stealing. Ongoing, the Area Director will complete random audits toensure that the Behavior Support Plans and Individualized Support Plans flowtogether for each client.</p> <p>Completion Date: June 21, 2013</p> <p>Responsible Party: Area Director and Home Manager</p>	06/21/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/22/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 5/16/13 at 3:45 PM. QIDP #1 indicated client #1's behavior plan included hoarding and stealing. QIDP #1 indicated client #1's ISP dated 2/7/13 did not include formal or informal training or supports regarding client #1's identified TPB theft/stealing.</p> <p>AS #1 (Administrative Staff) was interviewed on 5/16/13 at 3:50 PM. AS #1 indicated client #1's BSP dated 2/25/13 recommended formal/informal training to sensitize client #1 to the potential negative outcomes associated with theft. AS #1 indicated client #1's ISP dated 2/7/13 should have formal/informal training and supports regarding client #1's theft/stealing behaviors.</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/22/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254		
(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	
W000263	<p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#1), the facility's HRC (Human Rights Committee) failed to obtain the client's written informed consent before implementation of a BSP (Behavior Support Plan) with restrictive measures.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 5/16/13 at 11:36 AM. Client #1's BSP dated 2/25/13 included the use of bedroom searches and personal searches in regard to management of the targeted behavior of stealing/theft. Client #1's BSP did not indicate client #1 had given written informed consent for the 2/25/13 BSP, personal search procedures or phone use restrictions. Client #1's ISP (Individual Support Plan) dated 2/7/13 indicated client #1 was an emancipated adult with no guardian or HCR (Health Care Representative).</p> <p>The facility's HRC (Human Rights Committee) record was reviewed on 5/16/13 at 12:00 PM. The HRC minutes</p>	W000263	<p>The new Program Director will be trained in obtaining guardian and/or client signatures on documents before obtaining Human Rights Committee approvals. Ongoing, the new Program Director will correctly retrieve the approvals for all future Behavior Controlling/Sedatives from the Guardian/Health Care Representative first, then once received, will get the appropriate approval from the Human Rights Committee, before implementing. Ongoing, the Area Director will complete random quarterly audits to ensure that all of the proper approvals are in place from the IDTs.</p> <p>Completion Date: June 21, 2013 Responsible Party: Program Director and Area Director</p>	06/21/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254
---	---

(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>dated 3/13/13 indicated the HRC had approved client #1's 2/25/13 BSP. The HRC minutes dated 3/13/13 indicated, "Due to [client #1's] stealing issue he has to be checked before and after work for stealing food from the home and items from work. The facility HRC minutes dated 3/13/13 indicated, "Due to [client #1's] excessive phone calls, this right will be restricted."</p> <p>AS (Administrative Staff) #1 was interviewed on 5/16/13 at 3:49 PM. AS #1 indicated restrictive practices should have client or guardian written informed consent before being approved by HRC and/or implemented.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/22/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) plus 4 additional clients (#5, #6, #7 and #8), the facility failed to conduct evacuation drills for each quarter on each shift.</p> <p>Findings include:</p> <p>The facility's evacuation drills record was reviewed on 5/15/13 at 3:00 PM. The review indicated the facility failed to conduct an evacuation drill for 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7 and #8) for the first quarter, January through March 2013 for the 7:00 AM through 3:00 PM shift.</p> <p>AS (Administrative Staff) #1 was interviewed on 5/16/13 at 3:49 PM. AS #1 indicated there were no additional fire/evacuation drills.</p> <p>9-3-7(a)</p>	W000440	<p>All Direct Support Professionals will receive a retraining every other month to ensure that they understand the importance of completing the monthly fire drills. The retraining will include reviewing a copy of the Fire Drill Schedule.</p> <p>Ongoing, the Direct Support Professionals will complete one fire drill per month (or more as needed) according to the schedule to ensure that the health and safety of the client's needs are met.</p> <p>Ongoing, all completed fire drill reports will be turned into and reviewed by Quality Assurance for accuracy and thoroughness of each drill.</p> <p>Completion Date: June 21, 2013 Responsible Party: Home Manager</p>	06/21/2013	