

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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 a recertification and state licensure survey.</p> <p>Survey Dates: February 15, 16, 17, 18, 19, 22, 23, 2016</p> <p>Facility number: 001009 Provider number: 15G495 Aim number: 100244970</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/1/16.</p>	W 0000		
W 0154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to thoroughly investigate an allegation of staff abuse for 1 of 3 investigations reviewed (#6).</p> <p>Findings include: The facility's reportable incident reports</p>	W 0154	The Program Director will be retrained on Indiana MENTOR's policy and procedure for completing an investigation. This retraining will also include the expectation of the completion of the recommendations that are results of the completed investigation, and what is included to make a thorough investigation.	03/24/2016

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: 15G495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2016	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220			
(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 0227 Bldg. 00	<p>and investigations were reviewed on 2/16/16 at 10:27a.m. An investigation of the reportable incident, dated 9/17/15, indicated client #6 had alleged a facility staff had pushed her and had made her fall. The report indicated the two staff who were working at the time of the allegation were interviewed. There were no documented interviews of the other facility staff and clients.</p> <p>Professional staff #3 was interviewed on 2/16/16 at 2:02p.m. Staff #3 indicated the facility failed to complete a thorough investigation for the 9/17/15 allegation of abuse. Staff #3 indicated the facility failed to have documented staff and client interviews in regards to the allegation.</p> <p>9-3-2(a)</p> <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 observation, record review and interview, the facility failed for 3 of 4 sampled clients (#1, #2, #3) to ensure the clients' individual support plans (ISP) had training programs in place to address their identified training needs.</p>	W 0227	<p>To ensure that all investigations are completed accurately and thoroughly, Indiana MENTOR's Quality Assurance Specialist will assist this PD with the next three investigations. Ongoing, all investigations will be reviewed by the Area Director and the Quality Assurance Specialist to ensure that all issues are addressed, that the investigation is completed thoroughly, that recommendations are made and that all recommendations are completed and followed up on in a timely manner.</p> <p>Client 1 will have an IDT completed to discuss the inappropriate smoking situation. The IDT discussed his ISP and BSP and added in the smoking protocol for Client 1. All staff were retrained on this new smoking</p>	03/24/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G495		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2016	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220			
(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>An observation was done on 2/15/16 at the group home from 4:38p.m. to 6:40p.m. At 5:04p.m., there were 21 cigarette butts on the back porch floor. There was a bucket for cigarette disposal located just to the left of the porch. At 5:09p.m. client #1 went out to the back porch to smoke. On 2/15/16 at 5:47p.m., staff #5 indicated the cigarette butts belonged to client #1. Also during the observation, client #3 was observed on two occasions to use the bathroom with the door open, sitting on the toilet and visible from the hallway. Staff gave client #3 verbal prompts to shut the door for privacy. At 5:50p.m., staff #4 indicated it was a constant verbal prompt to client #3 to close the bathroom door.</p> <p>1. Record review for client #1 was done on 2/18/16 at 2:12p.m. Client #1 had an interdisciplinary team meeting on 10/8/15. The team meeting indicated client #1 needed to be "Encouraged to not throw cigarettes on the ground." Client #1 had an ISP dated 11/23/15. The ISP did not have a documented training program in place to address client #1's training need for the disposal of his cigarettes.</p>		<p>protocol. Client 1 and the staff were retrained on these plan changes. The Program Director will complete 3 weekly Active Treatment Observations to ensure that Direct Support Staff are following all behavior support plans and to ensure that all clients are participating in meaning day activities and following all appropriate client specific protocols. The Program Director will put in place a procedure for staff and client 1 to appropriately get rid of the cigarette butts. The Program Director, in conjunction with the team, will create a goal and/or training for client 1 to learn to appropriately get rid of the cigarette butts. The Program Coordinator will retrain the direct support staffs on assessing the front and back yards for dropped cigarette butts on the ground. The Program Coordinator and Program Director will put a cleaning schedule in place to ensure that staff are cleaning up the yard, with the assistance of client 1. The Program Director will complete 3 weekly Active Treatment Observations to ensure that Direct Support Staff are following all behavior support plans and to ensure that all clients are participating in meaning day activities and following all appropriate client specific protocols. The Program Director will be retrained on writing client goals and objectives</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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>Staff #1 was interviewed on 2/22/16 at 10:52a.m. Staff #1 indicated client #1 had training needs with the disposal of his cigarette butts. Staff #1 indicated this identified need had not been addressed.</p> <p>2. Record review for client #3 was done on 2/18/16 at 12:10p.m. Client #3 had an ISP dated 6/8/15. The ISP did not have a documented training program in place to address client #3's training need for privacy while in the bathroom.</p> <p>Staff #1 was interviewed on 2/22/16 at 10:52a.m. Staff #1 indicated client #3 had training needs with shutting the bathroom door for his privacy. Staff #1 indicated this identified need had not been addressed.</p> <p>3. Record review for client #2 was done on 2/18/16 at 12:44p.m. Client #2 had a 1/14/16 Dietary review. The Dietician indicated client #2 had a 12 pound weight gain. The dietician recommended a diet change to no extra portions and to exercise 30 minutes daily. Client #2's 10/15/15 ISP did not have a documented exercise training program in place.</p> <p>Staff #1 was interviewed on 2/22/16 at 10:52a.m. Staff #1 indicated client #2 has had a weight gain over the past year. Staff #1 indicated client #2's identified</p>		<p>based on their individual needs. The Program Director will be retrained on including the client goals in the Individualized Support Plan. The Program Director, in conjunction with the Interdisciplinary teams, will create a goal surrounding dignity and privacy for client 3. Ongoing, the Program Director will work with the interdisciplinary teams to ensure that each client has training goal to identify their specific areas of need. Ongoing, all Individualized Support Plans will be reviewed by the Area Director and/or Quality Assurance Manager, to ensure accuracy and to ensure that all areas of need are met for each client.</p> <p>Responsible Party: Program Director, Area Director, and Quality Assurance Manager. The Area Director will retrain the Program Director on ensuring that trainings recommended by the Team, a medical professional, etc, are followed up on and put into place if made. The Program Director will put an exercise goal and training in place for Client 2. Area Director will review all medical appointments, including all PT and OT evaluations one time per month for 3 months and then quarterly thereafter. After the review, the Area Director will follow up to be sure that all recommendations are addressed appropriately and all doctor's orders followed correctly.</p> <p>Responsible Party: Program</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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 0242 Bldg. 00	<p>need to exercise was not addressed with a documented training program. Staff #1 indicated client #2 was in need of a training program to exercise 30 minutes a day.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (#4) to ensure client #4's individual support plan (ISP) had a training program in place to address his identified dental hygiene and toileting training needs.</p> <p>Findings include:</p> <p>Record review for client #4 was done on 2/18/16 at 11:15a.m. Client #4 had a 11/23/15 dental exam that indicated client #4 had several fillings that needed</p>	W 0242	<p>Director and Program Director and Area Director</p> <p>The Program Director will be retrained on writing client goals and objectives based on their individual needs.</p> <p>The Program Director will be retrained on including the client goals in the Individualized Support Plan.</p> <p>The Program Director, in conjunction with the Interdisciplinary teams, will create a goal surrounding a dental hygiene needs for client 4.</p>	03/24/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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 0262 Bldg. 00	<p>replaced. The Dentist also indicated poor oral hygiene and "Please help [client #4] brush upper and back teeth." Client #4 had an 8/31/15 ISP. Client #4's ISP did not address his identified dental hygiene need. Client #4's ISP also indicated "a continence training goal using an effective task analysis, prompting system and reinforcement, should be developed to help [client #4] use the toilet appropriately." Client #4's ISP did not have this identified toilet training need addressed.</p> <p>Staff #1 was interviewed on 2/22/16 at 10:52a.m. Staff #1 indicated client #4's 11/23/15 dental recommendations had not been addressed. Staff #1 indicated client #4 did not have any training programs in place to address his identified dental hygiene needs. Staff #1 indicated the toileting training program recommendation had not been addressed.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection</p>		<p>The Program Director, in conjunction with the Interdisciplinary teams, will create a toileting goal for client 4.</p> <p>Ongoing, the Program Director will work with the interdisciplinary teams to ensure that each client has training goal to identify their specific areas of need.</p> <p>Ongoing, all Individualized Support Plans will be reviewed by the Area Director and/or Quality Assurance Manager, to ensure accuracy and to ensure that all areas of need are met for each client.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2016
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
(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 0312	<p>and rights. Based on record review and interview, the facility's Human Rights Committee (HRC) failed for 1 of 4 sampled clients (#1) with behavior support plans (BSP) to ensure the client's BSP (including behavior medications) was reviewed/monitored.</p> <p>Findings include:</p> <p>The record of client #1 was reviewed on 2/18/16 at 2:12p.m. Client #1's 11/23/15 individual support plan (ISP) and BSP indicated client #1's diagnoses included, but were not limited to, Schizophrenia, for which client #1 received the medications Haldol, Clonazepam and Trazodone. There was no documentation the ISP/BSP had been reviewed by the HRC.</p> <p>Interview of facility staff #1 on 2/22/16 at 10:52a.m. indicated there was no documentation the facility's HRC had reviewed client #1's restrictive ISP/BSP during the past year.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE</p>	W 0262	<p>The Program Director will be retrained on Indiana MENTOR's Human Rights Committee policy and procedures. The Program Director will be trained on the correct process for retrieving the appropriate approvals for the Behavior Support Plans. Ongoing, the new Program Director will correctly retrieve the approvals for all future Behavior Support Plans from the Guardian/Health Care Representative first, then once received, will get the appropriate approval from the Human Rights Committee, before implementing. Ongoing, the Area Director will complete random quarterly audits to ensure that all of the proper approvals are in place from the IDTs.</p>	03/24/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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
Bldg. 00	<p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview, the facility failed for 1 of 3 sampled clients (#2) who took behavior control drugs, to ensure the behavior control medication was part of the client's individual behavior support plan (BSP) which included a plan of reduction.</p> <p>Findings include:</p> <p>Review of the record of client #2 was done on 2/18/16 at 12:44p.m. Client #2's 10/15/15 BSP indicated client #2's diagnosis included, but was not limited to, Self Injurious Behavior (SIB). Physician's orders on 12/11/15 indicated client #2 received the behavior control medications Zyprexa and Zoloft. The BSP failed to include the behavior control medications in a plan which included withdrawal criteria.</p> <p>Interview of professional staff #1 on 2/22/16 at 10:52a.m. indicated client #2 did not have his current behavior control medications addressed in a plan of reduction.</p> <p>9-3-5(a)</p>	W 0312	<p>The Program Director will be retrained on ensuring all Behavior Support Plans include a medication titration plan upon completion. The Behavior Specialist will add in the titration plan to client # 2s current Behavior Support Plan. Ongoing, the Program Director, in conjunction with the team, will ensure that the titration plan is included in the Behavior Support Plan.</p> <p>Ongoing, the Area Director will complete random quarterly audits to ensure that all of the proper approvals are in place from the IDTs.</p>	03/24/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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 0325 Bldg. 00	<p>483.460(a)(3)(iii) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (#2, #4) to ensure clients #2 and #4 received routine laboratory examinations as ordered by their physician.</p> <p>Findings include:</p> <p>Record review for client #2 was done on 2/18/16 at 12:44p.m. Client #2's 7/17/15 physician's orders indicated the physician ordered a prostatic serum (PSA) lab. There was no documentation the PSA lab had been completed.</p> <p>Record review for client #4 was done on 2/18/16 at 11:15a.m. Client #4's 2/10/16 physician's orders indicated the physician had ordered Depakote levels (labs) to be done every 6 months. The most recent documented Depakote lab was done on 2/5/15.</p> <p>Staff #2 (nurse) was interviewed on 2/22/16 at 10:52a.m. Staff #2 indicated</p>	W 0325	<p>The Area Director will retrain the Program Nurse on the ensuring that all components of the physical exams are completed, including but not limited to all requests for labs made by the physician. The Program Nurse will ensure the completion of the needed labs for client number 1 as soon as possible. Ongoing, the Area Director will complete random quarterly audits to ensure that all proper medical care is followed up on and documented correctly. Responsible Party: Program Nurse and Director of Program Nursing</p>	03/24/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220
---	---

(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 0383 Bldg. 00	<p>the most recent documented Depakote lab for client #4 were dated 2/5/15. Staff #2 indicated client #2 did not have a PSA lab completed for the 7/17/15 physician order. Staff #2 indicated client #2 should have had a PSA lab completed per the physician order. Staff #2 indicated client #4 was to have his Depakote labs every 6 months. Staff #2 indicated the labs should have been completed during 8/15 and were due this month.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview, the facility failed for 8 of 8 clients residing in the group home (#1, #2, #3, #4, #5, #6, #7, #8), to ensure the keys to the drug storage cabinet were inaccessible to unauthorized people.</p> <p>Findings include:</p> <p>An observation at the group home was done on 2/15/16 from 4:38p.m. to 6:40p.m. At 4:58p.m., staff #5 got a key from an unlocked cabinet with an open door. The cabinet was located in a room</p>	W 0383	<p>The keys to the group home medication closet were relocated to a more private area and away from the public eye.</p> <p>The direct care staff will be retrained on keeping the keys put away, out of eyesight, and in a more secure and private location.</p> <p>After the retraining occurs, the Home Manager will complete two (2) weekly medication administration observations to ensure that the administration is being completed according to Indiana MENTOR policy and</p>	03/24/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G495		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2016	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220			
(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>connected to the living room and kitchen and accessible to clients #1, #2, #3, #4, #5, #6, #7 and #8. Staff #5 used the key to open a medication door that contained client medications. Staff #5 returned the medication room key to the open drawer of the cabinet.</p> <p>Staff #2 (nurse) was interviewed on 2/22/16 at 10:52a.m. Staff #2 indicated the medication keys should not be left in the open drawer of a cabinet accessible to the clients. Staff #2 indicated the medication room keys should be kept in a secured place.</p> <p>9-3-6(a)</p>		<p>procedures for four (4) weeks. These will then be reviewed by the Program Director ensuring that there are no further training needs. After the initial four (4) weeks, the Home Manager and/or Program Director will complete weekly medication administration observations ongoing, and will ensure that all needed future retrainings will be completed.</p>				