

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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 fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 9/21/15, 9/22/15, 9/23/15, 9/24/15, 9/25/15 and 9/29/15.</p> <p>Facility Number: 001020 Provider Number: 15G506 AIMS Number: 100244980</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed by #09182 on 9/30/2015.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#1 and #2), the facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients #1 and #2 did not use their personal funds to purchase haircuts.</p> <p>Findings include:</p> <p>1. Client #1's financial record was</p>	W 0104	<p>The Area Director completed an Indiana MENTOR Request for Payment for client # 1 to be reimbursed the \$14 for the haircut that he paid for. See attachment for information.</p> <p>The Area Director completed an Indiana MENTOR Request for Payment for client # 2 to be reimbursed the \$14 for the haircut that she paid for. See attachment for information.</p>	10/29/2015

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:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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 0149 Bldg. 00	<p>reviewed on 9/22/15 at 9:45 AM. Client #1's receipts indicated client #1 paid \$14.00 for a haircut on 9/3/15.</p> <p>2. Client #2's financial record was reviewed on 9/22/15 at 9:55 AM. Client #2's receipts indicated client #2 paid \$14.00 for a haircut on 9/3/15.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/22/15 at 10:10 AM. QIDP #1 indicated clients #1 and #2 had paid \$14.00 for haircuts on 9/3/15. QIDP #1 indicated the facility should pay for haircuts.</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 record review and interview for 1 of 4 sampled clients (#3), the facility failed to implement its policy and procedures to immediately report an injury of unknown origin regarding client #3's contusions (bruises) to BDDS (Bureau of Developmental Disabilities Services) and to investigate the origin of client #3's contusions.</p>	W 0149	<p>The Program Coordinator will be retrained on what is to be covered by Medicaid versus what is covered by Indiana MENTOR.</p> <p>The Program Director will be retrained on what is to be covered by Medicaid versus what is covered by Indiana MENTOR.</p> <p>All financial transactions are monitored by the Program Coordinator, reconciled on a monthly basis by the Program Director, and then reviewed by the Client Finance Specialist at the completion of each month. Ongoing, the Area Director will complete quarterly reviews of a random sample of client finances to ensure that all is completely accurately and correctly.</p> <p>The Program Coordinator will be retrained on incident reporting requirements, including but not limited to reporting these incidents to the appropriate supervisor and/or administrator.</p> <p>The Program Director will be retrained on BDDS reports requirements.</p> <p>The Program Nurse that responded to this incident is no longer with</p>	10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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>Client #3's record was reviewed on 9/22/15 at 12:08 PM. Client #3's ER (Emergency Room) forms dated 3/22/15 indicated client #3 was evaluated at the ER. Client #3's ER form dated 3/22/15 indicated, "Your diagnosis was multiple contusions." Client #3's ER form dated 3/22/15 indicated client #3 was prescribed Naproxen Sodium 550 milligrams (pain relief).</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/22/15 at 1:45 PM. QIDP #1 indicated he was not aware of client #3's 3/22/15 ER visit. QIDP #1 indicated client #3's 3/22/15 ER visit and bruises from an unknown origin were not reported to BDDS and were not investigated. QIDP #1 indicated the facility's abuse and neglect policy should be implemented, injuries of unknown origin should be reported to BDDS within 24 hours and should be investigated.</p> <p>The facility's BDDS reports and investigations were reviewed on 9/21/15 at 1:43 PM. The review did not indicate documentation of client #3's 3/22/15 injury of unknown origin being reported to BDDS or investigated.</p>		<p>Indiana MENTOR as an employee. The new Program Nurse will be appropriately trained on reporting all incidents to the Program Director and the administrator as required. In the interim, the Program Nurse that is covering this home will be instructed to ensure that all reportable incidents are reported to the administrator. Ongoing all incidents will be appropriately reported. 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. 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>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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 0153  Bldg. 00	<p>The facility's policy and procedures were reviewed on 9/24/15 at 11:07 AM. The facility's April 2011 Quality and Risk Management form indicated the following:</p> <p>- "Indian Mentor follows the BDDS Incident Reporting policy as outlined in the Provider Standards. An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS."</p> <p>-"(i.) Injury to an individual when the origin or cause of the injury is unknown and the injury required medical evaluation or treatment."</p> <p>-"(j.) (6) Contusions or lacerations which require more than basic first aid."</p> <p>-"C. 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."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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>injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 1 incidents of an injury of unknown origin reviewed, the facility failed to report an injury of unknown origin regarding client #3's contusions (bruises) to BDDS (Bureau of Developmental Disability Services) within 24 hours in accordance with state law.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 9/22/15 at 12:08 PM. Client #3's ER (Emergency Room) forms dated 3/22/15 indicated client #3 was evaluated at the ER. Client #3's ER form dated 3/22/15 indicated, "Your diagnosis was multiple contusions." Client #3's ER form dated 3/22/15 indicated client #3 was prescribed Naproxen Sodium 550 milligrams (pain relief).</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/22/15 at 1:45 PM. QIDP #1 indicated he was not aware of client #3's 3/22/15 ER visit. QIDP #1 indicated client #3's 3/22/15 ER visit and bruises from an unknown origin were not reported to BDDS. QIDP #1 indicated injuries of unknown origin should be reported to</p>	W 0153	<p>The Program Coordinator will be retrained on incident reporting requirements, including but not limited to reporting these incidents to the appropriate supervisor and/or administrator. The Program Director will be retrained on BDDS reports requirements. The Program Nurse that responded to this incident is no longer with Indiana MENTOR as an employee. The new Program Nurse will be appropriately trained on reporting all incidents to the Program Director and the administrator as required. In the interim, the Program Nurse that is covering this home will be instructed to ensure that all reportable incidents are reported to the administrator. Ongoing all incidents will be appropriately reported. 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. To ensure that all investigations are completed accurately and thoroughly, Indiana MENTOR's Quality Assurance Specialist will assist</p>	10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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 0154 Bldg. 00	<p>BDDS within 24 hours.</p> <p>The facility's BDDS reports and investigations were reviewed on 9/21/15 at 1:43 PM. The review did not indicate documentation of client #3's 3/22/15 injury of unknown origin being reported to BDDS.</p> <p>9-3-1(b)(5) 9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 1 injury of unknown origin reviewed, the facility failed to complete a thorough investigation regarding an injury of unknown origin regarding client #3's contusions.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 9/22/15 at 12:08 PM. Client #3's ER (Emergency Room) forms dated 3/22/15 indicated client #3 was evaluated at the ER. Client #3's ER form dated 3/22/15 indicated, "Your diagnosis was multiple</p>	W 0154	<p>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>The Program Coordinator will be retrained on incident reporting requirements, including but not limited to reporting these incidents to the appropriate supervisor and/or administrator.</p> <p>The Program Director will be retrained on BDDS reports requirements.</p> <p>The Program Nurse that responded to this incident is no longer with Indiana MENTOR as an employee. The new Program Nurse will be appropriately trained on reporting all incidents to the Program Director and the administrator as required. In the interim, the Program Nurse that is covering this home will be</p>	10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  09/29/2015
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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 0159 Bldg. 00	<p>contusions." Client #3's ER form dated 3/22/15 indicated client #3 was prescribed Naproxen Sodium 550 milligrams (pain relief).</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/22/15 at 1:45 PM. QIDP #1 indicated client #3's 3/22/15 ER visit and bruises from an unknown origin were not investigated. QIDP #1 indicated injuries of unknown origin should be investigated.</p> <p>The facility's BDDS reports and investigations were reviewed on 9/21/15 at 1:43 PM. The review did not indicate documentation of client #3's 3/22/15 injury of unknown origin being investigated.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the QIDP (Qualified</p>	W 0159	<p>instructed to ensure that all reportable incidents are reported to the administrator. Ongoing all incidents will be appropriately reported. 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. 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>1.The Program Coordinator and Program Director will convene the IDT for client #3 to discuss the</p>	10/29/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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>Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients #1, #2, #3 and #4's active treatment programs by failing to convene the IDT (Interdisciplinary Team) to assess and make recommendations regarding client #3's dignity and self-advocacy regarding her missing teeth, to ensure client #1's ISP (Individual Support Plan) addressed client #1's mealtime use of utensil skills/needs, to ensure the facility's HRC (Human Rights Committee) reviewed, approved and monitored clients #3 and #4's use of psychotropic medications for behavior management, to ensure the facility's HRC ensured clients #3 and #4's behavior management program, which included the use of psychotropic medications, were conducted with the client or guardian's written informed consent, to promote the dignity of clients #2 and #3, to ensure client #3's use of psychotropic medications for behavior management was included in an active treatment program to reduce or eliminate the need for the medication and to ensure the facility provided client #3 with a pair of prescription eyeglasses and to ensure client #4's wheelchair was in good repair.</p> <p>Findings include:</p> <p>1. Observations were conducted at the</p>		<p>dignity concerns surrounding the ongoing dental issues. The team will discuss what can be done to improve client #3's appearance for dignity purposes.</p> <p>The Program Director and Program Coordinator will be retrained on client's rights with the specific information on respecting client's rights to dignity and social appearance.</p> <p>1. Please see W227</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 training for the appropriate dining utensils for clients 1.</p> <p>The Program Director and/or Program Coordinator will have client #1 assessed for the proper use of specific dining utensils, and then will purchased the utensil that is recommended.</p> <p>Ongoing, the Program Director will work with the interdisciplinary teams to ensure that each client has training goal to identify their specific</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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>group home on 9/21/15 from 4:40 PM through 6:08 PM. Client #3 was present in the home throughout the observation period. Client #3 interacted with her peers and staff working in the home throughout the observation period. While speaking with peers or staff, client #3's teeth were exposed. Client #3 had several missing teeth in both the top and bottom of her mouth. Client #3 had 3 visible teeth in the top front portion of her mouth and 2 visible teeth in the bottom front portion of her mouth.</p> <p>Client #3's record was reviewed on 9/22/15 at 12:08 PM. Client #3's record did not indicate IDT review or assessment regarding client #3's current dental status with regard to dignity and social implications of her appearance.</p> <p>QIDP #1 was interviewed on 9/22/15 at 1:45 PM. QIDP #1 indicated the IDT had not met to discuss client #3 or her guardian's preferences regarding the aesthetic quality of client #3's current dental status. QIDP #1 indicated the IDT should review and discuss client #3's current dental status with regard to dignity and social implications of her appearance.</p> <p>2. The QIDP failed to integrate, coordinate and monitor client #1's active</p>		<p>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> <p>The Direct Support Staff will be retrained on ensuring the proper dining utensils are provided for each client at each meal time.</p> <p>For the first 4 weeks, the Program Director and/or Program Coordinator will complete 2 weekly Meal Time Observations to ensure that staff are completing the family style dining as expected, which includes but is not limited to, using all dining utensils that are client specific. After the 4 weeks, the PD and PC will continue to complete the meal time Observations one time per week, or more if needed.</p> <p>1. Please see W262</p> <p>The Program Director will be trained on the correct process for retrieving the appropriate approvals for the Behavior Support Plans, including but not limited to, the use of behavior controlling medications. Ongoing, the 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</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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>treatment program by failing to ensure client #1's ISP addressed client #1's mealtime use of utensil skills/needs. Please see W227.</p> <p>3. The QIDP failed to integrate, coordinate and monitor clients #3 and #4's active treatment programs by failing to ensure the facility's HRC reviewed, approved and monitored clients #3 and #4's use of psychotropic medications for behavior management. Please see W262.</p> <p>4. The QIDP failed to integrate, coordinate and monitor clients #3 and #4's active treatment programs by failing to ensure the facility's HRC ensured clients #3 and #4's behavior management programs, which included the use of psychotropic medications, were conducted with the client or guardian's written informed consent. Please see W263.</p> <p>5. The QIDP failed to integrate, coordinate and monitor clients #2, #3's active treatment programs by failing to promote the dignity of clients #2 and #3. Please see W268.</p> <p>6. The QIDP failed to integrate, coordinate and monitor client #3's active treatment programs by failing to ensure client #3's use of psychotropic</p>		<p>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. The Program Director will be retrained on Indiana MENTOR's Human Rights Committee policy and procedures. Ongoing, the Program Director will seek guardian approval, then HRC approval, before implementing any behavior controlling measures, for all clients, including client #3 and 4.</p> <p>1. Please see W263</p> <p>The Program Director will be trained on the correct process for retrieving the appropriate approvals for the Behavior Support Plans, including but not limited to, the use of behavior controlling medications. Ongoing, the 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. The Program Director will be retrained on Indiana MENTOR's Human Rights Committee policy and procedures. Ongoing, the Program Director will seek guardian approval, then HRC approval, before implementing any</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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>medications for behavior management was included in an active treatment program to reduce or eliminate the need for the medication. Please see W312.</p> <p>7. The QIDP failed to integrate, coordinate and monitor clients #3 and #4's active treatment programs by failing to ensure the facility provided client #3 with a pair of prescription eyeglasses and to ensure client #4's wheelchair was in good repair. Please see W436.</p> <p>9-3-3(a)</p>		<p>behavior controlling measures, for all clients, including client #3 and 4.</p> <p>1. Please see W268</p> <p>The Program Coordinator and Program Director will convene the IDT for client #3 to discuss the dignity concerns surrounding the ongoing dental issues. The team will discuss what can be done to improve client #3's appearance for dignity purposes.</p> <p>The Program Coordinator and Program Director will convene the IDT for client #2 to discuss the dignity concerns surrounding the ongoing grooming needs. The team will discuss what can be done to improve client #2's appearance for dignity purposes.</p> <p>The Direct Support Staff will be retrained on assisting clients with hygiene and grooming needs on a regular basis.</p> <p>The Program Director and Program Coordinator will be retrained on client's rights with the specific information on respecting client's rights to dignity and social appearance.</p> <p>For the first 4 weeks, the Program Director and/or Program Coordinator will complete 2 weekly Active Treatment Observations to ensure that staff are assisting with the grooming and hygiene as needed. After the 4 weeks, the PD and HM will continue to complete the Active Treatment Observations one time per week, or more if needed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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>1.Please see W312 The Program Director will be retrained on ensuring the teams include titration plans in the behaviors support plan for each client, but specifically for client #3. The Program Director will review all behavior support plans in his cluster and ensure that titration plans are available and approved. The Program Director will work with the new Behavior Specialist for this group home and ensure that the behavior plans are updated with titration plans as needed. The Area Director will review the next three BSPs that are written to ensure that the titration plans are included. Ongoing, the Area Director will complete 3 random audits a quarter, per Program Director to ensure that updated BSPs have titration plans included and are appropriate.</p> <p>1.Please see W436 The Program Coordinator and Program Director will be retrained on ensuring that all adaptive equipment is up to date client specifically, as needed or required. The Direct Support Staff will be retrained on ensuring that clients are formally and informally offered their adaptive equipment as needed client specifically. The Area Director completed a check request for the wheel chair repairs for client #4. This check was received and sent to the company for repairs and new parts. See attachment for</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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	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 for 1 of 4 sampled clients (#1), the facility failed to ensure client #1's ISP (Individual Support Plan) addressed client #1's skills/needs for mealtime use of utensils.	W 0227	more information. The Program Coordinator will take client # 1 to purchase new glasses with the provided script. The Program Director will ensure that ISPs and RMAPs include the adaptive equipment. The new Program Nurse will be trained on ensuring that all medical adaptive equipment is secured and appropriately used. This will be monitored through observations at the home. For the first 4 weeks, the Program Director and/or Program Coordinator and/or Program Nurse will complete 2 weekly Active Treatment Observations to ensure that staff are assisting with using and caring for the provided adaptive equipment. After the 4 weeks, the PD and PC will continue to complete the Active Treatment Observations one time per week, or more if needed.  The Program Director will be retrained on writing client goals and objectives based on their individual needs.  The Program Director will be retrained on including the client	10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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>Observations were conducted at the group home on 9/21/15 from 4:40 PM through 6:08 PM. At 5:55 PM, client #1 participated in the home's family style evening meal. Client #1's meal was pureed consistency and included, but was not limited to, baked chicken patty, beets and green beans. Throughout the meal, client #1 utilized his fingers to transfer the pureed food to his mouth.</p> <p>Observations were conducted at the group home on 9/22/15 from 6:20 AM through 8:00 AM. At 7:30 AM, client #1 joined his peers for the morning family style meal. Client #1's meal included, but was not limited to, cold cereal. Throughout the meal, client #1 utilized his fingers to transfer the cereal from his bowl to his mouth.</p> <p>Client #1's record was reviewed on 9/22/15 at 9:30 AM. Client #1's ISP dated 4/3/15 indicated, "Assessment of food and liquid intake: Is able to eat and drink without assistance." Client #1's CFA (Comprehensive Functional Assessment) dated 3/30/15 indicated client #1 needed training/assistance to drink from a glass, eat with a spoon, drink through a straw, eat with a fork, use</p>		<p>goals in the Individualized Support Plan.</p> <p>The Program Director, in conjunction with the Interdisciplinary teams, will create a goal surrounding training for the appropriate dining utensils for clients 1.</p> <p>The Program Director and/or Program Coordinator will have client #1 assessed for the proper use of specific dining utensils, and then will purchased the utensil that is recommended.</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> <p>The Direct Support Staff will be retrained on ensuring the proper dining utensils are provided for each client at each meal time.</p> <p>For the first 4 weeks, the Program Director and/or Program Coordinator will complete 2 weekly Meal Time Observations to ensure that staff are completing the family</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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>a napkin, pour liquid and/or appropriate table etiquette.</p> <p>Client #1's ISP dated 4/3/15 did not indicate documentation of a formal training objective or supports to address client #1's 3/30/15 CFA assessed meal time needs.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/22/15 at 1:45 PM. QIDP #1 indicated client #1 required prompting to use his utensils to eat his meals. QIDP #1 indicated client #1 did not have formal training objectives to address client #1's needs regarding his meal/eating skills.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING &amp; 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 and rights.</p> <p>Based on record review and interview for 2 of 2 sampled clients who utilized psychotropic medication for behavior management (#3 and #4), the facility's HRC (Human Rights Committee) failed to review, approve and monitor clients #3 and #4's use of psychotropic medications</p>	W 0262	<p>style dining as expected, which includes but is not limited to, using all dining utensils that are client specific. After the 4 weeks, the PD and PC will continue to complete the Active Treatment Observations one time per week, or more if needed.</p> <p>The Program Director will be trained on the correct process for retrieving the appropriate approvals for the Behavior Support Plans, including but not limited to, the use of behavior controlling medications. Ongoing, the Program Director will correctly retrieve the approvals for</p>	10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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>for behavior management.</p> <p>Findings include:</p> <p>1. Client #3's record was reviewed on 9/22/15 at 12:08 PM. Client #3's BSP (Behavior Support Plan) dated May 2015 indicated client #3 received daily doses of Fluoxetine (anti-depressant) and Risperidone (mood stabilizer) for behavior management. Client #3's record did not indicate documentation of HRC review, approval or monitoring regarding client #3's use of Fluoxetine or Risperidone.</p> <p>2. Client #4's record was reviewed on 9/22/15 at 1:05 PM. Client #4's BSP dated May 2015 indicated client #4 received daily doses of Effexor (anti-depressant) and Abilify (mood stabilizer). Client #4's record did not indicate documentation of HRC review, approval or monitoring regarding client #4's use of Effexor or Abilify.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/22/15 at 1:45 PM. QIDP #1 indicated the facility's HRC should review, approve and monitor clients #3 and #4's use of psychotropic medications used for behavior management.</p>		<p>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. The Program Director will be retrained on Indiana MENTOR's Human Rights Committee policy and procedures.</p> <p>Ongoing, the Program Director will seek guardian approval, then HRC approval, before implementing any behavior controlling measures, for all clients, including client #3 and 4.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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 0263 Bldg. 00	<p>9-3-4(a)</p> <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 2 of 2 sampled clients who utilized psychotropic medication for behavior management (#3 and #4), the facility's HRC (Human Rights Committee) failed to ensure clients #3 and #4's behavior management program, which included the use of psychotropic medications, were conducted with the client or guardian's written informed consent.</p> <p>Findings include:</p> <p>1. Client #3's record was reviewed on 9/22/15 at 12:08 PM. Client #3's BSP (Behavior Support Plan) dated May 2015 indicated client #3 received daily doses of Fluoxetine (anti-depressant) and Risperidone (mood stabilizer) for behavior management. Client #3's ISP (Individual Support Plan) dated 3/20/15 indicated client #3 had a legal guardian.</p>	W 0263	<p>The Program Director will be trained on the correct process for retrieving the appropriate approvals for the Behavior Support Plans, including but not limited to, the use of behavior controlling medications. Ongoing, the 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. The Program Director will be retrained on Indiana MENTOR's Human Rights Committee policy and procedures. Ongoing, the Program Director will seek guardian approval, then HRC approval, before implementing any behavior controlling measures, for all clients, including client #3 and 4.</p>	10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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>Client #3's record did not indicate documentation of client #3's guardian's written informed consent regarding the use of Fluoxetine or Risperidone for behavior management.</p> <p>2. Client #4's record was reviewed on 9/22/15 at 1:05 PM. Client #4's BSP dated May 2015 indicated client #4 received daily doses of Effexor (anti-depressant) and Abilify (mood stabilizer). Client #4's ISP dated 5/15/15 indicated client #4 had a legal guardian.</p> <p>Client #4's record did not indicate documentation of client #4's guardian's written informed consent regarding client #4's use of Effexor or Abilify for behavior management.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/22/15 at 1:45 PM. QIDP #1 indicated the facility had obtained clients #3 and #4's guardian's written informed consent regarding the use of psychotropic medications and would locate and provide documentation of their consent.</p> <p>QIDP #1 did not provide additional documentation regarding clients #3 and #4's guardians' written informed consent.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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 0268  Bldg. 00	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT</p> <p>These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation and interview for 2 of 4 sampled clients (#2 and #3), the facility failed to promote the dignity of clients #2 and #3.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/21/15 from 4:40 PM through 6:08 PM. Clients #2 and #3 were present in the home throughout the observation period. Client #2, who was female, wore a pair of Capri style pants which exposed portions of her lower legs. Client #2's legs had dark, coarse 3/4 inch long hair covering both of her legs. Client #3 interacted with her peers and staff working in the home throughout the observation period. While speaking with peers or staff client #3's teeth were exposed. Client #3 had several missing teeth in both the top and bottom of her mouth. Client #3 had 3 visible teeth in the top front portion of her mouth and 2 visible teeth in the bottom front portion of her mouth.</p> <p>QIDP (Qualified Intellectual Disabilities</p>	W 0268	<p>The Program Coordinator and Program Director will convene the IDT for client #3 to discuss the dignity concerns surrounding the ongoing dental issues. The team will discuss what can be done to improve client #3's appearance for dignity purposes.</p> <p>The Program Coordinator and Program Director will convene the IDT for client #2 to discuss the dignity concerns surrounding the ongoing grooming needs. The team will discuss what can be done to improve client #2's appearance for dignity purposes.</p> <p>The Direct Support Staff will be retrained on assisting clients with hygiene and grooming needs on a regular basis.</p> <p>The Program Director and Program Coordinator will be retrained on client's rights with the specific information on respecting client's rights to dignity and social appearance.</p> <p>For the first 4 weeks, the Program Director and/or Program Coordinator will complete 2 weekly Active Treatment Observations to ensure that staff are assisting with the grooming and hygiene as needed. After the 4 weeks, the PD</p>	10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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 Bldg. 00	<p>Professional) #1 was interviewed on 9/22/15 at 1:45 PM. QIDP #1 indicated client #2 should be assisted with her grooming needs. QIDP #1 indicated client #3 had missing front top and bottom teeth.</p> <p>9-3-5(a)</p> <p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure client #3's use of psychotropic medications for behavior management was included in an active treatment program to reduce or eliminate the need for the medication.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 9/22/15 at 12:08 PM. Client #3's BSP (Behavior Support Plan) dated May 2015 indicated client #3 received daily doses of Fluoxetine (anti-depressant) and Risperidone (mood stabilizer) for behavior management. Client #3's record did not indicate documentation of a plan</p>	W 0312	<p>and HM will continue to complete the Active Treatment Observations one time per week, or more if needed.</p> <p>The Program Director will be retrained on ensuring the teams include titration plans in the behaviors support plan for each client, but specifically for client #3. The Program Director will review all behavior support plans in his cluster and ensure that titration plans are available and approved. The Program Director will work with the new Behavior Specialist for this group home and ensure that the behavior plans are updated with titration plans as needed. The Area Director will review the next three BSPs that are written to ensure that the titration plans are included. Ongoing, the Area Director will complete 3 random audits a quarter, per Program Director to ensure that</p>	10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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 0331 Bldg. 00	<p>of reduction or active treatment program to reduce or eliminate the need for client #3 to utilize Fluoxetine or Risperidone for behavior management.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/22/15 at 1:45 PM. QIDP #1 indicated the use of psychotropic medications should be included in an active treatment program to reduce or eliminate the need for the medication.</p> <p>9-3-5(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 record review and interview for 1 of 4 sampled clients (#1), the facility nursing services failed to ensure client #1's laboratory monitoring orders were implemented.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 9/22/15 at 9:30 AM. Client #1's POs (Physician's Orders) form dated 7/31/15 indicated client #1 received Phenobarbital (seizures) 48.6 milligrams daily at bedtime and 16.2 milligrams daily in the morning. Client #1's POs</p>	W 0331	<p>updated BSPs have titration plans included and are appropriate.</p> <p>The new Program Nurse will be trained to ensure that all client's follow up appointments are completed. This includes but is not limited to lab work that is requested at a specific timeframe. The Program Coordinator will work with the PCP to ensure that client #1 has the Phenobarbital levels are checked as soon as possible, and then no less than every 6 months thereafter, as requested by the physician. The Quality Assurance Specialist completes random quarterly audits under each Program Director to ensure that all health and safety assessments are followed up on as</p>	10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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 0436	<p>dated 7/31/15 indicated client #1's Phenobarbital levels should be checked every 6 months.</p> <p>Client #1's Seizure Protocol form dated 3/2/15 indicated client #1's Phenobarbital levels should be checked every 6 months.</p> <p>Client #1's Laboratory form dated 1/13/15 indicated client #1's Phenobarbital levels were checked. Client #1's record did not indicate additional documentation of client #1's Phenobarbital levels being monitored since 1/13/15.</p> <p>AD (Area Director) #1 was interviewed on 9/22/15 at 1:50 PM. AD #1 indicated the facility nurse was not available for interview. AD #1 attempted to contact the facility nurse via phone but was not able to facilitate a phone interview. AD #1 indicated the nurse had recently tendered her resignation and was non-cooperative with being interviewed. AD #1 indicated client #1's Phenobarbital levels should be checked as indicated on his POs dated 7/31/15. AD #1 indicated she was the nurse's supervisor.</p> <p>9-3-6(a)</p> <p>483.470(g)(2)</p>		<p>required.</p> <p>The Area Director retrained the current facility nurses on completing monthly specific peer reviews for each other. This will assist with each nurse ensuring that all medical follow up is completed timely. Ongoing, the Area Director will review the Peer Reviews that are completed to ensure that no additional follow up is needed at that time.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  09/29/2015	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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><b>SPACE AND EQUIPMENT</b></p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 2 of 4 clients with adaptive equipment, the facility failed to provide client #3 with a pair of prescription eyeglasses and to ensure client #4's wheelchair was in good repair.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/21/15 from 4:40 PM through 6:08 PM. Clients #3 and #4 were observed throughout the observation period. Client #3 did not wear eyeglasses. Client #4's wheelchair was missing the cushion in the seat.</p> <p>Observations were conducted at the group home on 9/22/15 from 6:20 AM through 8:00 AM. Clients #3 and #4 were observed throughout the observation period. Client #3 did not wear eyeglasses. Client #4's wheelchair was missing the cushion in the seat.</p> <p>Client #4 was interviewed on 9/22/15 at 7:50 AM. Client #4 indicated the</p>			W 0436	<p>The Program Coordinator and Program Director will be retrained on ensuring that all adaptive equipment is up to date client specifically, as needed or required. The Direct Support Staff will be retrained on ensuring that clients are formally and informally offered their adaptive equipment as needed client specifically.</p> <p>The Area Director completed a check request for the wheel chair repairs for client #4. This check was received and sent to the company for repairs and new parts. See attachment for more information.</p> <p>The Program Coordinator will take client # 1 to purchase new glasses with the provided script.</p> <p>The Program Director will ensure that ISPs and RMAPs include the adaptive equipment.</p> <p>The new Program Nurse will be trained on ensuring that all medical adaptive equipment is secured and appropriately used. This will be monitored through observations at the home.</p> <p>For the first 4 weeks, the Program Director and/or Program Coordinator and/or Program Nurse will complete 2 weekly Active</p>		10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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>wheelchair she was using was missing the seat cushion. Client #4 indicated her buttocks and back were hurting due to not having padding in the wheelchair.</p> <p>1. Client #3's record was reviewed on 9/22/15 at 12:08 PM. Client #3's Vision Examination Record of Visit form dated 12/4/14 indicated, "Prescription for glasses given."</p> <p>2. Client #4's record was reviewed on 9/22/15 at 1:05 PM. Client #4's ISP (Individual Support Plan) dated 5/5/15 indicated client #4 utilized a manual wheelchair for ambulation. Client #4's Wheelchair Service Work Order form dated 4/16/15 indicated client #4's wheelchair required repair regarding the locking mechanism on the foot rest and brakes not functioning properly. Client #4's Impaired Skin Integrity protocol form dated 12/5/14 indicated client #4 was at a potential risk for skin breakdown.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/22/15 at 1:45 PM. QIDP #1 indicated he was not aware of client #3 having a pair of prescription eyeglasses. QIDP #1 indicated client #4's current wheelchair had been a temporary chair due to the 4/16/15 maintenance issues with her</p>		<p>Treatment Observations to ensure that staff are assisting with using and caring for the provided adaptive equipment. After the 4 weeks, the PD and PC will continue to complete the Active Treatment Observations one time per week, or more if needed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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 0474 Bldg. 00	<p>primary wheelchair. QIDP #1 indicated client #4's wheelchair was missing the seat cushion. QIDP #1 indicated he was not aware of how long the cushion had been missing. QIDP #1 indicated client #4 had frequent bladder incontinence and could have thrown the cushion away.</p> <p>9-3-7(a)</p> <p>483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure staff implemented client #1's diet order regarding food consistency.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/21/15 from 4:40 PM through 6:08 PM. At 5:55 PM, client #1 participated in the home's family style evening meal. Client #1's meal was pureed consistency and included, but was not limited to, baked chicken patty, beets and green beans.</p> <p>Observations were conducted at the group home on 9/22/15 from 6:20 AM through 8:00 AM. At 7:30 AM, client #1</p>	W 0474	<p>The Direct Support staff will be retrained on client #1's diet orders. The Direct Support Staff will implement client #1's diet orders as written to ensure that no complications arise. For the first 4 weeks, the Program Director and/or Program Coordinator and/or Program Nurse will complete 2 weekly meal time observations to ensure that staff are completing meal time with all of the appropriate diet orders/restrictions for each client. After the 4 weeks, the PD and PC will continue to complete the meal time observations one time per week, or more if needed. Ongoing, the Direct Support staff will complete meal time with the appropriate diet orders as they are written.</p>	10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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 9999  Bldg. 00	<p>joined his peers for the morning family style meal. Client #1's meal included, but was not limited to, cold cereal and muffins that were broken into bite sized pieces.</p> <p>Client #1's record was reviewed on 9/22/15 at 9:30 AM. Client #1's ISP dated 4/3/15 indicated client #1 was on a mechanical soft diet. Client #1's Aspiration Protocol form dated 3/2/15 indicated client #1 was on a mechanical soft diet. Client #1's Physician's Orders form dated 7/31/15 indicated client #1 was on a mechanical soft diet.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/22/15 at 1:45 PM. QIDP #1 indicated client #1's diet orders were for mechanical soft. QIDP #1 indicated staff should ensure client #1's diet orders are implemented as written. QIDP #1 indicated client #1's food should not be pureed.</p> <p>9-3-8(a)</p> <p>State Findings</p>	W 9999	The Program Director will be retrained on BDDS reportable incidents.	10/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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>1. The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-1 Governing Body</p> <p>"(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division: (11.) An emergency intervention for the individual resulting from: (a.) a physical symptom; (b.) a medical or psychiatric condition; (c.) any other event."</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 3 incidents of emergency intervention utilization, the facility failed to immediately notify the BDDS (Bureau of Developmental Disabilities Services) regarding incidents of clients #2 and #4 requiring emergency medical assessment or services.</p> <p>Findings include:</p> <p>1. Client #2's record was reviewed on 9/22/15 at 10:43 PM. Client #2's ER (Emergency Room) form dated 3/24/15</p>		<p>Going forward, the Program Director will be ensure that a BDDS report will be completed after all incidents. The Program Coordinator will complete no less than weekly documentation reviews to ensure that all staff are documenting and appropriately reporting any incident. These documentation reviews will be reviewed and documented with a signature for the Program Director to ensure that no incidents go unreported.</p> <p>Ongoing, the Area Director will complete random quarterly audits to ensure that all incidents are reported appropriately to BDDS. The Program Nurse/RN who did have three checked references was hired in approximately 1990 and was employed the entire time. She had 2 references that were verified at that time.</p> <p>Indiana MENTOR's policy and procedure states that Human Resources will complete 3 verified reference checks upon hire. All future individuals offered a position will have 3 verified references before working with any clients.</p> <p>Indiana MENTOR's policy and procedure states that all staff will have a completed Driver's License check done to ensure that it is valid and meets all of the requirements for employment.</p> <p>The Indiana MENTOR Human Resources department will complete a current driver's license background check on staff #1.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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>indicated, "Your diagnosis was Acute Cystitis with Hematuria (urinary tract infection)."</p> <p>2. Client #4's record was reviewed on 9/22/15 at 1:05 PM. Client #4's ER form dated 7/16/15 indicated, "Your diagnosis was abnormal behavior." Client #4's 7/16/15 ER form indicated client #4 was evaluated at the ER due to a change in mental status related to Bipolar Disorder.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/22/15 at 1:45 PM. QIDP #1 indicated client #2's 3/24/15 and/or client #4's 7/16/15 ER visits were not reported to BDDS.</p> <p>The facility's BDDS reports and investigations were reviewed on 9/21/15 at 1:43 PM. The review did not indicate documentation of client #2's 3/24/15 and/or client #4's 7/16/15 ER visits being reported to BDDS.</p> <p>2. The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-2(c)(3) Resident Protections</p> <p>"...The provider shall obtain, as a</p>		<p>The Indiana MENTOR Human Resources Administrative Assistant completes an annual driving check on all employees once a year for the duration of their employment.</p> <p>The Indiana MENTOR Human Resources Generalist completes annual audit reviews of the personnel files for a sample of staff under each Area Director. The Area Director then reviews the results of the audits and with the assistance of the HR Admin Assistant, fixes all errors found at that time.</p> <p>Ongoing, Indiana MENTOR will continue to ensure that all staff have an annual driver's license check completed to ensure all required documents are kept up for the duration of employment.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/29/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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>minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5..., and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section."</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 3 employee files reviewed, the facility failed to ensure RN (Registered Nurse) #1 had 3 references and staff #1 had a bureau of motor vehicles check prior to working with clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. RN #1's personnel record was reviewed on 9/21/15 at 3:22 PM. RN #1's personnel record did not indicate documentation of 3 references.</li> <li>2. Staff #1's personnel record was reviewed on 9/21/15 at 3:25 PM. Staff #1's personnel record did not indicate documentation of a bureau of motor vehicles check. Staff #1's record indicated she was hired by the facility May 2015.</li> </ol>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/29/2015
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE 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	
	AD (Area Director) #1 was interviewed on 9/21/15 at 3:30 PM. AD #1 indicated there was not additional documentation available for review regarding references for RN #1. AD #1 indicated RN #1 had worked for the agency more than 15 years. AD #1 indicated there was not additional documentation available for review regarding staff #1's bureau of motor vehicles check.  9-3-1(b) 9-3-2(c)(3)				