STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G719		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	1406 W TARKINGTON DR GREENSBURG, IN 47240

(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	This visit was for a recertification and state licensure survey. Dates of Survey: March 7, 8 and 9, 2016. Facility Number: 004375 Provider Number: 15G719 Aim Number: 200510170 These federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/16/16.	W 0000		
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 1 of 2 sampled clients (#1) and one additional client (#3), the facility failed to ensure clients received medications in accordance with their physician's orders. Findings include: Review of facility reportable incident reports on 3/8/16 at 2:55 PM indicated	W 0368	Nurse will retrain all staff in the home onadministering client medications according to the prescriptions listed onPhysicians Orders and appropriate completion of buddy checks to preventerrors. Further incidents of medication errors will result in correctiveaction for staff. The QIDPand/or Program Coordinator and/or Nurse will complete at least 4 observationsweekly for 1	03/25/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1406 W TARKINGTON DR GREENSBURG, IN 47240	

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	the following medication error reports: Client #1: 9/1/15 7:00 PM staff failed to administer client #1's anxiety medication, clonazepam, 0.5 milligrams/mg. Client #3: 9/28/15 7:00 AM staff failed to administer client #3's Aspirin and Calcium with Vitamin D. 10/05/15 7:00 AM and 7:00 PM staff failed to administer client #3's Nystatin stoma medication. Interview with administrative staff on 3/9/16 at 12:00 PM indicated all medications should be administered without error. 9-3-6(a)		month and then 1x a week for 3 months and then monthly on anon-going basis to ensure that all medications are administered properly.	
W 0388 Bldg. 00	483.460(m)(1)(i) DRUG LABELING Labeling for drugs and biologicals must be based on currently accepted professional principles and practices. Based on observation, record review, and interview, the facility failed for 1 of 4 clients observed during morning medication administration (client #3), to have the medication labeled.	W 0388	Nurse will retrain allstaff in the home on checking in medication received from the pharmacy toensure it is labeled correctly and meets the current accepted professionalprinciples and practices for labeling drugs and biologicals.	03/25/2016

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	Findings include: An observation of the morning medication administration was conducted at the group home on 3/08/16 from 6:33 A.M. until 7:35 A.M. Client #3's medications were administered via gastric tube/g-tube by the House Manager/Program Coordinator (HM) #1 at 6:33 A.M. A bottle was taken from client #3's medication bin. The medication was applied to the stoma of the client's g-tube. The bottle was labeled as "Stomahesive." The bottle did not contain client #3's name or instructions for administration. The bottle did not contain a pharmacy label. A review of the Medication Administration Record/MAR dated March 2016 was conducted at 7:04 A.M. on 3/08/16. The MAR indicated client #3 received Nystatin powder (anti-fungal) to her stoma area twice daily. Interview with the QIDP/Qualified Intellectual Disabilities Professional was conducted on 3/08/16 at 11:45 A.M. The QIDP indicated all medications should be labeled with each client's name and instructions for administration. 9-3-6(a)		TheQIDP and/or Program Coordinator and/or Nurse will complete at least 4observations weekly for 1 month and then 1x a week for 3 months and then monthlyon an on-going basis to ensure that all medications are labeled correctly perthe current accepted professional principles and practices for labeling drugsand biologicals.	

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