

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G625	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/20/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3705 E 116TH ST CARMEL, IN 46032		
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: June 10, 11, 12, 13, 14, 18, 19 and 20, 2013.</p> <p>Facility number: 001174 Provider number: 15G625 AIM number: 100235590</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed June 21, 2013 by Dotty Walton, QIDP.</p>	W000000			

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

TITLE

(X6) DATE

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

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W000104	<p><b>483.410(a)(1) GOVERNING BODY</b> The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based upon observation and interview, for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, #8), the governing body failed to provide oversight and operating direction over the facility to ensure the home was maintained in good condition.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 6/11/13 from 6:16 AM until 7:25 AM. In the living room located at the rear of the home used by clients #1, #2, #3, #4, #5, #6, #7, and #8, there was an unpainted patched area on the wall measuring 14 inches by 2 inches.</p> <p>Staff #8 was interviewed on 6/11/13 at 7:01 AM and indicated the hole was caused by client #3 who had banged his head against the wall. Staff #8 indicated that client #8 wore a helmet because of his head banging behavior. He stated the incident happened "last year."</p> <p>The AD (Area Director) and Program Director (PD) were interviewed on 6/14/13 at 1:06 PM. The AD indicated it was the house managers' responsibility to report maintenance issues and the PD's</p>	W000104	<p>The Program Director will submit a request to have the unpainted patch on the living room wall painted obtaining a date for the completion of the painting. The Home Manager will provide the Program Director with a daily report on the progress of painting starting on the estimated date of completion. If the wall has not been painted within 3 days of the estimated date of completion the Program Director will inform the Area Director. The Area Director will ensure other arrangements are made to have the wall painted by 7-29-13. In the future the Home Manager will electronically inform the Program Director of maintenance needs in the home. The Program Director will ensure a maintenance request is submitted properly. The Home Manager will be responsible for keeping the PD informed of the progress on maintenance requests on a weekly basis. The PD will contact the Maintenance staff supervisor if the request has not been completed within 2 weeks of the request. Staff Responsible: Home Manager, program Director, Maintenance Staff, Office Manager</p>	07/20/2013			

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	responsibility to follow up with needed maintenance issues.  9-3-1(a)				

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W000221	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include auditory functioning. Based on interview and record review for 1 of 4 sampled clients (client #3), the facility failed to ensure an assessment of his hearing was conducted.</p> <p>Findings include:</p> <p>Client #3's records were reviewed on 6/13/13 at 11:53 AM. The record indicated client #3 had been admitted on 10/18/12. Client #3's physical examination dated 10/19/12 indicated client #3 required an annual hearing evaluation. There was no evidence in the record of a hearing evaluation since his admission.</p> <p>The Area Director (AD) indicated on 6/20/13 at 12:52 PM there was no evidence of a hearing evaluation for client #3.</p> <p>9-3-4(a)</p>	W000221	<p>An Auditory Assessment will be scheduled for the earliest available opportunity for client #3.</p> <p>The Program Director will be responsible for informing client #3's IDT of any recommendations resulting from the assessment.</p> <p>The Program Director will be retrained on the Annual Assessment Checklist which includes an annual assessment of hearing.</p> <p>The Area Director will review the next 3 ISPs completed by this QIDP to ensure auditory functioning is part of the comprehensive functional assessment annually.</p> <p>Responsible Staff: Program Director, Area Director</p>	07/20/2013	

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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (client #3), the client's ISP (Individualized Support Plan) failed to address when he was to wear a helmet.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 6/11/13 from 6:16 AM until 7:25 AM. In the living room located at the rear of the home used by clients #1, #2, #3, #4, #5, #6, #7, and #8, there was an unpainted patched area on the wall 14 inches by 2 inches. Client #3 wore a helmet during the observation.</p> <p>Staff #8 was interviewed on 6/11/13 at 7:01 AM and indicated the hole was caused by client #3 who had banged his head against the wall. Staff #8 indicated that client #8 wore a helmet because of his head banging behavior.</p> <p>During observations at the day services on 6/11/13 from 1:35 PM to 1:55 PM, upon arrival, client #3 was seated at a table, and did not have his helmet on. Client #3's helmet was placed on a windowsill above the chair client #3 was sitting in. At 1:50</p>	W000240	<p>The QIDP will be retrained on the completion of ISPs to include interventions for client #3 in regards to the use of his helmet.</p> <p>The Home Manager will be responsible for training the staff on the prescribed interventions including Day Service staff.</p> <p>The Program Director will be retrained on the requirement to include interventions in the ISP to support the client to independence.</p> <p>The Area Director will review the next 3 ISPs completed by this QIDP to ensure auditory functioning is part of the comprehensive functional assessment annually.</p> <p>Responsible Staff: Program Director, Area Director</p>	07/20/2013	

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	<p>PM, client #3 had his helmet on and retrieved connective plastic pieces at an adjacent table.</p> <p>The workshop supervisor was interviewed on 6/11/13 at 1:40 PM. She indicated the workshop staff had been informed client #3 could take his helmet on and off as client #3 desired.</p> <p>The Area Director (AD) and Program Director (PD) were interviewed on 6/11/13 at 1:06 PM. The AD indicated they would get clarification as to when client #3 was to wear his helmet.</p> <p>Client #3's record was reviewed on 6/13/13 at 11:53 AM. Client #3's seizure protocol dated 10/11/12 indicated he was to wear a helmet, but did not specify instructions for when to wear the helmet. Client #3's 11/18/12 ISP did not include instructions as to when staff was to wear his helmet. Client #3's 11/20/12 Behavioral Support Plan included self injurious behavior defined as "will hit his head using his hands and other objects." The plan did not indicate the use of the helmet to address client #3's self injurious behavior.</p> <p>A physician's order provided on 6/18/13 was reviewed on 6/19/13 at 5:00 PM and indicated client #3 was to "wear helmet</p>						

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	<p>when up and walking." There was no further evidence provided to indicate the physician's instructions were included in client #3's ISP.</p> <p>The AD indicated on 6/20/13 at 12:52 PM the instructions as to when client #3 was to wear his helmet were not in his ISP or in the seizure protocol.</p> <p>9-3-4(a)</p>			

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W000262	<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. Based on record review and interview, for 1 of 4 sampled clients (client #4), the facility failed to ensure the facility's Human Rights Committee (HRC) reviewed and approved the use of medication to treat symptoms of depression.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 6/13/13 at 4:05 PM. Client #4's physician's orders dated 6/1/13-6/30/13 indicated client #4 was prescribed Paroxetine HCL 40 mg (milligrams) daily for autistic behaviors (not defined) and propranolol 20 mg for autistic behaviors (not defined). Client #4's record did not include a plan to address his behaviors or the use of the medication to address his behaviors. The record did not include evidence of the facility's HRC review and approval of the medication to treat client #4's behaviors.</p> <p>The Area Director (AD) and Program Director (PD) were interviewed on</p>	W000262	<p>The QIDP will convene the IDT for client #4. The IDT will assess the behaviors for which client #4 is prescribed medication and develop an appropriate behavior plan.</p> <p>The QIDP will obtain required approvals as soon as the plan is available. The QIDP will also ensure the staff is trained on the implementation of the plan</p> <p>The QIDP will review each client's files to ensure each client that receives medication to manage behavior has an appropriate plan.</p> <p>Responsible Staff: Program Director, Area Director</p>	07/20/2013			

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	<p>6/14/13 at 1:06 PM. The PD indicated client #4's behavior clinician was working on behavior plans in the home. The PD indicated she would look for a behavior plan for client #4 and the facility's evidence of the HRC's review and approval for the plan.</p> <p>The AD indicated on 6/20/13 at 12:52 PM client #4 should have had a plan developed to address client #4's behaviors for which he was prescribed medication, but he did not have a plan.</p> <p>The AD was interviewed on 6/20/13 at 3:20 PM and indicated the facility's HRC had not reviewed or approved the use of client #4's psychotropic medication.</p> <p>9-3-4(a)</p>				

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W000289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on interview and record review for 1 of 4 sampled clients (client #3), the facility failed to ensure specific intervention strategies were written in the behavioral intervention plan.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 6/13/13 at 11:53 AM. The record included a 10/18/12 interim Behavior Support Plan/BSP to address anger control, property destruction, and self injurious behavior.</p> <p>The Area Director (AD) and Program Director (PD) were interviewed on 6/14/13 at 1:06 PM. When asked if client #3 had an updated plan, the PD indicated she would check with the behavior clinician.</p> <p>An updated Behavior Support Plan dated 11/10/12 provided by the AD on 6/18/13 at 4:23 PM via e-mail was reviewed on 6/20/13 at 8:00 AM. The plan included the use of a behavior intervention system</p>	W000289	<p>The QIDP will convene the IDT for client #3 to develop specific interventions to manage his inappropriate behavior.</p> <p>The Behavior Consultant will be retrained on the requirement to include systemic interventions to manage inappropriate client behavior.</p> <p>The Behavior Consultant will revise client #3's plan to include specific interventions to manage his inappropriate behavior.</p> <p>The QIDP will obtain required approvals as soon as the plan is available. The QIDP will also ensure the staff is trained on the implementation of the plan</p> <p>The QIDP will review each client's files to ensure each client that receives medication to manage behavior has an appropriate plan.</p> <p>Responsible Staff: Program Director, Behavior Consultant, Area Director</p>	07/20/2013			

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	<p>using physical techniques to address his behavior. The BSP dated 11/10/12 did not indicate which behavior intervention system techniques were to be used or a hierarchy of techniques to be used.</p> <p>The Area Director (AD) indicated on 6/20/13 at 12:52 PM, the physical interventions were not specific in client #3's plan.</p> <p>9-3-5(a)</p>			

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W000312	<p><b>483.450(e)(2) DRUG USAGE</b></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.</p> <p>Based on record review and interview, for 1 of 4 sampled clients (client #4) who used medications to address behavior, the facility failed to develop a plan to reduce the need for medication to address his autistic behaviors.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 6/13/13 at 4:05 PM. Client #4's physician's orders dated 6/1/13-6/30/13 indicated client #4 was prescribed Paroxetine HCL 40 mg (milligrams) daily for autistic behaviors (not defined) and propranolol 20 mg for autistic behaviors (not defined). Client #4's record did not include a plan to address his behaviors for which the medications were used.</p> <p>The Area Director (AD) and Program Director (PD) were interviewed on 6/14/13 at 1:06 PM. The PD indicated client #4's behavior clinician was working on behavior plans in the home, and she would check to see if a plan was completed for client #4.</p> <p>The AD was interviewed on 6/20/13 at 3:20 PM and indicated there had not been a plan completed for client #4 to address medication withdrawal criteria based on his behaviors.</p> <p>9-3-5(a)</p>	W000312	<p>The QIDP will convene the IDT for client #4. The IDT will assess the behaviors for which client #4 is prescribed medication and develop an appropriate titration plan.</p> <p>The Behavior Consultant will be retrained on the requirement to include an appropriate plan to address medication withdrawal based on behaviors.</p> <p>The Behavior Consultant will revise the Behavior Plan to include the titration plan developed by the IDT.</p> <p>The QIDP will obtain required approvals as soon as the plan is available. The QIDP will also ensure the staff is trained on the implementation of the plan</p> <p>The QIDP will review each client's files to ensure each client that receives medication to manage behavior has an appropriate titration plan.</p> <p>Responsible Staff: Program Director, Area Director, Behavior Consultant</p>	07/20/2013	

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>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, the facility failed for 2 of 4 sampled clients (clients #1 and #3), and 1 additional client (client #6), to administer medications per physician's orders.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 6/10/13 at 3:10 PM and included the following medication errors:</p> <p>1. A report dated 3/30/13 indicated group home staff accidentally gave another client's morning medications to client #1. The medications were calcium (supplement) 600 mg (milligrams), clonazepam 1 mg (anxiety), lamotrigine 100 mg (seizures), oxcarbazepine 100 mg (seizures), propranolol (hypertension), quetiapine (schizophrenia/manic depression), Vimpat 200 mg (seizures) and vitamin D 3 20 mg (supplement). The report indicated staff were re-trained on checking medication administration for accuracy and client #1 was monitored for medication side effects.</p>	W000368	<p>Indiana MENTOR recently switched Pharmacy providers in order to address ongoing issues of medications not being delivered timely creating medication errors beyond MENTORs control</p> <p>The Home Manager will continue to ensure medications are inventoried upon arrival and requests for any medications not delivered are made immediately.</p> <p>The Home Manager will be responsible for ensuring the medication is ordered and delivered. The QIDP will determine how frequently the HM will contact the pharmacy.</p> <p>The staff working in this home will be retrained on medication administration policy and procedures.</p> <p>The Home Manager and/or the QIDP will complete a weekly medication administration observation to ensure the staff administer medications as prescribed. The HM and/or PD will be responsible for ensuring any necessary follow-up is completed for any errors made in the administration of medications.</p>	07/20/2013			

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	<p>2. A report dated 5/2/13 indicated client #3 did not receive his 9 PM clonazepam 1 mg, and on 5/3/13 his 7:00 AM clonazepam 1 mg as the pharmacy had not delivered the medication. The report indicated the house manager and the nurse were working with the pharmacy to ensure the medication was available and a new pharmacy would begin delivering medications to the group home on 6/1/13.</p> <p>3. A report dated 6/2/13 indicated client #6 did not receive his 7:00 AM dose of olanzapine 1 mg (mood disorder) as a result of late delivery from the pharmacy. The plan to resolve indicated the nurse was notified and client #3 would be monitored for health and safety.</p> <p>The Area Director (AD) and Program Director (PD) were interviewed on 6/14/13 at 1:06 PM. The AD indicated the facility had recently switched the pharmacy who delivered medications and stated, "We're still getting the bugs worked out."</p> <p>9-3-6(a)</p>		Responsible Staff: Program Director, Area Director				

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W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on interview and record review for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7 and #8) living in the group home, the facility failed to ensure evacuation drills were conducted every ninety (90) days for each shift of personnel.</p> <p>Findings include: The facility evacuation drills for clients #1, #2, #3, #4, #5, #6, #7 and #8 were reviewed on 6/13/13 at 4:55 PM and indicated there were no evacuation drills documented for the first shift from July, Aug, Sept, 2012 from 6:00 AM to 2:00 PM and no evacuation drills documented for July, Aug, Sept., or Oct., 2012 on the evening shift from 2:00 PM to 10:00 PM. The Area Director (AD) and the Program Director (PD) were interviewed on 6/14/13 at 1:06 PM and indicated they would try to locate the missing drills. The AD indicated on 6/18/13 at 12:52 PM there were no additional evacuation drills to review for those time frames.</p> <p>9-3-7(a)</p>	W000440	<p>The Home Manager will be retrained on the policy and procedures for the completion of evacuation drills.</p> <p>The Home Manager will be responsible for submitting a copy of the fire drill to the Program Director and Quality Assurance Specialist before the last day of each month.</p> <p>The QAS will review the report and request any necessary follow-up. The Program Director will be responsible for ensuring the needed follow-up is completed.</p> <p>Responsible Staff: Program Director, Home Manager</p>	07/20/2013			

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W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>460 IAC 9-3-3 Facility Staffing (e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This state rule is not met as evidenced by:</p> <p>Based on interview and record review for 1 of 2 staff personnel records reviewed, (staff #1), the facility failed to ensure staff #1 received an annual Mantoux test/screening.</p>	W009999	<p>Home Manager and Program Director will review Mantoux records for all staff. Home Manager and Program Director will notify any staff if their Mantoux is outdated and provided them with the list of next clinic dates and deadline for completion.</p> <p>Home Manager and Program Director will monitor expiration dates for Mantoux for all staff no less than monthly and notify staff as needed of completion.</p> <p>Responsible Party: Home Manager, Program Director</p>	07/20/2013			

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	<p>Findings include:</p> <p>The facility's personnel records were reviewed on 6/13/13 at 4:10 PM. Review of staff personnel files indicated the most recent Mantoux test for staff #1 was dated 6/13/12. There was no evidence of chest x-rays being conducted.</p> <p>The Area Director (AD) was interviewed on 6/14/13 at 1:06 PM. She indicated staff #1's Mantoux test was out of date and the facility was making arrangements to have him complete the test.</p> <p>9-3-3(e)</p>				