

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G399	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/04/2011
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4313 E 46TH ST INDIANAPOLIS, IN46226
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W0000	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00098286.</p> <p>Complaint #00098286: Substantiated, federal/state deficiencies related to the allegation(s) are cited at W149 and W157.</p> <p>Survey Dates: October 31, November 1, 2, 3, 4, 2011</p> <p>Provider Number: 15G399 Aims Number: 100249300 Facility Number: 000913</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/21/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0124	<p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>Based on observation, record review and</p>	W0124	The Program Director will be retrained on conducting a meeting	12/08/2011

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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	<p>interview, the facility failed for 1 of 4 sampled clients (B) to ensure client B's guardian was informed of locked linens and cleaning supplies at the group home.</p> <p>Findings include:</p> <p>An observation was done on 10/31/11 at the group home from 4:45p.m. to 7:10p.m. At 5:34p.m., direct care staff #6 used a key to unlock a hallway closet that contained linens and cleaning supplies. Staff #6 indicated the items were locked due to client A, C and D's behaviors. Staff #6 indicated only staff had a key to the locked items.</p> <p>The record for client B was reviewed on 11/3/11 at 2:34p.m. Client B's 2/3/11 individual support plan (ISP) indicated client B had a guardian. Client B's record did not have any documentation that client B's guardian had been informed of the facility's practice to lock up the group home linens and cleaning supplies.</p> <p>Staff #1 (QMRPD-Qualified Mental Retardation Professional Designee) was interviewed on 11/3/11 at 3:17p.m. Staff #1 indicated there was no documentation client B's guardian had been informed of the facility's practice to lock the linens and cleaning supplies.</p> <p>9-3-2(a)</p>		<p>with the team before putting restrictions into place for the clients. This includes, but is not limited to, ensuring the guardians have given approval, as well as the Human Rights Committee's review and approval.</p> <p>The Program Director will be retrained on ensuring that all restrictions are included in the Individualized Support Plan for each consumer as needed.</p> <p>Ongoing, the Program Director will conduct meetings at least annually, with the entire team, to review all restrictions that are in place, to ensure that they are still adequate and needed.</p> <p>Ongoing, the Area Director and/or Quality Assurance Specialist, will review all ISP's to ensure that all restrictions were listed and reviewed on a yearly basis.</p> <p>Completion Date: December 8, 2011 Responsible Party: Program Director and Area Director.</p>		

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W0149	<p>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 1 investigation reviewed (client E), the facility failed to implement facility policy and procedures in regards to securing client funds entrusted to the facility and ensuring corrective action was completed.</p> <p>Findings include:</p> <p>Review of the facility's incidents/investigations was done on 11/1/11 at 10:50a.m. The following investigation did not have appropriate corrective action identified: On 10/10/11 staff #1 reported to the facility an allegation of mistreatment of client funds entrusted to the facility for client E. The incident report indicated client E's checkbook entrusted to the facility had not been properly secured by staff who had taken it to the bank and then had left the check book on the facility van. The report indicated a check had been taken from the check book (not by the client) and cashed at a check cashing business. The facility's investigation summary did not indicate the facility staff were in need of retraining on the proper security and storage of client check books entrusted to the facility.</p> <p>The facility policy and procedures were reviewed on 11/3/11 at 12:14p.m. The facility's 4/11 policy and procedure entitled "Management of an Individual's Funds"" indicated "it is the Company's responsibility to ensure that all funds received on</p>	W0149	<p>The Program Director will retrain the Home Manager on ensuring the client finances remain locked up while not in the community. The Home Manager and/or Program Director will retrain the Direct Care Staff on ensuring all client finances remain locked up while not in the community. The Direct Care staff will also be retrained to inform/report to the Home Manager and/or Program Director if the finances are not locked up so that this can be rectified.</p> <p>The Home Manager will be retrained that when out in the community, the finances should be secured in a briefcase or bag, and will remain in the home manager's possession at all times in order to keep them secure.</p> <p>Ongoing, the Program Director and/or Home Manager will complete weekly checks on the finances to ensure that they remain accurate and are being kept secure.</p> <p>Completion Date: December 8, 2011 Responsible Party: Home Manager and Program Director.</p>	12/08/2011

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W0157	<p>behalf of an individual are properly managed and accounted for. " The policy indicated "all cash being held for individuals will be kept in a secure lock box."</p> <p>Staff #4 (area director) was interviewed on 11/1/11 at 12:24p.m. Staff #4 indicated the facility had not identified the need to retrain staff on the proper security protocol for securing client check books entrusted to the facility. Staff #4 indicated there was no documentation of staff retraining (since the 10/10/11 investigation) on securing client funds. Staff #4 indicated when possible clients should be involved with their personal banking. Staff #4 indicated client check books should be kept secured in a locked box in the group home.</p> <p>This federal tag relates to complaint #IN00098286. 9-3-2(a)</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed for 1 of 1 investigation of alleged mistreatment of client funds entrusted to the facility reviewed (client E), to ensure appropriate corrective action was identified.</p> <p>Findings include:</p> <p>Review of the facility's incidents/investigations was done on</p>	W0157	<p>The Home Manager will be retrained on properly securing the client's finances at all times, both in the home, and when out in the community.</p> <p>The Home Manager will ensure that all client finances are kept in a locked filing cabinet at all times when in the home, and will be kept in a locked bag and will not leave the Home Manager when out in the community.</p> <p>Ongoing, the Area Director will</p>	12/08/2011	

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	<p>11/1/11 at 10:50a.m. The following investigation did not have appropriate corrective action identified for the following incident: On 10/10/11 staff #1 reported to the facility an allegation of mistreatment of client funds entrusted to the facility for client E. The incident report indicated client E's checkbook entrusted to the facility had not been properly secured by staff after staff had taken the check book to the bank. The report indicated staff had left client E's check book on the facility van. The report indicated a check had been taken from the check book (not by the client) and cashed at a check cashing business. The facility's investigation summary did not indicate the facility staff were in need of retraining on the proper security and storage of client check books entrusted to the facility.</p> <p>Staff #4 (area director) was interviewed on 11/1/11 at 12:24p.m. Staff #4 indicated the facility had not identified the need to retrain staff on the proper security protocol for securing client check books entrusted to the facility. Staff #4 indicated there was no documentation of staff retraining (since the 10/10/11 investigation) on securing client funds. This federal tag relates to complaint #IN00098286. 9-3-2(a)</p>		<p>complete quarterly visits to the group home to ensure that all finances remain locked up at all times.</p> <p>Completion Date: December 8, 2011 Responsible Party: Home Manager and Area Director.</p>		

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W0217	<p>The comprehensive functional assessment must include nutritional status.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (D) to ensure client D's nutritional status was identified for skills with drinking.</p> <p>Findings include:</p> <p>An observation was done on 11/1/11 from 6:26a.m. to 7:51a.m. At 7:15a.m., client D drank a full glass of juice and a full glass of his supplement in one long drink. Client D used a straw.</p> <p>Record review for client D was done on 11/3/11 at 1:40p.m. Client D had a Dietary Review on 4/26/11 that indicated client D was to use a straw with liquids and to have his liquids presented in small amounts. Client D had physician's orders on 9/23/11 that indicated client D was to use a straw with liquids, presented in small amounts. Client D's current 9/21/11 "Dining Plan" indicated client D was to use no straws.</p> <p>Staff #2 (nurse) and staff #1 and #3 were interviewed on 11/3/11 at 3:17p.m. Staff #2 indicated the 9/21/11 Dining plan was</p>	W0217	<p>The Program Nurse will be retrained on writing all dining plans according to the physician's orders and to ensure that they remain accurate with the dietary reviews that are completed.</p> <p>The Program Nurse will ensure that another swallow study is scheduled and completed for client D to discuss if the use of a straw is needed or not. The Program Nurse will review and ensure that the Dining Plan is written according to the recommendations from the swallow study and the doctor's review of the swallow study.</p> <p>The Program Director will retrain the Direct Care Staff on the updated dining plan to ensure that it is appropriately being followed.</p> <p>The Program Director will complete 2 weekly meal time observations for 4 weeks, and then 1 per week afterwards to ensure that all dining plans are being followed as written. Completion Date: December 8, 2011 Responsible Party: Home Manager and Program Director.</p>	12/08/2011

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W0227	<p>what was being implemented (no straw use). Staff #1 and staff #3 indicated client D had been receiving his liquids with a straw per the current physician's order. There was no documentation client D had been assessed to indicate whether he needed a straw with liquids. 9-3-4(a)</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview, the facility failed for 3 of 4 sampled clients (A, C, D) to ensure the clients' individual support programs (ISP) had training programs in place to address client A and D's communication needs and client C's identified resistiveness to audiological procedures.</p> <p>Findings include:</p> <p>An observation was done at the group home on 10/31/11 from 4:45p.m. to 7:10p.m. Clients A and D were non verbal and were observed to not use any communication boards or sign language.</p> <p>Record review of client A was done on 11/3/11 at 12:18p.m. Client A's 5/20/11 ISP indicated client A was non-verbal.</p>	W0227	<p>The Area Director will retrain the Program Director on ensuring that trainings recommended by the Team, a medical professional, etc, are followed up on and put into place if made.</p> <p>The Program Director will put communication trainings in place for Client A.</p> <p>The Program Director will put communication trainings in place for Client D.</p> <p>The Program Director will put a training place to desensitize Client C to the headphones so that a future audiological exam may be completed.</p> <p>Area Director will review all medical appointments, including all PT and OT evaluations one time per month for 3 months and then quarterly thereafter. After the review, the Area Director will follow up to be</p>	12/08/2011

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	<p>Client A had a 12/1/08 speech evaluation with recommendations to use a picture board on a daily basis and use signs. Client A did not have a communication training program.</p> <p>Record review of client D was done on 11/3/11 at 1:40p.m. Client D's 10/9/11 ISP indicated client D was non-verbal. Client D had a 9/22/10 speech evaluation with recommendations to use a communication board. Client D did not have a communication training program.</p> <p>Record review of client C was done on 11/3/11 at 10:58a.m. Client C's 6/17/11 audiological exam indicated client C "would not let examine ears." The audiological exam had recommendations to get client C comfortable with wearing headphones, try to teach to clap and learn to point to different body parts. Client C's 2/3/11 ISP did not have any training programs in place to address her lack of cooperation with audiological exams.</p> <p>Staff #1 was interviewed on 11/3/11 at 3:17p.m. Staff #1 indicated client C was resistive to audiological exams. Staff #1 indicated there was no documentation the 6/17/11 audio exam recommendations had been addressed. Staff #1 indicated client C did not have a training program in place to address her resistiveness to</p>		<p>sure that all recommendations are addressed appropriately and all doctor's orders followed correctly. Completion Date: December 18, 2011 Responsible Party: Home Manager and Program Director and Area Director</p>		

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W0249	<p>audiological exams. Staff #1 indicated clients A and D were non-verbal and did not have communication training programs in place. 9-3-4(a)</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 4 sampled clients (D) to ensure the client's dining training program was implemented when opportunities were present.</p> <p>Findings include:</p> <p>An observation was done on 11/1/11 from 6:26a.m. to 7:51a.m. At 7:15a.m., client D drank a full glass of juice and a full glass of his supplement in one long drink. Client D used a straw.</p> <p>Record review for client D was done on 11/3/11 at 1:40p.m. Client D had a Dietary Review on 4/26/11 that indicated client D was to use a straw with liquids and to have his liquids presented in small amounts. Client D had physician's orders on 9/23/11 that indicated client D was to use a straw with liquids, presented in small amounts to slow down his drinking.</p>	W0249	<p>The Program Nurse will be retrained on writing all dining plans according to the physician's orders and to ensure that they remain accurate with the dietary reviews that are completed.</p> <p>The Program Nurse will ensure that another swallow study is scheduled and completed for client D to discuss if the use of a straw is needed or not. The Program Nurse will review and ensure that the Dining Plan is written according to the recommendations from the swallow study and the doctor's review of the swallow study.</p> <p>The Program Director will retrain the Direct Care Staff on the updated dining plan to ensure that it is appropriately being followed.</p> <p>The Program Director will complete 2 weekly meal time observations for 4 weeks, and then 1 per week afterwards to ensure that all dining</p>	12/08/2011	

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W0288	<p>Staff #3 was interviewed on 11/3/11 at 3:17p.m. Staff #3 indicated client D's dining training program included pouring client D small amounts of liquid into his cup to decrease his drinking speed. 9-3-4(a)</p> <p>Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. Based on record review and interview, the facility failed for 1 of 3 sample clients (D) with behavior management interventions to ensure client D's identified misuse of liquids and eating toothpaste, both kept locked due to his behavior, were part of client D's training program.</p> <p>Findings include:</p> <p>The record of client D was reviewed on 11/3/11 at 1:40p.m. Client D's 10/9/11 individual support plan (ISP) indicated client D would improperly use liquids and would eat toothpaste. The ISP indicated these items were kept locked due to client D's behavior. Client D did not have a documented training program to address the proper use of liquids and toothpaste.</p> <p>Interview on 11/3/11 of staff #1 at 3:17p.m. indicated client D misused liquids and toothpaste and these items</p>	W0288	<p>plans are being followed as written. Completion Date: December 8, 2011 Responsible Party: Home Manager and Program Director.</p> <p>The Area Director will retrain the Program Director on ensuring that trainings recommended by the Team, a medical professional, etc, are followed up on and put into place if needed. The Program Director will put trainings in place for Client D to address improper usage of liquids and toothpaste. Area Director will review all medical appointments, including all PT and OT evaluations one time per month for 3 months and then quarterly thereafter. After the review, the Area Director will follow up to be sure that all recommendations are addressed appropriately and all doctor's orders followed correctly. Completion Date: December 8, 2011 Responsible Party: Program Director.</p>	12/08/2011	

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W0440	<p>were kept locked due to his behavior. Staff #1 indicated only staff had a key to the locked items. Staff #1 indicated client D did not have documented training programs to address his misuse of liquids and toothpaste. 9-3-5(a)</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 8 of 8 clients (A, B, C, D, E, F, G, H) to ensure evacuation drills were completed quarterly, for each of the facility's personnel shifts, from 10/1/10 through 11/1/11.</p> <p>Findings include:</p> <p>Record review of the facility's evacuation drills from 10/1/10 through 11/1/11 for clients A, B, C, D, E, F, G and H was completed on 11/1/11 at 12:48p.m. The documented day shift drills were dated 1/9/11 at 8:50a.m. and 10/4/11 at 7:12a.m.; night shift evacuation drills were documented on 3/8/11, 6/7/11 and 9/10/11.</p> <p>Interview of staff #1 on 11/3/11 at 3:20p.m. indicated the facility personnel shifts were: day shift 6a.m.-2p.m.;</p>	W0440	<p>All Direct Support Professionals will receive a retraining every other month to ensure that they understand the importance of completing the monthly fire drills. The retraining will include reviewing a copy of the Fire Drill Schedule. Ongoing, the Direct Support Professionals will complete one fire drill per month (or more as needed) according to the schedule to ensure that the health and safety of the client's needs are met. Ongoing, all completed fire drill reports will be turned in to and reviewed by Quality Assurance for accuracy and thoroughness of each drill. Completion Date: December 8, 2011 Responsible Party: Home Manager</p>	12/08/2011

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	evening shift 2p.m.-11p.m.; night shift 11p.m.-8a.m. Staff #1 indicated evacuation drills should have been completed per shift per quarter during the past year. 9-3-7(a)				