

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
W000000	<p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Dates of Survey: February 18, 19, 20, 21 and 24, 2014</p> <p>Facility number: 004445 Provider number: 15G722 AIM number: 200518250</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/27/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on record review and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to ensure the clients' Personal Property Inventories were completed or updated as needed.</p> <p>Findings include:</p>	W000137	<p>After internal audit of all clients records it was determined that all clients were affected by this deficient practice. HM in conjunction with PD will ensure that each client has an updated inventory sheet in place. HM will check weekly that inventories are in place and current and document on HM documentation</p>	03/26/2014

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: 15G722		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220			
(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>A review of client #1's record was conducted on 2/19/14 at 10:02 AM. There was no documentation in client #1's record indicating a Personal Property Inventory was completed.</p> <p>A review of client #2's record was conducted on 2/19/14 at 9:06 AM. Client #2's most recent Personal Property Inventory was completed on 5/15/11.</p> <p>A review of client #3's record was conducted on 2/19/14 at 8:47 AM. There was no documentation in client #3's record indicating a Personal Property Inventory was completed.</p> <p>A review of client #4's record was conducted on 2/19/14 at 9:36 AM. There was no documentation in client #4's record indicating a Personal Property Inventory was completed.</p> <p>On 2/19/14 at 10:13 AM, the Program Director (PD) indicated clients #1, #3 and #4 had Personal Property Inventories in the past. The PD indicated if the old inventories were not located, new inventories would be completed. The PD indicated the Personal Property Inventories should be completed upon admission and as items</p>		checklist.PD will check monthly that inventories are in place and current and document on supervisory visit form.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
W000140	<p>were purchased or removed.</p> <p>9-3-2(a)</p> <p>483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 2 of 4 clients living at the group home (#1 and #2), the facility failed to account for the clients' personal finances.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 2/18/14 at 3:48 PM and indicated the following:</p> <p>Client #1's Cash on Hand ledger, dated February 2014, indicated client #1 should have \$122.15. The Program Director (PD) counted client #1's actual cash on hand. The total of the cash on hand was \$121.15. There was no documentation on the February 2014 ledger accounting for the discrepancy (\$1.00) between the ledger and the actual cash on hand. A count of client #1's cash on hand, handwritten on a</p>	W000140	<p>Upon further review it was determined that no other client was affected by this deficient practice. Area Director will retrain PD and HM on client finances. HM will check petty cash weekly and balance to ledger to ensure accuracy. PD will check petty cash monthly and balance to ledger to ensure accuracy. AD will check petty cash 1x a month for 3 months to ensure that correct procedures are being completed. As an ongoing effort to monitor finances, Area Director will complete routine quarterly reviews of all finances to ensure that policy continues to be implemented.</p>	03/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220			
(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>piece of paper, in client #1's cash on hand storage container indicated there was \$121.15 on 1/13/14. On 1/13/14, a count conducted by the PD indicated no issues with client #1's money.</p> <p>Client #2's Cash on Hand ledger, dated February 2014, indicated client #2 should have \$254.25. The Program Director (PD) counted client #2's actual cash on hand. The total of the cash on hand was \$234.25. There was no documentation on the February 2014 ledger accounting for the discrepancy (\$20.00) between the ledger and the actual cash on hand. A count of client #2's cash on hand, handwritten on a piece of paper, in client #2's cash on hand storage container indicated there was \$234.25 on 1/12/14. On 1/13/14, a count conducted by the PD indicated no issues with client #2's money.</p> <p>On 2/18/14 at 3:53 PM, the PD and the Home Manager (HM) indicated they did not know where the missing money was for clients #1 and #2.</p> <p>On 2/18/14 at 4:10 PM, the PD indicated the facility should account for the clients' money to the penny. The PD indicated the PD and HM had access to the money which was stored in a locked safe.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220			
(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			
W000149	<p>9-3-2(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 16 incident/investigative reports reviewed affecting 4 of 4 clients (#1, #2, #3 and #4) living in the group home, the facility failed to implement its policies and procedures for reporting incidents to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/18/14 at 1:50 PM and indicated the following:</p> <p>On 6/4/13 at 6:30 AM, the Registered Nurse (RN) for the group home arrived to the group home and observed a direct care staff that had her dog with her for an entire shift and failed to follow the visitor policy for the group home. The investigation indicated, "[RN] reported that the dog immediately started barking</p>	W000149	Area Director will retrain PD on the BDDS reportable incidents including abuse, neglect and exploitation. PD will retrain Home manager and staff on Indiana Mentors policy for reporting BDDS reportable incidents. Home Manager will review daily support records daily to ensure that any incident that meets the BDDS definition of a reportable incident was reported to the Program Director. Program Director will review daily support records weekly to ensure that any incident meeting the definition of a BDDS reportable incident had been reported and a BDDS report filed. Area Director will review daily support records monthly to ensure that all incidents that meet the BDDS definition of a reportable incident has been reported to BDDS.	03/26/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220			
(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>and growling at her. [Name of former staff] picked the dog up and started calling someone to come and get the dog. [RN] reported that for approx. (approximately) 45 minutes [name of former staff] walked around holding the dog and was unable to do much of the morning routine with getting the clients ready for day services. [RN] reports that around 7:15 AM a male arrived at the home and took the dog outside and put the dog in the truck, then the male re-entered the home and got a cup of coffee and sat on the couch watching TV. [Name of former staff] went about her morning routine with the clients. [RN] then reported that at approximately 7:45 AM [former staff] and the male visitor left. [Former staff] was scheduled for her shift until 8:00 AM." The Conclusion of the investigation indicated, "Staff failed to follow visitor policy and had her dog was with her (sic) during her entire shift. Staff also falsified her time sheet documenting that she finished her shift at 8am." This affected clients #1, #2, #3 and #4. The facility failed to report the incident of neglect to BDDS.</p> <p>On 2/19/14 at 9:29 AM, the PD indicated the facility did not feel the incident was reportable to BDDS. The PD indicated an investigation was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220		
(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>conducted and determined the staff failed to follow policy. On 2/19/14 at 10:18 AM, the PD indicated there were no BDDS reports due to the incident being a staff performance issue.</p> <p>A review of the facility's abuse and neglect policy, dated April 2011, was conducted on 2/18/14 at 12:51 PM. The policy indicated the following, "Any allegation of abuse or human rights violation is thoroughly investigated by the Area Director in consultation with Human Resources Department and/or Quality Assurance/Risk Management Department." The policy indicated, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e. Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment... o. The following actions are prohibited by employees of Indiana MENTOR: 1) abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds. 2) violation of an individual's rights." The policy indicated, in part, "All incidents that require a report to the Bureau of Developmental Disabilities Services, or</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220		
(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	
W000153	<p>internal incident reports will be entered into a database maintained by The Mentor Network." The policy indicated, in part, "Indiana MENTOR follows the BDDS Incident Reporting policy as outlined in the Provider Standards." The policy indicated, in part, "An initial report regarding an incident shall be submitted within twenty-four (24) hours of: a) the occurrence of the incident; or b) the reporter becoming aware of or receiving information about an incident."</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 injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 16 incident/investigative reports</p>	W000153	Area Director will retrain PD on the BDDS reportable incidents	03/26/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220		
(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>reviewed affecting 4 of 4 clients (#1, #2, #3 and #4) living in the group home, the facility failed to report an incident to the Bureau of Developmental Disabilities Services (BDDS), in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/18/14 at 1:50 PM and indicated the following:</p> <p>On 6/4/13 at 6:30 AM, the Registered Nurse (RN) for the group home arrived to the group home and observed a direct care staff that had her dog with her for an entire shift and failed to follow the visitor policy for the group home. The investigation indicated, "[RN] reported that the dog immediately started barking and growling at her. [Name of former staff] picked the dog up and started calling someone to come and get the dog. [RN] reported that for approx. (approximately) 45 minutes [name of former staff] walked around holding the dog and was unable to do much of the morning routine with getting the clients ready for day services. [RN] reports that around 7:15 AM a male arrived at the home and took the dog outside and put the dog in the truck, then the male</p>		<p>including abuse, neglect and exploitation. PD will retrain Home manager and staff on Indiana Mentors policy for reporting BDDS reportable incidents. Home Manager will review daily support records daily to ensure that any incident that meets the BDDS definition of a reportable incident was reported to the Program Director. Program Director will review daily support records weekly to ensure that any incident meeting the definition of a BDDS reportable incident had been reported and a BDDS report filed. Area Director will review daily support records monthly to ensure that all incidents that meet the BDDS definition of a reportable incident has been reported to BDDS.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220		
(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>re-entered the home and got a cup of coffee and sat on the couch watching TV. [Name of former staff] went about her morning routine with the clients. [RN] then reported that at approximately 7:45 AM [former staff] and the male visitor left. [Former staff] was scheduled for her shift until 8:00 AM." The Conclusion of the investigation indicated, "Staff failed to follow visitor policy and had her dog was with her (sic) during her entire shift. Staff also falsified her time sheet documenting that she finished her shift at 8am." This affected clients #1, #2, #3 and #4. The facility failed to report the incident of neglect to BDDS.</p> <p>On 2/19/14 at 9:29 AM, the PD indicated the facility did not feel the incident was reportable to BDDS. The PD indicated an investigation was conducted and determined the staff failed to follow policy. On 2/19/14 at 10:18 AM, the PD indicated there were no BDDS reports due to the incident being a staff performance issue.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220		
(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	
W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview for 4 of 4 clients living at the group home (#1, #2, #3 and #4), the facility failed to provide sufficient direct care staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>Findings include:</p> <p>On 2/19/14 at 7:08 AM, direct care staff #1 indicated there was one staff working at the group home from 8:00 AM to 9:15 AM. Staff #1 indicated this was not sufficient staffing to meet the needs of the clients. Staff #1 indicated there was insufficient staff supervision of the clients when the clients were being loaded onto the van for transport to the day program. Staff #1 indicated there was one day recently when client #2 vomited after the other 3 clients were loaded onto the van. Staff #1 indicated she had to assist client #2 to clean up leaving clients #1, #3 and #4</p>	W000186	<p>PD in conjunction with HM will review schedule and adjust to have adequate staffing available for loading and unloading of clients prior to transportation to and from day program. Supervisory staff will conduct observations 3x a week for 4 weeks to ensure staffing is adequate and ongoing after that. Supervisory staff will complete monthly observations as an ongoing effort to ensure that staffing levels remain adequate.</p>	03/26/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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>unsupervised on the van. Staff #1 indicated client #3 could have a seizure and staff would not be aware since they did not observe it. Staff #1 indicated client #3 could be having more seizures than staff realize since there were times he was unsupervised either on the van or in the home.</p> <p>On 2/19/14 at 7:10 AM, direct care staff #2 indicated one direct care staff at the group home was not sufficient from 8:00 AM to 9:15 AM. Staff #2 indicated there had been times during transport in the van with one staff (driver) when client #3 had a seizure. Staff #2 indicated there was no staff to supervise the clients in the home when one staff was loading the van and then no staff to supervise the clients on the van when the one staff went into the home to get another client. Staff #2 indicated recently, she loaded clients #1, #3 and #4 into the van and when she returned to get client #2, client #2 was in her bed. Staff #2 indicated both transports (to and from day program) were completed by one staff.</p> <p>On 2/19/14 at 8:31 AM, staff #2 was working at the group home with clients #1, #2, #3 and #4 with no additional direct care staff. At 8:31 AM, staff #2 took client #4 to the group home van to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220			
(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>load. At 8:35 AM, staff #2 entered the group home to get client #3 to load. At 8:39 AM, staff #2 entered the home to get client #1 to load. At 8:44 AM, staff #2 entered the home to get client #2 to load into the van. When staff #2 was in the home, the clients on the group home van were unsupervised. When staff #2 was out of the home, the Program Director (PD) was present however there were no additional direct care staff at the home.</p> <p>A review of client #1's record was conducted on 2/19/14 at 10:02 AM. Client #1's Individual Support Plan (ISP), dated 4/8/13, indicated, in part, "[Client #1's] home provides the 24/7 (24 hours per day/7 days per week) care and supervision she currently requires to maintain health and provide assistance with ADL (activities of daily living) skills." The ISP indicated, "[Client #1] is non-ambulatory and non-weight bearing and uses a tilt-in-space wheelchair. She has spastic quadriplegia and cannot move or re-position herself. OT (Occupational Therapy) has developed a positioning schedule based on [client #1's] needs and preferences (being on her right side) and position changes occur every two hours. She receives passive range of motion exercises from staff daily. She</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220			
(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>requires total assistance for all transfers. As such, she is a two person lift or use of the Arjo lift."</p> <p>A review of client #2's record was conducted on 2/19/14 at 9:06 AM. Client #2's ISP, dated 6/11/13, indicated, in part, "Assessment of his/her supervision needs: [Client #2] is unaware of environmental dangers and requires 24/7 awake staff for supervision and supports. She is unable to meet ADL needs without total staff supports as well."</p> <p>A review of client #3's record was conducted on 2/19/14 at 8:47 AM. Client #3's ISP, dated 3/15/13, indicated, in part, "[Client #3's] home provides the 24/7 care and supervision he currently requires to maintain health and provide assistance with ADL skills. [Client #3] is diagnosed with tonic-clonic epilepsy. A VNS (vagus nerve stimulator) was implanted in [client #3] on 10/22/07 to aid in his seizure management. Activation of the device was on 11/30/07 and he has had minimal side effects of extra drooling and dry cough, except initially. He has a seizure protocol which includes swiping of his VNS as soon as possible and use of diastat if VNS appears ineffective to stop the seizure after longer than 4</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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>minutes or [client #3] has 3 seizures in an hour. Staff will call 911 if the seizure lasts 6 minutes or longer. [Client #3] is non-ambulatory and is no longer able to bear weight. In the past he would pivot transfer but this skill/ability has declined and he is consistently now a two person lift or staff use the Arjo lift. The stander positioner was discontinued in his positioning schedule in 2/10. He exhibits good head control and has intermittent trunk control while sitting. He is dependent on staff for wheelchair mobility and for repositioning every 2 hours although he can shift his weight slightly while in his wheelchair."</p> <p>A review of client #4's record was conducted on 2/19/14 at 9:36 AM. Client #4's ISP, dated 7/24/13, indicated, in part, "[Client #4's] home provides the 24/7 care and supervision he currently requires to maintain his health and provide assistance with ADL skills. [Client #4] is non-ambulatory and non-weight bearing and uses a tilt in space wheelchair. He has a congenital right knee defect and cannot move or re-position himself. OT has developed a positioning schedule based on [client #4's] needs and position changes occur every hour during AM waking hours and every two hours in the PM hours and while in his Airflow mattress bed at</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220		
(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>night. He receives passive range of motion exercises from staff daily. He requires total assistance for all transfers. As such, he is a 2 person lift or use of the Arjo lift."</p> <p>On 2/21/14 at 2:09 PM, the Area Director (AD) stated there was "more than adequate" supervision of the clients with one staff. The AD stated, "it's no different than when they are in their rooms." The AD indicated the clients did not require line of sight supervision. The AD indicated she would review the staff supervision levels with the PD.</p> <p>On 2/20/14 at 11:59 AM, the Registered Nurse (RN) indicated there were times during the day the clients were unsupervised while the staff were loading the van. The RN indicated with one staff at the home, there were times the clients were unsupervised. The RN indicated the clients needed and were supposed to receive 24 hours a day supervision.</p> <p>On 2/19/14 at 10:13 AM, the PD indicated one staff worked at the home starting at 8:00 AM until the clients were transported to the day program around 8:45 AM. The PD indicated unless one of the clients was ill, one staff was sufficient staffing for the group</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220			
(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>home. The PD indicated she thought it was okay to leave the clients unsupervised for periods up to five minutes. The PD stated, "I would love to have additional staff." On 2/20/14 at 3:10 PM, the PD indicated in an electronic mail message, "Yes, this is correct most times. The Home Manager at times does assist with transport but not on a daily basis." This was in response to the question, "When is there one staff at the home? I know there is one staff from 12:00 AM to 5:30 AM, 8:00 AM to drop off at the day program and I think there is one staff from 3:15 PM to 4:00 PM. Is this correct?"</p> <p>9-3-3(a)</p>						
W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 1 of 2 non-sampled clients (#3), the facility failed to ensure client #3's Skin Integrity Protocol included the steps the nurse would take after the direct care staff notified the nurse of issues related</p>	W000240	AD in conjunction with Nurse, QA and PD will review client #3 and all other clients skin integrity protocols to ensure they include the steps the nurse would take after the direct care staff notified the nurse of issues related to skin integrity.PD will retrain staff on	03/26/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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>to client #3's skin integrity.</p> <p>Findings include:</p> <p>A review of client #3's record was conducted 2/19/14 at 8:47 AM and indicated the following:</p> <p>Client #3's Individual Support Plan (ISP), dated 3/15/13, indicated, in part, "[Client #3] is at risk for skin breakdown. He had a 2" (inch) open area on his posterior buttocks in 6/10. Area treated and healed without MD (medical doctor) or wound care intervention. He had an 8mm (millimeter) open area on his right buttocks in 12/12 and Hydrocolloid patches were used per the [name of wound care center] RN consultation. This area was closed by 1/2/13. He is on a positioning schedule of every 2 hours. Staff are trained in positioning specific to [client #3]. He has a tilt-in-space wheelchair which is incorporated in his positioning schedule as well as a Hill-Rom chair and his bed. Stander positioner was discontinued per PT on 2/25/10 due to decreased weight bearing ability. A large mat is placed bedside when he is in bed. Impaired Skin Integrity Protocol is in place. Skin integrity is checked at bath time and personal care changes and issues are</p>		<p>new skin integrity protocols Program Director and Home Manager will notify AD anytime there is a non-life threatening event, including skin integrity issues. AD will follow up with Nurse to determine when she will complete her assessment of client. If Nurse is unable to assess within 24 hours then client will be seen by PCP. Nurse will send all assessments to AD within 24 hours of completion for review.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220		
(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>reported to the Nurse. He has a 'dimpled' area above his rectum that is monitored for redness and infection. Lotion is applied following his bath and PRN. Barrier cream is applied to his buttocks 2x (two times) daily. PT (physical therapy) and OT (occupational therapy) provide annual evaluations and services as needed."</p> <p>Client #3's Risk Management Assessment and Plan (RMAP), dated 3/15/13, indicated he was at risk for pressure sores/skin ulcers. The RMAP indicated, in part, "Impaired Skin Integrity Protocol in place. Skin to be kept clean and dry. Re-position in accordance with schedule. Incontinence care provided every two hours and as needed. Lotion or barrier cream applied at changes. Skin integrity will be monitored daily during bathing and at changes. Nurse to be contacted if there are any worsening red areas, changes or breaks in skin integrity."</p> <p>The Impaired Skin Integrity Protocol, dated 6/10/13, indicated, "[Client #3's] skin will easily open if positioning schedule and depend changes are not completed." The protocol did not include interventions to be taken by the nurse including assessments and monitoring.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220			
(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>The Indiana Mentor Nursing Progress Notes were reviewed on 2/20/14 at 12:40 PM. Client #3's Nursing Progress Notes did not include documentation client #3's pressure wounds were staged. The notes indicated the RN did not assess and monitor client #3's wounds on a regular basis. The nursing notes indicated the RN did not conduct her initial and follow-up assessments and monitoring in August 2013, November/December 2013 and February 2014 in a timely manner.</p> <p>On 2/20/14 at 11:59 AM, the Registered Nurse (RN) indicated there was no plan indicating the nurse's responsibilities for wound care. The RN indicated the protocols were directed at the direct care staff and did not include the actions the nurse would take. The RN stated, "it may not be a bad idea" to have a plan of action for the nurse.</p> <p>On 2/21/14 at 2:09 PM the Area Director (AD) indicated the Skin Integrity Protocol should indicate the steps the nurse was supposed to take including assessments and monitoring.</p> <p>9-3-4(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
--------------------	--	---------------	---	----------------------

W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION 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 for 3 of 4 clients living in the group home (#1, #2 and #4), the facility failed to ensure staff implemented 1) clients' (#1 and #4) medication training objectives and 2) client #2's communication training objective.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 2/19/14 from 6:00 AM to 7:50 AM.</p> <p>a) On 2/19/14 at 6:20 AM, staff #1 administered client #1's medications. Client #1 was not prompted to find her medications (staff were to hold the medications up by her face).</p> <p>A review of client #1's record was conducted on 2/19/14 at 10:02 AM. Client #1's Individual Support Plan (ISP), dated 4/8/13, indicated she had a medication training objective to give eye</p>	W000249	<p>Program Director will retrain staff on the goals and objectives including client #1 and #4 medication objectives and client #2 communication objective, for all clients to ensure they are being implemented correctly. Supervisory staff will complete observations 3x a week for 4 weeks to ensure objectives are being completed. Supervisory staff will complete monthly observations on an ongoing basis to ensure objectives are being completed.</p>	03/26/2014
---------	---	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220			
(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>contact when medication was presented.</p> <p>On 2/19/14 at 6:25 AM, staff #1 indicated client #1 had a medication training objective to hold her syringe. Staff #1 indicated she did not implement client #1's medication training objective. Staff #1 stated to client #1, "[Client #1], you got out of one this morning, girl." Staff #1 indicated client #1 held her syringe at 5:00 AM when she received cranberry juice.</p> <p>On 2/19/14 at 10:13 AM, the Program Director (PD) indicated the staff should implement the clients' medication training objectives at each medication administration time.</p> <p>b) On 2/19/14 at 6:32 AM, client #4 received his medications from staff #1. Client #4 was not prompted to shake a bottle of liquid medication, find his medications (hold medications up so he could see them), grasp the medication cup, and throw away his medication cup.</p> <p>A review of client #4's record was conducted on 2/19/14 at 9:36 AM. Client #4's ISP, dated 7/24/13, indicated he had a medication training objective to shake a bottle of a liquid medication, find his medications (hold medications up so he could see them), grasp the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220		
(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>medication cup, and throw away his medication cup.</p> <p>On 2/19/14 at 10:13 AM, the Program Director (PD) indicated the staff should implement the clients' medication training objectives at each medication administration time.</p> <p>2) Observations were conducted at the group home on 2/18/14 from 3:45 PM to 5:27 PM and 2/19/14 from 6:00 AM to 7:50 AM and 8:16 AM to 8:46 AM. During the observations, staff were not observed to get client #2's picture book when an activity changed, and staff did not show client #2 a picture of the upcoming activity or prompt her to touch the picture. During the observations, staff did not use client #2's communication book.</p> <p>A review of client #2's record was conducted on 2/19/14 at 9:06 AM. Client #2's ISP, dated 6/11/13, indicated she had a goal to increase her communication skills by pointing to the desired activity picture. The steps included staff getting client #2's picture book when any change in activity was made, staff would show the picture of the upcoming activity, and staff would prompt client #2 to touch the picture of the upcoming activity.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
--------------------	--	---------------	---	----------------------

W000318	<p>On 2/19/14 at 10:13 AM, the Program Director (PD) indicated the group home had a communication book with pictures for client #2 to use. The PD indicated the staff should have implemented client #2's program plan to increase her communication skills during the morning and evening observations at the group home.</p> <p>9-3-4(a)</p> <p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on record review and interview for 1 of 2 clients in the sample (#4) and 1 of 2 additional clients (#3), the facility failed to meet the Condition of Participation: Health Care Services. The facility's Health Care Services failed to provide timely assessments and monitoring of client #3's recurring issues with skin breakdown. The facility's Health Care Services failed to ensure client #3's Skin Integrity Protocol included the steps the nurse was to implement to assess and monitor client #3's skin integrity. The facility's Health Care Services failed to ensure client #4 had his hearing evaluated annually.</p>	W000318	AD in conjunction with Nurse, QA and PD will review client #3 and all other clients skin integrity protocols to ensure they include the steps the nurse would take after the direct care staff notified the nurse of issues related to skin integrity. PD will retrain staff on new skin integrity protocols. Program Director and Home Manager will notify AD anytime there is a non-life threatening event, including skin integrity issues. AD will follow up with Nurse to determine when she will complete her assessment of client. If Nurse is unable to assess within 24 hours then client will be seen by PCP. Nurse will send all assessments to AD	03/26/2014
---------	--	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
W000323	<p>Findings include:</p> <p>1) Please refer to W331. For 1 of 2 non-sampled clients (#3), the nurse failed to assess and monitor client #3's skin integrity in order to prevent additional incidents of skin breakdown.</p> <p>2) Please refer to W323. For 1 of 2 clients in the sample (#4), the facility failed to ensure client #4's hearing was evaluated annually.</p> <p>3) Please refer to W240. For 1 of 2 non-sampled clients (#3), the facility failed to ensure client #3's Skin Integrity Protocol included the steps the nurse would take after the direct care staff notified the nurse of issues related to client #3's skin integrity.</p> <p>9-3-6(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 2 clients in the sample (#4), the facility failed to ensure client #4's hearing was evaluated annually.</p> <p>Findings include:</p> <p>A review of client #4's record was conducted on 2/19/14 at 9:36 AM.</p>	W000323	<p>within 24 hours of completion for review.</p> <p>Nurse will complete quarterly appointment tracking form for all appointments. Nurse will notify PD and HM of upcoming appts. for clients. HM will ensure that all necessary appts are scheduled in advance and any needed scripts/referrals have been obtained prior to scheduling appts. Nurse, PD and AD will monitor completion of appts.</p>	03/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220			
(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 #4's most recent hearing exam was conducted on 12/6/12. The Medical Appointment Form, dated 12/6/12, indicated, "Rec: annual hearing check." Client #4's 7/5/13 Individual Support Plan indicated, "[Client #4's] hearing was assessed on 12/6/12. Exam was presented in a field test 'booth.' Audiologist findings were that [client #4] has near normal hearing for conversational speech in both ears. He will be re-tested on an annual basis. He does respond to normal voice tones and normal TV/music levels within his home. He will become restless or agitated and more vocal if left in a noisy or loud environment for an extended period of time."</p> <p>On 2/19/14 at 10:13 AM, the Program Director indicated client #4 should have an annual hearing test. The PD indicated there was no currently scheduled hearing test.</p> <p>On 2/20/14 at 11:59 AM, the Registered Nurse (RN) indicated she was aware client #4 was overdue for his annual hearing test. The RN indicated she gave the home manager a spreadsheet with appointments that needed to be scheduled at the beginning of January 2014. The RN stated client #4's hearing appointment was "overlooked." The RN</p>		quarterly to ensure all appts are being completed as needed.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
W000331	<p>indicated the appointment should have been held or scheduled.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 2 non-sampled clients (#3), the nurse failed to assess and monitor client #3's skin integrity in order to prevent additional incidents of skin breakdown.</p> <p>Findings include:</p> <p>On 2/18/14 at 1:50 PM, a review of the facility's incident reports was conducted and indicated the following: 1) On 8/23/13 at 9:00 AM, client #3 was found to have a nickel size open area on left side of gluteal fold near his rectum. The nurse was notified. The nurse instructed the staff to position client #2 off the area as much as possible, cover with barrier cream, and keep open to air as much as possible. The Home Manager (HM) contacted the Primary Care Physician's office for</p>	W000331	AD in conjunction with Nurse, QA and PD will review client #3 and all other clients skin integrity protocols to ensure they include the steps the nurse would take after the direct care staff notified the nurse of issues related to skin integrity. PD will retrain staff on new skin integrity protocols. Program Director and Home Manager will notify AD anytime there is a non-life threatening event, including skin integrity issues. AD will follow up with Nurse to determine when she will complete her assessment of client. If Nurse is unable to assess within 24 hours then client will be seen by PCP. Nurse will send all assessments to AD within 24 hours of completion for review.	03/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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>consult and possible referral to wound care. The Bureau of Development Disabilities Services (BDDS) report, dated 8/23/13, indicated, "He had a history of open areas in the same general area."</p> <p>2) On 11/30/13 at 1:00 PM, client #3 was found to have a quarter size open area on his left buttock near his anus and a dime size open area on his right buttock near his anus. The BDDS report, dated 11/30/13, indicated, "Areas were previously healed but skin was not 'toughened' up yet so patches (medication) were continuing to be applied. [Client #3] had episode of diarrhea within 24 hours of his date and areas re-opened with the constant changing in the 24 hour period. He was previously seen by [name of wound center] and message was left at office this date for a new evaluation." The BDDS report indicated, "Per RN (Registered Nurse), staff were instructed to position off bottom as much as possible, continue use of duoderm patches to areas and provide good peri-care and showers to keep area clean." The report indicated, "Follow up with [name of company] on new seat cushion from previous Wound Care evaluation for possible 'loaner' of new/different cushion."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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>A review of client #3's record was conducted 2/19/14 at 8:47 AM and indicated the following:</p> <p>The Indiana Mentor Nursing Progress Notes were reviewed on 2/20/14 at 12:40 PM.</p> <p>-On 8/22/13 at 4:00 PM, the note indicated, "Text from HM (Home Manager), [client #3] has an open area on his buttocks again. Should she contact wound care. Yes."</p> <p>-On 8/28/13 at 6:30 AM, the note indicated, "At home with [client #3], he had 2 1" (one inch) x 2" open areas parallel to each other on his buttocks either side of his rectum. Area coated with barrier cream and powder. Instructed staff to clean area. Staff reports order for dressing on treatment sheet but when HM called to get more. No current script." This was the first assessment documented in the nurse's progress notes.</p> <p>-On 9/17/13 at 12:30 PM the nurse conducted her second assessment of client #3. The note indicated, "At day program with [client #3] he is sleeping in side lying position. Spoke to HM, she still needs to schedule appointment with w/c (wheelchair) clinic. She reports that</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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>per staff no change in wound. [Client #3] has a follow-up appointment with wound care next (sic) sending another type of wound patches this week to try."</p> <p>-On 9/26/13 at 11:00 AM, the note indicated, "Accompanied [client #3] to wound care appointment, his wounds are closed. He continues to (sic) 3x4" reddish, purple skin at the site. Wound care nurse recommends to continue dressing as long as area is discolored to protect the new skin. Spoke with HM, can be up in wheelchair more but staff watch area. If area looks worse to lay him down. HM passed info onto day program staff. While at wound care HM spoke with scheduler regarding seating eval. Person who does eval (evaluations) not there today. Wound care nurse will get with her and set up a time when both can see him same day, then call HM will time and date."</p> <p>-On 11/30/13 at 2:00 PM, the note indicated, "Text from HM, areas of [client #3's] buttocks which are prone to breakdown opened up again. One side is quarter sized area and the other is dime sized."</p> <p>-On 12/2/13 at 10:00 AM, the first assessment of the areas indicated, "At day program with [client #3], spoke to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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>HM. Asked if staff have sent any patches to day program for client if they become soiled. She reports they have not but will have some sent to day program tomorrow. Patch on place over area. Visible through patch is a 2" by 1" on Rt (right) and 3" x 1" on Lt (left) discolored area."</p> <p>-On 12/3/13 at 12:00 PM, the note indicated, "At day program with [client #3], staff report patches sent today. He needs changed. Removed loose patch from area. He has a 50 mm x 25 mm red peeling (sic) area on the Rt side with a 15 mm in diameter open area to the edge of the red near the rectum. On the Lt side he has a 75 mm x 30 mm red peeling area with an oral (oval) open area measuring 20 mm x 15 mm. Replaced patch and educated day service staff on the use of the patch and how to apply. Notified PD (Program Director) of assessment."</p> <p>-On 12/10/13 at 10:00 AM, the note indicated, "At home with [client #3], patch in place over area. No discoloration of the skin around patch noted. Discoloration under the patch observed. On the Lt side discoloration is 40 mm x 20 mm. Discoloration of the Rt side is 35 mm x 15 mm. [Client #3] to see wound care late this week."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220			
(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>-On 12/20/13 at 10:00 AM, the note indicated, "Per wound care open area is 10 mm on Rt side and Lt is red but closed. [Client #3] seen at day service patch securely on area not removed. Spoke with staff, they report that area is much better. Lt side is red most of the time but if off for a while is pink. Rt side continues to be open but is much smaller and less deep."</p> <p>-On 1/2/14 at 8:00 AM, the note indicated, "At home with [client #3], staff report that area of Rt side was closed for about 1 week then opened up about nickel sized. Patch in place over area. There is a 2 mm in diameter whitish area under patch. Staff reports it is the open area. Using barrier cream around site."</p> <p>-On 1/9/14 at 10:00 AM, the note indicated, "At day program with [client #3], he is up in his w/c getting ready to eat a snack. Spoke to HM. She reports that no change in wound area. Dressing in place. Due to snow days this week he was able to spend most of the days in bed..."</p> <p>-On 1/14/14 at 6:15 AM, the note indicated, "At home with [client #3], dressing securely in place over buttocks.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Staff report that in (sic) has been covered everyday that she has worked for the last couple of days."</p> <p>-On 1/14/14 at 12:00 PM, the note indicated, "At day program with [client #3], area under dressing is red but not open."</p> <p>-On 2/7/14 at 10:00 AM, the note indicated, "Spoke with HM, she reports [client #3's] wound is open again. Requested HM make him an appt (appointment) w/ (with) wound care. Spoke with day service staff and ask that they lay him down as much as possible today."</p> <p>-On 2/11/14 at 7:30 AM, the note indicated, "At home with [client #3], Lt side of his buttocks has a 1"x1/2" area that is red and the Rt side has a 1/2" in diameter area that is red. Neither area is peeling or open. Assisted HM in reapplying patch to area."</p> <p>-On 2/20/14 at 10:00 AM, the note indicated, "At day program with [client #3]. He has a quarter sized red area on his Lt side and a nickel sized red area on his Rt side of buttocks. Patch in place."</p> <p>Client #3's Nursing Progress Notes did not include documentation client #3's</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220			
(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>pressure wounds were staged. The notes indicated the RN did not assess and monitor client #3's wounds on a regular basis. The notes indicated the RN did not conduct her initial and follow-up assessments and monitoring in August 2013, November/December 2013 and February 2014 in a timely manner.</p> <p>Client #3's Individual Support Plan (ISP), dated 3/15/13, indicated, in part, "[Client #3] is at risk for skin breakdown. He had a 2" open area on his posterior buttocks in 6/10. Area treated and healed without MD (medical doctor) or wound care intervention. He had an 8mm (millimeter) open area on his right buttocks in 12/12 and Hydrocolloid patches were used per the [name of wound care center] RN consultation. This area was closed by 1/2/13. He is on a positioning schedule of every 2 hours. Staff are trained in positioning specific to [client #3]. He has a tilt-in-space wheelchair which is incorporated in his positioning schedule as well as a Hill-Rom chair and his bed. Stander positioner was discontinued per PT on 2/25/10 due to decreased weight bearing ability. A large mat is placed bedside when he is in bed. Impaired Skin Integrity Protocol is in place. Skin integrity is checked at bath time and personal care changes and issues are</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220		
(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>reported to the Nurse. He has a 'dimpled' area above his rectum that is monitored for redness and infection. Lotion is applied following his bath and PRN. Barrier cream is applied to his buttocks 2x (two times) daily. PT (physical therapy) and OT (occupational therapy) provide annual evaluations and services as needed."</p> <p>Client #3's Risk Management Assessment and Plan (RMAP), dated 3/15/13, indicated he was at risk for pressure sores/skin ulcers. The RMAP indicated, in part, "Impaired Skin Integrity Protocol in place. Skin to be kept clean and dry. Re-position in accordance with schedule. Incontinence care provided every two hours and as needed. Lotion or barrier cream applied at changes. Skin integrity will be monitored daily during bathing and at changes. Nurse to be contacted if there are any worsening red areas, changes or breaks in skin integrity."</p> <p>The Impaired Skin Integrity Protocol, dated 6/10/13, indicated, "[Client #3's] skin will easily open if positioning schedule and depend changes are not completed." The protocol did not include interventions to be taken by the nurse including assessment and monitoring.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220			
(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>On 2/24/14 at 11:01 AM, an electronic mail message was received by the surveyor on 2/24/14 at 11:01 AM. The information was sent from the Director of Nursing. The DON indicated, "Yes here is the non life Threatening injuries policy and it is not new. Generally if a nurse can't see someone within a business day to assess they would be seen elsewhere. That should be few and far between that can't happen. So I would like to know more about the specifics of this and if I understood that it is taking her 6 days to see a client after something is reported. I believe that is what I understood and that would not be a practice anywhere. Thanks."</p> <p>On 2/24/14 at 11:01 AM, the Non-Life Threatening Injuries policy/procedure, dated 4-2012, was reviewed. The policy indicated, "Upon notification of client injury the nurse will provide phone consultation to review information provided by the home staff. The Nurse will focus on the symptom-based assessment to gather enough information from the staff to determine how to best proceed in obtaining the appropriate level of care, in a timely manner.</p> <p>The nurse will provide direction of care to staff, which may include obtaining additional data such as vital</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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>signs, and/or directing in-house treatment such as applying ice, offering prn medication for pain, or instructing to take client to urgent care or the emergency department. If additional assessment appears to be indicated based on description of injury, and the Nurse is not available to assess the client within 1 hour of notification, the client will be referred to urgent care or the local emergency department. If assessment is non-acute, but it is at a level that indicates follow-up is necessary, in addition to telephone advice and instruction, then the nurse will see the client within 1 business day or instruct staff to schedule an appointment with PCP within 1 business day. Nurse will provide follow-up care as indicated. The Nurse will document care provided in the clients file."</p> <p>On 2/20/14 at 11:59 AM, the Registered Nurse (RN) indicated the facility received a seating evaluation with a recommendation to change the seating cushion. This recommendation was pending Medicaid/Medicare approval. The RN indicated client #3 was lying down at the day program most of the day and while at home to relieve pressure off the area. The RN indicated it was the same area that has been open in the past year. The RN indicated the area was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	currently red but not open. The RN stated she assessed client #3 "almost every week." The RN indicated she staged the area and determined it was a stage 2 in August and December 2013. The RN indicated client #3 was taken to wound care both times for an evaluation and recommendations. The RN indicated she was at the home or the day program every week. On 2/21/14 at 11:55 AM, the RN indicated she was not sure why pressure areas on client #3 were still an issue. The RN indicated wound care requested a seating evaluation which was done. Client #3 was waiting to receive his air cushion system. The RN indicated she thought the facility was borrowing a cushion from someone who was not using their cushion until client #3 received his air cushion. The RN indicated the borrowed cushion was an egg crate foam cushion. The RN indicated the egg crate was not as good as the air system they are waiting on but it was better than client #3's current cushion. The RN indicated instead of staging the ulcer, she documented a description of the measurement she took of the wounds. The RN indicated measuring was better than staging due to being more descriptive. The RN stated there were gaps in her assessments of client #3's wounds due to "I'm very spread out."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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>The RN stated, "I assess as soon as I can." The RN stated "it's hard to get to [name of city where the group home was located]." The RN stated she would preferably assess the client the next day "if she was able to." The RN indicated it was preferable to conduct assessments sooner. The RN indicated during some of the gaps in her assessments client #3 was seen at wound care which was an assessment. The RN indicated there was no plan indicating the nurse's responsibilities for wound care. The RN indicated the protocols were directed at the direct care staff and did not include the actions the nurse would take. The RN stated, "it may not be a bad idea" to have a plan of action for the nurse.</p> <p>On 2/21/14 at 2:09 PM the Area Director (AD) indicated the RN should have conducted an assessment of client #3 within 24 hours of being notified of the pressure sores. The AD stated the RN should have conducted assessments "more often" while client #3 had pressure sores. The AD stated the RN was supposed to have "face to face contact" with the client "weekly." The AD indicated the Skin Integrity Protocol should indicate the steps the nurse was supposed to take including assessments and monitoring.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220			
(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
W009999	<p>9-3-6(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(a) 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 the division: 14. A significant injury to an individual that includes but is not limited to: f. any occurrence of skin breakdown related to a decubitus ulcer, regardless of the severity.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 16 incident reports reviewed affecting client #3, the facility failed to report a pressure ulcer to the Bureau of Developmental Disabilities Services</p>			W009999	<p>Area Director will retrain PD on incident reporting. PD will ensure that all incidents are reported to BDDS within 24 hours. AD will monitor timeliness of incident reporting weekly.</p>		03/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220		
(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>(BDDS) within 24 hours.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/18/14 at 1:50 PM and indicated on 11/30/13 at 1:00 PM (reported to BDDS on 12/2/13), client #3 was found to have a quarter size open area on his left buttock near his anus and a dime size open area on his right buttock near his anus. The BDDS report indicated, "Areas were previously healed but skin was not 'toughened' up yet so patches (medication) were continuing to be applied. [Client #3] had episode of diarrhea within 24 hours of his date and areas re-opened with the constant changing in the 24 hour period. He was previously seen by [name of wound center] and message was left at office this date for a new evaluation."</p> <p>On 2/18/14 at 2:22 PM, the Program Director (PD) indicated BDDS reports were to be submitted within 24 hours.</p> <p>9-3-1(b)(f)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2014
---	--	--	--

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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