

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2011
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN46342		
(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	
W0000	<p>This visit was for the investigation of complaint #IN00098364.</p> <p>COMPLAINT #IN00098364: UNSUBSTANTIATED, due to lack of evidence.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: November 3, 4 and 7, 2011</p> <p>Facility number: 001107 Provider number: 15G593 AIM number: 100245570</p> <p>Surveyor: Christine Colon, Medical Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/28/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			

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:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2011
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN46342		
(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	
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 2 of 4 sampled clients (clients A and C), the facility neglected to implement its abuse/neglect policy by assuring clients were not physically aggressed upon and neglected to provide appropriate supervision to prevent elopement from the group home.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS)/internal incident reports was conducted at the facility's administrative office on 11/3/11 at 1:45 P.M.. Review of the facility's BDDS/internal incident reports indicated:</p> <p>Incidents involving client A:</p> <p>Incident dated 9/3/11: "[Client A] was watching television and another housemate (client H) attacked [client A], causing a bruise...[client A] had a bruise on his chest."</p> <p>Incident dated 10/29/11: "I received a call at 4:30 P.M. stating that [client A] had eloped from the home. Staff went to look for him. I received a telephone call from</p>	W0149	<p>All staff are trained upon hire and at least once annually on the facilities abuse and neglect policy. Staff have been retrained on Client A and C behavior support plan in regards to eloping. The staff who were responsible for the supervision level of the client during this incident was terminated. Staff were retrained on the behavior support plan and one on one protocol for Client H. Staff was also retrained on Indiana Mentor's policy regarding abuse and neglect. Person Responsible: Area Director Completion Date: 12/10/2011</p>	12/10/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2011
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN46342		
(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>[Hospital name] stating that they have (sic) located [client A]."</p> <p>Review of the investigation record dated 11/2/11 was conducted on 11/3/11 at 2:30 P.M.. Review of the record indicated client A was last seen on 10/29/11 at 2:30 P.M. by group home staff. At 4:00 P.M., staff began looking for him and found out he was missing from the group home. The Group Home Manager (GHM) was notified at 4:30 P.M. and the local hospital which is located 2.3 miles (Rand McNally) from the group home called to inform the staff client A was at the hospital. Further review of the record indicated staff were trained on the level of supervision for client A, which is 24 hour supervision, checking on him every 15 minutes which was addressed at the October staff meeting. The conclusion of the investigation indicated: "The facts support that [client A] eloped from the home. Staff was negligent in knowing [client A]'s whereabouts. Staff did not complete all documentation for their shift."</p> <p>Incident involving client C:</p> <p>Incident dated 10/6/11: "[Client B] put [client C] in a headlock when she was exhibiting behavior issues."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2011
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN46342		
(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 the facility's "Supervised Group Living Policy Manual: Human Rights" dated 8/10/06 was conducted at the facility's administrative office on 11/3/11 at 2:10 P.M.. Review of the facility's policy indicated: "Ensure clients are not subjected to physical abuse...are free from unnecessary restraints...The following actions are prohibited by employees of Indiana Mentor: abuse, neglect, exploitation or mistreatment of an individual."</p> <p>An interview with the Area Director (AD) was conducted at the facility's administrative office on 11/7/11 at 1:30 P.M.. The AD indicated clients A and C were physically aggressed upon by other housemates as documented. The AD indicated group home staff neglected to properly supervise client A leading to his elopement. The AD further indicated the facility's abuse neglect policy should be followed at all times.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2011
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN46342		
(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	
W0153	<p>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.</p> <p>Based on record review and interview, the facility failed for 1 of 1 allegation involving 1 of 4 sampled clients (client C), to report an allegation of physical abuse immediately 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 BDDS reports was conducted on 11/3/11 at 1:45 P.M.. Review of the facility's reports indicated:</p> <p>Incident dated 10/6/11: [Client C] fell and it was reported by an outside source that the staff kicked her to try to get her to get off the ground." Further review of the report indicated the report was submitted to BDDS on 10/8/11.</p> <p>An interview was conducted with the Area Director (AD) at the facility's administrative office on 11/7/11 at 10:40 A.M.. The AD indicated the incident occurred on 9/28/11 but was not reported to the facility until 10/4/11. The AD indicated the facility had several clients who volunteer for the outside program</p>	W0153	<p>Indiana Mentor has policy and procedures place mandating that incidents involving a client must be reported in accordance with the BDDS Incident Reporting Policy. All staff are trained in the policy upon hire and at least annually thereafter. Indiana Mentor Day Services staff have been retrained on the incident reporting policies specifically including the timeframe in which incidents should be reported. The Program Director has been retrained to assure that all incidents are reported with in 24 hours of notification of the incident. The Area Director will review all incident reports to assure that the reporting timeframes have been met in accordance with BDDS Incident Reporting policies. Person Responsible: Area Director Completion Date: 12/10/2011</p>	12/10/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/07/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN46342
---	--

(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
W0157	<p>and figured out who the client was on 10/6/11. When asked if the incident was reported to BDDS on 10/6/11, she stated "No, it was reported on 10/8/11." The AD stated "Incidents are to be reported within 24 hours to BDDS."</p> <p>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 2 of 4 sampled clients (clients A and C) to take immediate effective/sufficient corrective action for 3 of 4 documented incidents of physical aggression and elopement.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS)/internal incident reports was conducted at the facility's administrative office on 11/3/11 at 1:45 P.M.. Review of the reports dated 9/3/11 to 10/29/11 indicated the following incidents:</p> <p>Incidents involving client A:</p> <p>Incident dated 9/3/11: "[Client A] was</p>	W0157	<p>A team meeting was held on 11/17/2011 for client A regarding his elopement and it was determined that there no changes would be made at this time as his Behavioral Development Plan addresses elopement. Staff have been retrained on Client A's Behavior Development Plan and supervision level. All staff have been trained in Indiana Mentor's abuse and neglect policy as well as the policy on human rights. All staff have also been trained in the Behavior Developmental Plans for client's C and H as well as the one on one protocol for client H. The Home Manager and the Program Director have been trained that when an incident occurs involving a client, immediate corrective and/or protective measures must be put in place to protect the client and prevent a recurrence. The Area Director will review all incident</p>	12/10/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2011
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN46342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>watching television and another housemate (client H) attacked [client A], causing a bruise...[client A] had a bruise on his chest...Plan to Resolve: Staff will continue to follow Behavior Support Plan (BSP) for both individuals." Further review of the report failed to indicate the facility completed documented immediate effective/sufficient corrective action to prevent/protect client A from being physically aggressed upon by client H.</p> <p>Incident dated 10/29/11: "I received a call at 4:30 P.M. stating that [client A] had eloped from the home. Staff went to look for him. I received a telephone call from [Hospital name] stating that they have (sic) located [client A]." Further review of the report failed to indicate the facility completed documented immediate effective/sufficient corrective action to prevent/protect client A from eloping from his home.</p> <p>Review of the investigation record dated 11/2/11 was conducted on 11/3/11 at 2:30 P.M.. Review of the record indicated client A was last seen on 10/29/11 at 2:30 P.M. by group home staff. At 4:00 P.M., staff began looking for him and found out he was missing from the group home. The Group Home Manager (GHM) was notified at 4:30 P.M. and the local hospital which is located 2.3 miles from</p>		<p>reports to assure that corrective measures have been put in place to the protect the clients and prevent recurrence.Responsible Person: Area DirectorCompletion Date: 12/10/2011</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2011
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN46342		
(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 group home called to inform the staff client A was at the hospital. Further review of the record indicated staff were trained on the level of supervision for client A, which is 24 hour supervision, checking on him every 15 minutes which was addressed at the October staff meeting. The conclusion of the investigation indicated: "The facts supports that [client A] eloped from the home. Staff was negligent in knowing [client A]'s whereabouts. Staff did not complete all documentation for their shift." Further review of the record failed to indicate the facility completed documented immediate effective/sufficient corrective action to prevent/protect client A from eloping from his home.</p> <p>Incident involving client C:</p> <p>Incident dated 10/6/11: "[Client B] put [client C] in a headlock when she was exhibiting behavior issues." Further review of the report failed to indicate the facility completed documented immediate effective/sufficient corrective action to prevent/protect client C from being physically aggressed upon by client B.</p> <p>A review of client A's record was conducted on 11/3/11 at 6:35 P.M.. Review of client A's record indicated a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2011
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN46342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>most current Behavior Development Plan (BSP) dated 6/21/10 with no current review date noted which addressed "Runs/Wanders away." Further review of the record failed to indicate the facility completed documented effective/sufficient corrective action to prevent/protect client A from recurrence of elopement.</p> <p>A review of client B's record was conducted on 11/3/11 at 6:40 P.M.. Review of client B's record indicated a most current BSP dated 3/25/11 with no current review date noted and which addressed Physical Assault. Further review of the record failed to indicate the facility completed documented effective/sufficient corrective action to prevent client B from physically assaulting his housemates.</p> <p>A review of client H's record was conducted on 11/3/11 at 6:50 P.M.. Review of client H's record indicated a most current BSP dated 9/15/11 with no current review date noted which addressed Physical Assault. Further review of the record failed to indicate the facility completed documented effective/sufficient corrective action to prevent client H from physically assaulting his housemates.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2011
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN46342		
(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>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/3/11 at 7:00 P.M.. The QMRP indicated the team did not meet after each of the incidents of aggression/elopement and further indicated no revisions to the clients' BSP/programs were made. There was no documentation available for review to indicate the facility took effective/sufficient corrective action to prevent recurrence of physical aggression/elopement after each of these incidents involving clients A and C.</p> <p>An interview with the Area Director (AD) was conducted on 11/7/11 at 1:30 P.M.. The AD indicated client A's team is scheduled to meet on 11/17/11 to address his elopement. The AD further indicated no other changes have been implemented to address the mentioned incidents.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/07/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN46342
---	--

(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
W0186	<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 record review and interview, the facility failed 1 of 4 sampled clients (client A) to provide sufficient numbers of direct care staff to supervise and to implement Behavior Support Plans (BSP).</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS)/internal incident reports was conducted at the facility's administrative office on 11/3/11 at 1:45 P.M.. Review of the reports dated 9/3/11 to 10/29/11 indicated the following incidents:</p> <p>Incident dated 10/29/11: "I received a call at 4:30 P.M. stating that [client A] had eloped from the home. Staff went to look for him. I received a telephone call from [Hospital name] stating that they have (sic) located [client A]."</p> <p>Review of the investigation record dated 11/2/11 was conducted on 11/3/11 at 2:30</p>	W0186	<p>All staff are trained on each individuals client specific information prior to working with the clients which included a client's supervision level and their Behavior Development Plan. All staff have been retrained on the importance of working their shift as scheduled and if a situation arrises where a staff person can not make it to their scheduled shift they must call the supervisor on call to report this according to company policy so the supervisor can ensure that there is adequate coverage for the health and safety of the clients.</p> <p>The Home Manager or the Program Director will submit a schedule weekly to the Area Director for one month so the Area Director can monitor that adequate coverage is being provided. Responsible Party: Area Director Completion Date: 12/10/2011</p>	12/10/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2011
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN46342		
(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>P.M.. Review of the record indicated client A was last seen on 10/29/11 at 2:30 P.M. by group home staff. At 4:00 P.M., staff began looking for him and found out he was missing from the group home. The Group Home Manager (GHM) was notified at 4:30 P.M. and the local hospital which is located 2.3 miles from the group home called to inform the staff client A was at the hospital. The record indicated: "Staff #13 interview: [Client A] had a bowl of soup around 2:00 P.M.. After that he went outside to have a cigarette smoke. No one was there with him. Aware that [client A] has schizophrenia, wasn't aware that he elopes because they allow him to go out by himself to smoke....Around noon [client A] was sitting in kitchen, he was grumpy. He was saying you guys are crazy and you don't belong here." Review of the record indicated staff were trained on the level of supervision for client A, which is 24 hour supervision, checking on him every 15 minutes. Further review of the record indicated staff #13 left prior to the ending of her shift and the relief staff reported for her scheduled shift (30) minutes late, leaving only 2 staff available for the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/07/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN46342
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>clients at the group home. The conclusion of the investigation indicated: "The facts supports that [client A] eloped from the home. Staff was negligent in knowing [client A]'s whereabouts. Staff did not complete all documentation for their shift."</p> <p>A review of client A's record was conducted on 11/3/11 at 6:35 P.M.. Review of client A's record indicated a most current Behavior Development Plan (BSP) dated 6/21/10 which indicated: "Irritability-When he begins to show signs of anger, refer to the 'How to Relax' list...Runs/Wanders away."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted at the group home on 11/3/11 at 7:15 P.M.. The QMRP indicated client A should be within eye sight of staff at all times due to his wandering. The QMRP further indicated staff should implement client A's BSP at all times. She further indicated there should be enough staff present to carry out the BSP. When asked if there were enough staff at the group home at the time of client A's elopement, the QMRP stated "No."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2011
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN46342		
(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	
W0249	<p>An interview with the Area Director (AD) was conducted on 11/7/11 at 1:30 P.M.. When asked how many staff are to be at the group home with the 8 clients who reside there, the AD stated "There should be at least three staff there at all times to provide proper supervision."</p> <p>9-3-3(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 record review and interview, the facility failed for 1 of 4 sampled clients (client A) to implement the Behavior Development Program (BSP) dated 6/21/10 for client A's targeted behavior of "Runs/Wanders away."</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS)/internal incident reports was conducted at the facility's administrative</p>	W0249	All staff are trained upon hire and at least once annually of the supervision level of the clients that are being served. Staff was retrained on the supervision level as well as behavior support plan of Client A. The Program Director as well as Home manager was retrained on the behavior support plan of Client A as well as implementing protective measures for the client immediately. The Program Director and Home Manager was retrained that the most current information must be documented	12/10/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2011
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN46342		
(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>office on 11/3/11 at 1:45 P.M.. Review of the facility's reports indicated an incident dated 10/29/11: "I received a call at 4:30 P.M. stating that [client A] had eloped from the home. Staff went to look for him. I received a telephone call from the [Hospital name] stating that they have (sic) located [client A]."</p> <p>Review of the investigation record dated 11/2/11 was conducted on 11/3/11 at 2:30 P.M.. Review of the record indicated client A was last seen on 10/29/11 at 2:30 P.M. by group home staff. Further review of the record indicated client A was outside smoking unsupervised and scheduled staff indicated he often goes outside to smoke unsupervised. At 4:00 P.M., staff began looking for him and found out he was missing from the group home. The Group Home Manager (GHM) was notified at 4:30 P.M. and the local hospital which is located 2.3 miles (Rand McNally) from the group home called to inform the staff client A was at the hospital. Further review of the record indicated staff were trained on the level of supervision for client A, which is 24 hour supervision, checking on him every 15 minutes which per the record was addressed at the October staff meeting. The conclusion of the investigation indicated: "The facts support that [client A] eloped from the home. Staff was</p>		<p>and maintained in the files at the home to be available for all staff and other parties that might enter the home. The Area Director will do random audits of the files to make sure all current information is in the home. Responsible person: Area Director Completion Date: 12/10/2011</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2011
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN46342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>negligent in knowing [client A]'s whereabouts. Staff did not complete all documentation for their shift."</p> <p>A review of client A's record was conducted on 11/3/11 at 6:35 P.M.. Client A's BSP dated 6/21/10 indicated: "Targeted Behaviors-Runs/Wanders away: Monitor [client A] while he is smoking." Further review of client A's record indicated he is to have 24/7 supervision.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted at the group home on 11/3/11 at 7:15 P.M.. The QMRP indicated client A should be within eye sight of staff at all times due to his wandering.</p> <p>9-3-4(a)</p>				