

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G438	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2012
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7555 GRANDVIEW DR INDIANAPOLIS, IN 46260
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W0000	<p>This visit was for the PCR (Post Certification Revisit) to the investigation of complaint #IN00109399 completed on 7/9/12.</p> <p>This visit was in conjunction with the annual fundamental recertification and state licensure survey.</p> <p>Complaint #IN00109399: Not Corrected.</p> <p>Dates of Survey: 9/18/12, 9/19/12, 9/20/12, 9/21/12, 9/24/12, 9/26/12 and 9/28/12.</p> <p>Facility Number: 000952 Provider Number: 15G438 AIMS Number: 100244640</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/9/12 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.

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W0149	<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 4 sampled clients (#2) plus one additional client (#6), the facility failed to implement its policy and procedure to complete an investigation in regards to client #6's bruises of unknown origin. The facility failed to implement its policy and procedure to complete an investigation in regards to client #2's bruise of unknown origin within 5 business days.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 9/18/12 at 11:40 AM. The review indicated the following:</p> <p>-BDDS report dated 7/8/12 indicated, "On 7/7/12, staff was assisting [client #2] with his evening bathing and noticed a small bruise about the size of a quarter on his left buttock. They were unable to determine where or when this bruise may have occurred. Staff will monitor [client #2] for his health and safety. The nurse was paged but did not return page."</p> <p>-Investigation dated 7/17/12 regarding the</p>	W0149	<p>The Program Director will receive retraining on investigations including ensuring that all reports of injuries of unknown origin for consumes are investigated, investigations are completed thoroughly and accurately and all investigations are reported to the administrator or designee the results within 5 work days.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Quality Assurance Specialist. If the investigations are not thorough enough the Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Program Director, Quality Assurance Specialist, Area Director.</p>	10/28/2012	

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	<p>7/8/12 BDDS indicated the investigation had been initiated on 7/8/12 to determine the origin of client #2's bruise.</p> <p>-BDDS report dated 9/1/12 indicated on 8/31/12, "[HM (Home Manager) #1] noticed a small bruise on [client #6's] left arm. [HM #1] reported that the bruise looked like it was a few days old, it is approximately 1 inch long and half inch wide. One staff said the bruise had been there for some time."</p> <p>The review did not indicate an investigation regarding the origin of client #6's bruise.</p> <p>Interview with AS (Administrative Staff) #1 on 9/20/12 at 11:30 AM indicated the 8/31/12 injury of unknown origin for client #6 should have been investigated as an injury of unknown origin. AS #1 indicated investigations for injuries of unknown origin should be completed within 5 business days. AS #1 indicated the 7/17/12 Investigation regarding the 7/7/12 injury of unknown origin for client #2 was not completed within 5 business days.</p> <p>The facility's policy and procedures were reviewed on 9/26/12 at 4:03 PM. The facility's 4/11 policy and procedure entitled Quality Risk Management indicated "Indiana Mentor is committed to completing a thorough investigation for any event</p>			

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	<p>out of the ordinary which jeopardizes the health and safety of any individual served or other employee." The Quality Risk Management policy dated 4/11 indicated, "Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident."</p> <p>This deficiency was cited on 7/9/12. the facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>			

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W9999	<p>STATE FINDINGS:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>(1) 460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin (TB) test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview for 1 of 3 sampled staff (staff #1) personnel records reviewed, the facility failed to obtain yearly PPD's and/or a chest x-ray and/or PPD screening checklist for employed staff.</p> <p>Findings include:</p> <p>Staff #1's personnel record was reviewed on</p>	W9999	<p>Program Director and Area Director will review Mantoux records for all staff. Program Director and Area Director will notify any staff if their Mantoux is outdated and provided them with the list of next clinic dates and deadline for completion.</p> <p>Program Director and Area Director will monitor expiration dates for Mantoux for all staff no less than monthly and notify staff as needed of completion.</p> <p>Responsible Party: Program Director, Area Director</p>	10/28/2012			

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	<p>9/18/12 at 1:04 PM. Staff #1's personnel record did not include a Mantoux test, chest x-ray or TB (Tuberculosis) checklist/screening to indicate the staff person was free of TB symptoms.</p> <p>Interview with AS (Administrative Staff) #1 on 9/20/12 at 1:07 PM indicated there were no additional Mantoux test, chest x-ray or TB (Tuberculosis) checklist/screening documents available for review. AS #1 indicated staff #1's personnel record should contain evidence of completion of an annual Mantoux test, chest x-ray or TB (Tuberculosis) checklist/screening to indicate the staff person was free of TB symptoms.</p> <p>This deficiency was cited on 7/9/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(e)</p>				