

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/01/2012
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
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W0000	<p>This visit was for an annual fundamental recertification and state licensure survey. This visit included the investigation of Complaint #IN00107312.</p> <p>Complaint #IN00107312: Unsubstantiated, due to lack of sufficient evidence.</p> <p>This visit was conducted in conjunction with a post certification revisit (PCR) to the investigation of Complaint #IN00097769 completed on 10/14/11.</p> <p>This visit was conducted in conjunction with a PCR to the investigation of Complaint #IN00099335 completed on 11/15/11.</p> <p>Dates of survey: 4/16/12, 4/17/12, 4/18/12, 4/19/12, 4/20/12, 4/23/12, 4/25/12, 4/27/12 and 5/1/12.</p> <p>Facility Number: 001082 Provider Number: 15G568 AIM Number: 100245520</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</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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	Quality Review completed 5/10/12 by Ruth Shackelford, Medical Surveyor III.			

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W0153	<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.</p> <p>Based on record review and interview for 1 of 7 allegations of abuse, neglect, mistreatment and/or injuries of unknown origin reviewed, the facility failed to immediately notify the administrator and the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law regarding an incident of client to client aggression for client #1 and client #4.</p> <p>Findings include:</p> <p>A review of the facility's BDDS reports was conducted on 4/16/12 at 12:45 PM. The review indicated the following:</p> <p>-BDDS report dated 3/5/12 indicated on 2/4/12, "Housemates were at the library. [Client #4] asked [client #1] to rent a video under [client #1's] card. The subject of renting for housemates and individuals had been discussed during a house meeting and it was agreed that no one can rent for another person. [Client #1] in return got upset and when they returned home and got off the van [client #1]</p>			W0153	<p>All Direct care staff will be receive retraining on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents.</p> <p>The Home Manager will receive retraining on documentation review including reviewing all consumer Daily support records, behavior tracking and narrative notes to ensure all incidents that have been documented have been reported to the Program Director so reports can be made to the Bureau of Developmental Disability Services and investigations can be completed as needed.</p> <p>Ongoing the HM will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 3 times per week for 2 months to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the program director within the</p>		05/31/2012

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	<p>swung to hit [client #4] but missed. Staff intervened and [client #1] chose to utilize his alone time. While he was walking in the back yard he picked up a brick and threw it through [client #'s] bedroom window. No one was in the room at the time. [Client #4] got upset because of the broken window and went into [client #1's] room and picked up his laptop and threw it at the bedroom wall and kicked a table on his way out."</p> <p>Interview with QMRP #1 (Qualified Mental Retardation Professional) on 4/19/12 at 1:45 PM indicated the incident regarding client #4 and client #1 occurred on 2/4/12 and the date of knowledge was 2/4/12. QMRP #1 indicated the BDDS report should have been reported within 24 hours. QMRP #1 indicated the BDDS report was completed late.</p> <p>9-3-2(a)</p>		<p>designated timeframes.</p> <p>After the 2 month period, the HM will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 1 time per week to ensure all incidents are reported the Program Director within the designated timeframes.</p> <p>For 2 months, the Program Director will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 1 time per week to ensure all incidents have been reported within the designated timeframes.</p> <p>The Program Director will receive retraining on ensuring that any incidents that fall within BDDS reportable incident guidelines are reported to the Bureau of Developmental Disability Services and the Area Director within the designated reporting guidelines.</p> <p>Ongoing, the Area Director will review all BDDS reports to ensure that they are being submitted within the designated reporting guidelines.</p> <p>Responsible Party: Home Manager, Program Director, Area Director</p>		

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W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 2 of 4 clients with adaptive equipment, the facility failed to address the refusals of client #1 and client #2 to use prescription eyeglasses.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/16/12 from 4:30 PM through 5:30 PM and on 4/17/12 from 6:00 AM through 8:00 AM. Client #1 and client #2 were at the group home throughout the observation periods. Client #1 and client #2 were not wearing eyeglasses. Client #1 and client #2 were not encouraged to wear eyeglasses by staff #1, staff #2, staff #3, or staff #4.</p> <p>Client #1's record was reviewed on 4/17/12 at 10:52 AM. Client #1's ISP (Individual Support Plan) dated 7/20/11 indicated client #1, "...does wear glasses and needs reminders from staff to wear them." Client #1's Monthly Status Summary dated March 2012 did not</p>	W0436	<p>Training goals have been developed for Client #1 and #2 to prompt them to wear their eyeglasses. All Direct Support Staff will receive training on implementing Client #1 and Client #2 training goals for their adaptive equipment.</p> <p>The Program Director will receive retraining to include the need to ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment.</p> <p>Ongoing, the Program Director will ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment. The Area Director will review the next 3 ISPs submitted by this Program Director to ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment.</p> <p>Responsible Staff: Program Director, Area Director</p>	05/31/2012			

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	<p>indicate client #1 had training or supports in place to assist him in using his glasses.</p> <p>Client #2's record was reviewed on 4/17/12 at 1:01 PM. Client #2's ISP dated 9/9/11 indicated client #2 had eyeglasses, "...however [client #2] refuses to wear them (sic) he feels he don't (sic) need them." Client #2's vision record of visit form dated 12/20/11 indicated a prescription for eyeglasses. Client #2's ISP did not indicate training or supports in place to assist him in using his glasses.</p> <p>Interview with QMRP #1 (Qualified Mental Retardation Professional) on 4/19/12 at 1:45 PM indicated client #1 and client #2 both should be encouraged to wear eyeglasses. QMRP #1 indicated client #1 and client #2 should have training or supports to assist them in using their eyeglasses.</p> <p>9-3-7(a)</p>			