

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G498		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/29/2012	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 102 OAKTREE CT LOGANSPORT, IN 46947			
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W0000	<p>This visit was for the post certification revisit (PCR) to the annual recertification and state licensure survey completed April 13, 2012.</p> <p>Dates of survey: June 28 and 29, 2012.</p> <p>Provider Number: 15G498 Facility Number: 001012 AIM Number: 100239780</p> <p>Surveyors: Susan Eakright, Medical Surveyor III/QMRP/Team Leader Amber Bloss, Medical Surveyor III/QMRP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on July 06, 2012 by Dotty Walton, 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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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, for 3 of 3 sample clients (clients #2, #3, and #5), and 1 additional client (client #1), who had medications administration observed, the facility failed to ensure client #1, #2, #3, and #5's ISP (Individual Support Plan) objectives/goals were implemented during formal and informal opportunities.</p> <p>Findings include:</p> <p>1. On 6/28/12 at 6:38 am, GHS (Group Home Staff) #3 requested client #2 to come into the medication area. GHS #3 assembled, punched each medication tablet out of its package into a medication cup, and administered the medications to client #2. Client #2's cup of medications included loratadine 10 mg (milligrams) for allergies, Oyster Shell Calcium 500 mg with vitamin D for nutritional health, Depakote 125 mg for seizures, and Levetiracetam 500 mg for seizures. GHS #3 did not name each medication and the reason for its use. At 6:47 am, client #2's</p>	W0249	<p><b>W249:</b> The facility currently meets with the client Interdisciplinary team to formulate an individual program plan. The group home staff are trained to implement on all treatment program goals to support achievement by the client of such goals.</p> <p>The Home Manager will re-train the staff on client medication administration including the goals of all clients to ensure active treatment is evident and continuous. The training will include using formal and informal opportunities to provide training when ever possible.</p> <p>In the future, the Home manager will continue to train and follow up on staff to implement client goals and ensure client activity to encourage client progress. The Home manager will observe medication pass once weekly. The Program Director will observe active treatment at least monthly to ensure clients receive training opportunities.</p> <p>Responsible Person: Program</p>	07/26/2012			

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	<p>medication goal sheet inside the MAR (Medication Administration Record) book indicated a goal to "point to and punch out her morning medications." Client #2's medication objective was not implemented.</p> <p>Client #2's records were reviewed on 6/28/12 at 11 am. Client #2's 8/2/11 ISP (Individual Support Plan) indicated a goal for client #2 to "point to and punch out her morning medications."</p> <p>2. On 6/28/12 at 6:47 am, GHS #3 requested client #1 to come into the medication area. GHS #3 assembled, punched each medication tablet out of its package into a medication cup, and administered the medications to client #1. Client #1's cup of medications included Sertaline 100 mg for obsessive compulsive disorder and Lamictal 200 mg for seizures. GHS #3 did not encourage client #1 to name the medication, GHS #3 did not name each medication, and the reason for its use. At 6:53 am on 6/28/12, client #1's medication goal sheet inside the MAR (Medication Administration Record) book indicated a goal for client #1 "will be able to name one of morning pills by looking at that pill on a daily basis." Client #1's medication objective was not implemented.</p>		<p>Director Completion Date: 7/26/12</p>		

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	<p>Client #1's records were reviewed on 6/28/12 at 11:05 am. Client #1's 6/2012 ISP medication objective was "will be able to name one of her morning pills by looking at that pill on a daily basis."</p> <p>3. On 6/28/12 at 7 am, GHS #3 requested client #3 to come into the medication area. GHS #3 assembled, punched each medication tablet out of its package into a medication cup, and administered the medications to client #3. Client #3's cup of medications included Gabitril 4 mg for agitation and Omeprazole 40 mg for stomach upset. GHS #3 poured client #3 a three ounce glass of water and handed it to client #3 to take with his medications. GHS #3 did not encourage client #3 to name the medication, GHS #3 did not name each medication, and the reason for its use. At 7:03 am on 6/28/12, client #3's medication goal sheet inside the MAR (Medication Administration Record) book indicated a goal for client #3 to "get his water from the bathroom sink for his evening medications." Client #3's medication objective was not implemented during informal opportunities.</p> <p>Client #3's records were reviewed on 6/28/12 at 11:10 am. Client #3's 1/5/12 ISP medication objective was "to get his</p>						

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	<p>water from the bathroom sink for his evening medications."</p> <p>4. On 6/28/12 at 7:03 am, GHS #3 requested client #5 to come into the medication area. GHS #3 assembled, punched each medication tablet out of its package into a medication cup, poured client #5 a three ounce glass of water, and administered the medications to client #5. Client #5's cup of medications included Risperidone 2 mg for intermittent explosive disorder, Geodon 80 mg for intermittent explosive disorder, and glycopyrrolate 2 mg for drooling. GHS #3 did not encourage client #5 to name the medication, GHS #3 did not name each medication, and the reason for its use. At 7:16 am, client #5's medication goal sheet inside the MAR (Medication Administration Record) book indicated a goal for client #5 "will get his water for each med. (medication) pass." Client #5's medication objective was not implemented.</p> <p>Client #5's records were reviewed on 6/28/12 at 11:15 am. Client #5's 2/6/12 ISP medication objective was "will get his water for each med. (medication) pass."</p> <p>On 6/28/12 at 11:20 am, the QDP (Qualified Developmental Professional) indicated client #1, #2, #3, and #5's ISP</p>			

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	<p>medication administration objectives/goals should have been implemented during formal and informal opportunities to teach and train clients #1, #2, #3, and #5 about their medications.</p> <p>This deficiency was cited on 4/13/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>			

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W0455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation and interview, for 3 of 3 sample clients (clients #2, #3 and #5), and 1 additional client (client #1), who had medication administration observed in the morning, the facility failed to ensure a clean area for medication administration.</p> <p>Findings include:</p> <p>On 6/28/12 at 6:38 am, GHS (Group Home Staff) #3 wiped the medication counter and administered client #1's medications. From 6:38 am, until 7:16 am, GHS #3 completed medication administration with clients #1, #3, and #5. From 6:38 am until 7:16 am, GHS #3 placed on the counter: client #1, #3, and #5's medication cards, clients' mucus tissues from clients #1, #2, and #3 used during their medication administrations. During the medication administration GHS #3 punched out each client's medication on the same counter into a medication cup, and did not clean the medication administration counter between each client's medication administration.</p> <p>At 6:38 am, GHS #3 administered client #2's medications, wiped client #2's mouth</p>	W0455	<p>W455: The facility currently has established and follows policy to the prevention, control, and investigation of infection and communicable diseases.</p> <p>All staff are trained upon hire and annually to adhere to the format and policy for infection control and prevention.</p> <p>The staff will be retrained by Home Manager to sanitize the working surface after each administration of each client's medication to avoid infectious contact with germs.</p> <p>The Program Director will monitor the staff to ensure that the policy and format for prevention, control of infection and communicable diseases per facility policy.</p> <p>The home manager will observe a medication pass once weekly for one month to ensure the protocol for medication administration is followed. In addition, the Program Director will</p>	07/26/2012			

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	<p>with a tissue, and laid the mucus tissue on the counter.</p> <p>At 6:47 am, GHS #3 administered client #1's medications, the mucus tissue from client #2's mouth laid on the counter, and GHS #3 had not wiped clean the medication administration counter.</p> <p>At 7 am, GHS #3 administered client #3's medications, wiped client #3's nose with a tissue, laid the mucus tissue on the counter, did not wash her hands after wiping client #3's nose, and did not wipe clean the medication administration counter.</p> <p>At 7:03 am, GHS #3 did not wipe clean the medication administration counter. GHS #3 assembled, punched each medication tablet out of its package into a medication cup, dropped client #5's Risperidone 2 mg for intermittent explosive disorder onto the counter after punching the tablet from the bubble pack. GHS #3 picked up the tablet, placed the Risperidone 2 mg into the medication cup with client #5's Geodon 80 mg for intermittent explosive disorder, and glycopyrrolate 2 mg for drooling, and administered the medications to client #5.</p> <p>At 7:16 am, GHS #3 stated she "wiped off the counter before (she) started the medication pass." GHS #3 indicated she did not wipe clean the medication administration counter between clients.</p>		<p>observe a medication administration once monthly.</p> <p>Person responsible: Program Director Completion Date: 7/26/12</p>				

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	<p>On 6/28/12 at 11:20 am, the QDP (Qualified Developmental Professional) indicated the staff should have washed their hands and should have cleaned the medication administration counter between client #1, #2, #3, and #5's medication administrations.</p> <p>This deficiency was cited on 4/13/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-7(a)</p>			