

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/11/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902
---	---

(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
W 0000 Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: 6/2, 6/3, 6/4, 6/5, 6/10, and 6/11/2015</p> <p>Provider Number: 15G282 AIM Number: 100243610 Facility Number: 000802</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0130 Bldg. 00	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, for 2 of 4 sampled clients (clients #3 and #4) and 1 additional client (client #5), the facility failed to encourage and teach personal privacy when opportunities existed for clients #3, #4, and #5.</p> <p>Findings include: On 6/2/15 from 5:40am until 7:55am, observation and interview were</p>	W 0130	<p>W130: The facility ensures the rights of all clients. The facility allows and encourages each individual to exercise their rights as clients and citizens including the right to file complaints and the right to due process.</p> <p>The Program Coordinator will train the direct support professionals to encourage privacy while working with the clients. The training will discuss ensuring the clients wear robes or cover up with revealing</p>	07/11/2015

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: 15G282	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/11/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902
---	---

(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>completed at the group home and one staff was on duty. From 5:40am until 6:35am, client #3 sat on the sofa in the living room on an incontinence pad and wore a sheer short night gown which exposed the tops of her legs and had a low cut neckline which exposed client #3's cleavage. From 5:40am until 6:35am, client #4 sat backwards crossed legged in a chair with her head against the back rest of the chair. Client #4 wore a short, sheer night gown, and exposed her bottom area where the night gown was not tucked under her. From 5:40am until 6:35am, clients #3 and #4 were not offered a blanket or a bathrobe to ensure their privacy. At 6:00am, client #5 exited her bedroom, walked down the hallway to the bathroom outside the living room, and that client #5 took off her night shirt which exposed her breasts. GHS (Group Home Staff) #1 commented client #5 gets up on her own to go to the bathroom. Client #5 walked to the toilet inside the bathroom, did not close the bathroom door, sat down, and took off her night pants which exposed client #5's nude body. No privacy was taught or encouraged. Client #5 stood up from the toilet, was nude, and walked out of the bathroom, down the hallway, walked by GHS #1 in the hallway, and no privacy was taught or encouraged.</p>		<p>night clothes. A formal goal will be developed for client #5 to teach the client how to ensure privacy for self.</p> <p>In the future, the facility will encourage all staff to work formally and informally with clients to ensure privacy. The Program Coordinator will monitor the clients and staff through at least weekly routine active treatment checks in the home.</p> <p>Person Responsible: Program Director Completion Date: 7/11/15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/11/2015	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902			
(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
W 0225 Bldg. 00	<p>On 6/3/15 at 9:05am, an interview with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) was conducted. The QIDP/PD indicated the group home had male and female clients living there. The QIDP/PD indicated clients #3, #4, and #5 should have been redirected during formal and informal opportunities to teach and encourage personal privacy.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must include, as applicable, vocational skills. Based on observation, record review, and interview, for 3 of 4 sampled clients (clients #1, #2, and #3) who attended workshop services, the facility failed to assess client #1, #2, and #3's vocational abilities related to their individual work history, work skills, and work interests.</p> <p>Findings include:</p> <p>1. On 6/2/15 from 8:10am until 10:15am, client #1 was observed at the workshop. From 8:10am until 10:15am, client #1 sat at her work table assembling parts and placed the finished bag of parts into a bin on the table.</p>			W 0225	<p>W225</p> <p>The facility currently reviews all clients' needs at an annual Interdisciplinary Team Individual Support Plan and as needed throughout the year. The Comprehensive Functional Assessment within the Individual Support Plan is developed from information gleaned from assessments to determine the level of need of the client prior to developing a plan for all client developmental and behavioral needs.</p> <p>The Program Coordinator will complete vocational assessments for clients 1, 2 and 3 to determine the vocational abilities related to work. The assessments results will be incorporated into the client CFA by the Program Director.</p>		07/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/11/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902
---	---

(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 #1's record was reviewed on 6/3/15 at 9:15am. Client #1's 10/10/14 ISP (Individual Support Plan) and 10/2014 Risk Assessment did not include her work history and/or work interests.</p> <p>2. On 6/2/15 from 8:10am until 10:15am, client #2 was observed at the workshop classroom. From 8:10am until 10:15am, client #2 sat at her work table looking around the room, identified coins with a staff person, and colored on paper.</p> <p>Client #2's record was reviewed on 6/3/15 at 10:40am. Client #2's 7/2/14 ISP (Individual Support Plan) and 1/11/15 Risk Assessment did not include her work history and/or work interests.</p> <p>3. On 6/2/15 from 8:10am until 10:15am, client #3 was observed at the workshop classroom. From 8:10am until 10:15am, client #3 sat at her work table looking around the room, identified coins with a staff person, looked at a magazine, and wrote with a crayon on paper.</p> <p>Client #3's record was reviewed on 6/3/15 at 10:10am. Client #3's 8/6/14 ISP (Individual Support Plan) and 12/11/14 Risk Assessment did not include her work history and/or work interests.</p>		<p>In the future the facility will ensure client assessments are completed at least yearly or as needed with skill level change of the client. The information from those assessments will be written in the CFA and goals developed as needed in the future. The Area Director will review future CFAs as written and updated, to ensure vocational content from all assessments is included.</p> <p>Person Responsible: Area Director Completion Date: 7/11/15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/11/2015	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902			
(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			
W 0240 Bldg. 00	<p>On 6/3/15 at 9:05am, an interview with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) was conducted. The QIDP/PD indicated clients #1, #2, and #3's ISPs and assessments did not include a work history, work skills, and/or their work interests.</p> <p>9-3-4(a)</p> <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 observation, record review, and interview, for 1 of 3 sampled clients (client #3) with adaptive equipment, the facility failed to develop guidelines for when client #3 should use her wheelchair.</p> <p>Findings include:</p> <p>On 6/2/15 from 5:40am until 7:55am, client #3 was observed at the group home. Client #3 sat on the sofa in the living room, was assisted to stand, pivot, and transfer into and from a wheelchair. During the observation period client #3 was pushed in her wheel chair throughout the group home.</p>	W 0240	<p>W240 The facility currently reviews all clients' needs at an annual Interdisciplinary Team Individual Support Plan and as needed throughout the year. The Comprehensive Functional Assessment within the Individual Support Plan is developed from information gleaned from assessments to determine the level of need of the client prior to developing a plan for all client developmental and behavioral needs.</p> <p>The Program Coordinator will work with the nurse to develop a set of guidelines for wheelchair use for Client #3. The staff at the residential home and staff at day program will be trained on the wheelchair guidelines for client # 3.</p>	07/11/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/11/2015	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902			
(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			
W 0331 Bldg. 00	<p>On 6/2/15 from 3:30pm until 5:15pm, client #3 was observed at the group home and did not use a wheel chair. During the observation periods client #3 was assisted by facility staff to walk to and from the living room, bathroom, bedroom, medication room, kitchen, and dining room.</p> <p>On 6/3/15 at 10:10am, client #3's record was reviewed. Client #3's 8/6/14 ISP (Individual Support Plan) indicated client #3 used a wheel chair for long distances. Client #3's record did not include guidelines for the use of the wheel chair.</p> <p>On 6/3/15 at 9:05am, an interview was conducted with the QIDP/PD. The QIDP/PD indicated client #3 used a wheel chair for long distances. The QIDP/PD indicated client #3's ISP did not contain guidelines for the use of her wheel chair. The QIDP/PD indicated no further information was available for review.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 1 of 4 clients (client #2)</p>	W 0331	<p>In the future the facility nurse will ensure that clients with adaptive equipment have the proper guidelines for equipment usage to direct staff as needed.</p> <p>Person Responsible: Program Director Completion Date: 7/11/15</p> <p>W 331 The facility assesses all clients for</p>	07/11/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/11/2015
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902		
(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>who had medications administered in the morning at the group home, the facility staff failed to follow the facility's policy and procedure for medication destruction for dropped medications.</p> <p>Findings include:</p> <p>On 6/2/15 at 6:38am, GHS (Group Home Staff) #2 selected client #2's medications which included "Doc Sod (Docusate Sodium) 100mg (milligrams)" for constipation medication, popped the medication into a medication cup, and handed the medication to client #2. Client #2 flipped the medication cup towards her mouth and the medication bounced against client #2's lips then fell to the floor.</p> <p>On 6/2/15 at 6:40am, client #2's 6/2015 MAR (Medication Administration Record) indicated "Doc. Sod. 100mg" for constipation.</p> <p>On 6/2/15 at 11:00am, an interview was conducted with the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) and the Residential Manager (RM). Both professional staff indicated client #2's pill was located under the dryer in the medication room. Both professional staff indicated the envelope with client #2's</p>		<p>medical needs monthly by nursing staff. The facility then provides clients with nursing services in accordance with their needs. The staff are trained to administer medication to the client upon hire and annually per facility policy and procedures.</p> <p>The Program Coordinator will retrain the staff on the procedures and policy to follow for medication destruction for dropped medication. The training will include the correct labeling format to include the client name, dosage, reason for medication needing destruction, the date, staff initials and directions that the medication needed to be destroyed.</p> <p>In the future, the facility nurse and Program Coordinator will check the medication administration records and medication cabinet at least weekly for pills needing to be disposed. The nurse will check the envelope and medication records to ensure the staff have correctly labeled the envelope with the proper information per policy.</p> <p>Person Responsible: Program Director Completion Date: 7/11/15</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/11/2015
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902		
(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	
W 0368	<p>Doc. Sod. capsule indicated the client's name and the name of the medication. The envelope did not include the dosage, the fact the medication was dropped, the date, or that the medication should be destroyed.</p> <p>On 6/3/15 at 11:30am, an interview with the agency nurse was conducted. The agency nurse indicated "staff were trained and should follow Core A/Core B Medication Training" for labeling dropped medications which were to be destroyed. The agency nurse indicated the facility staff should write the date, client's name, name of the medication, dosage, reason for the medication to be destroyed, that the medication should be destroyed, and the staff members initials.</p> <p>On 6/2/15 at 9:30am, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders. The Core A/Core B policy indicated the facility staff should follow the agency's policy.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/11/2015	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902			
(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			
Bldg. 00	<p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, for 1 of 4 sampled clients (client #1), the facility failed to administer medications without error and as prescribed by the client #1's personal physician.</p> <p>Findings include:</p> <p>On 6/2/15 at 12:00noon, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 1/1/2015 through 6/2/15 were reviewed and indicated the following medication error for client #1.</p> <p>-A 5/22/15 BDDS report for an incident on 5/22/15 at 7:00am indicated the facility "staff gave [client #1] another client's 7am meds (medications) this morning." The report indicated client #1 was given client #2's medications of "MV (Multi Vitamin), Nabumatone which is for arthritis, and loratadine which is for puritis (itching/allergies)."</p> <p>On 6/3/15 at 9:15am, client #1's record was reviewed. Client #1's 4/23/15 "Physician's orders" and 6/2015 MAR (Medication Administration Record) both did not indicate the medications of Multi Vitamin, Nabumatone, and loratadine.</p>	W 0368	<p>W 368</p> <p>The facility trains all staff upon hire to administer client medication per Core A and B Living in the Community state approved training. The facility maintains the medication administration record for each client per doctor's orders. All staff have been trained on the policy and procedures of medication administration plus documentation. The training includes checking the label on the medication against the Medication Administration Record three times prior to administering the medication to the client to prevent medication errors. The Program Coordinator will check the medication administration records and the daily support records at least weekly for accuracy. The Program Coordinator will observe a medication administration as least 2 times per week for one month. Program Coordinator will complete a weekly checklist listing any deficiencies in the documentation or medication errors. The weekly review will be reviewed, and signed off on by the Program Director each month.</p> <p>Person Responsible: Area Director, Completion Date: 7/11/15</p>	07/11/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/11/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902
---	---

(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 6/3/15 at 9:05am, an interview with PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted. PD/QIDP indicated staff should administer medications according to physician's orders. PD/QIDP indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders. PD/QIDP indicated client #1 was given a different client #2's medications on 5/22/15.</p> <p>On 6/3/15 at 11:30am, an interview with the agency LPN (Licensed Practical Nurse) was conducted. The LPN indicated staff should follow Core A/Core B Living in the Community medication administration training when administering medications. The LPN indicated staff should follow physician's orders to administer medications. The LPN indicated staff did not follow the training or physician's orders when client #1 was given client #2's medications on 5/22/15.</p> <p>On 6/3/15 at 9:05am, a review of the facility's 4/2011 Medication Administration Policy and Procedure was conducted. The policy and procedure indicated staff should administer client</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/11/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902
---	---

(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
W 0383 Bldg. 00	<p>medications according to physician's orders.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the facility staff failed to ensure the medication keys were kept secured and to ensure clients #1, #2, #3, #4, #5, #6, and #7 did not have access to the medication keys.</p> <p>Findings include:</p> <p>During observation on 6/2/15 from 5:40am until 7:55am at the group home, the medication room door was open and clients #1, #2, #3, #4, #5, #6, and #7 walked and accessed each area of the group home. From 7:00am until 7:55am, Group Home Staff (GHS) #1 administered medications and laid the medication keys on the desk between clients entering and exiting the medication room. GHS #1 left the medication room, and the medication keys were left behind on top of the desk.</p>	W 0383	<p>W383: The facility keeps all drugs and topical medications locked except when being prepared for administration. All staff have been trained to ensure the keys to the locked medication closet are secure on their person or in a location not attainable by the clients. In the future, the Program Coordinator will complete Medication Administration observations at least 2 times per week for one month. Thereafter, the Program Coordinator will observe once weekly to ensure the staff are following all the policy and procedures for medication administration.</p> <p>Responsible Staff: Program Director Completion Date: 7/11/15</p>	07/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/11/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902
---	---

(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>At 7:15am and at 7:25am, the Residential Manager (RM) picked up the keys two separate times and handed the keys each time to GHS #1. At 7:15am and at 7:25am, GHS #1 returned to the medication room, administered a different client's medication, GHS #1 left the medication room, and left the medication keys unsecured on top of the desk inside the medication room each time. At 7:45am, GHS #1 had the medication keys secured in her possession. GHS #1 indicated the medication keys were not kept secure on her person throughout the observation period and clients #1, #2, #3, #5, #6, and #7 had access to the keys when left on the desk top.</p> <p>On 6/3/15 at 11:30am, an interview was conducted with the LPN (Licensed Practical Nurse) and the QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director). The LPN and the QIDP/PD indicated the medication keys should not have been left unsecured on top of the desk inside the open medication room/laundry room. Both professional staff indicated clients #1, #2, #3, #4, #5, #6, and #7 had access to the unsecured medication keys. The LPN indicated the keys for the medication cart at the group home should be kept secured. The LPN indicated the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/11/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902
---	---

(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
W 0436 Bldg. 00	<p>facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 6/3/15 at 9:05am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications keys should be kept secured.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT 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 sampled clients (clients #1 and #3) with adaptive equipment, the facility failed to teach and encourage client #1's partial plate during the morning meal and client #3 to wear her prescribed eye glasses at the group home.</p> <p>Findings include:</p> <p>1. On 6/2/15 from 5:40am until 7:55am,</p>	W 0436	<p>W436</p> <p>The facility will 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>The Program Coordinator will train direct support professionals to implement the goal to ensure that Client 3 to wear the eyeglasses. In</p>	07/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/11/2015	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902			
(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 #1's partial plate was stored in the bathroom off the dining room inside a bowl of water on top of the sink counter. At 6:05am, client #1 did not have her partial plate inside her mouth. From 6:05am until 6:15am, client #1 consumed her regular consistency of food at the table without staff redirecting or providing teaching to wear her partial plate to chew food. At 7:15am, client #1 indicated she was not wearing her partial plate. Client #1 fed herself 1-2 two inch size bites of toast and cold cereal at a time before chewing the item.</p> <p>On 6/2/15 from 3:30pm until 5:15pm, client #1 wore her partial plate with teeth inside her mouth. At 5:00pm, client #1 sat down at the dining room table for supper and had regular diet consistency of food.</p> <p>On 6/3/15 at 9:15am, client #1's record was reviewed. Client #1's 11/18/14 and 4/30/13 Dental appointments indicated she had a partial plate to eat with.</p> <p>On 6/3/15 at 9:05am, an interview was conducted with QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director). The QIDP/PD indicated client #1 should have been taught and encouraged to wear her dental partial plate while eating.</p>		<p>addition the training will include informally cueing client #1 to wear her partial plate when eating and other opportunities. In the future, the Program Coordinator will complete a monthly review of programming goals to ensure goals are appropriate and being implemented by staff. The Program Coordinator will complete an active treatment observation twice weekly for 4 weeks to ensure the staff are encouraging clients to wear adaptive devices and to ensure the clients' needs are being met.</p> <p>Person Responsible: Program Director Completion Date: 7/11/15</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/11/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902
---	---

(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>2. On 6/2/15 from 5:40am until 7:55am and on 6/2/15 from 3:30pm until 5:15pm, client #3 did not wear her prescribed eye glasses at the group home. During the observation periods client #3 watched television, looked at magazines, completed writing on a sheet of paper, completed medication administration, and consumed meals. During the observation periods client #3 was not observed taught or encouraged to wear her prescribed eye glasses.</p> <p>On 6/3/15 at 10:10am, client #3's record was reviewed. Client #3's 8/6/14 ISP (Individual Support Plan) indicated client #3 wore prescribed eye glasses and did not include a goal/objective to teach client #3 to wear her eye glasses at the group home. Client #3's 8/20/14 visual examination indicated client #3 wore prescribed eye glasses to see.</p> <p>On 6/3/15 at 9:05am, an interview was conducted with the QIDP/PD. The QIDP/PD indicated client #3 did not wear her prescribed eye glasses during the observation periods and should have been taught and encouraged to wear her glasses.</p> <p>9-3-7(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/11/2015	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902			
(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			
W 0460 Bldg. 00	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview, and record review for 1 of 4 sampled clients (client #2), the facility failed to ensure client #2 received her specified mechanical soft diet as prescribed.</p> <p>Findings include:</p> <p>On 6/2/15 from 5:40am until 7:55am and on 6/2/15 from 3:30pm until 5:15pm, client #2 was observed at the group home and the Residential Manager (RM) pureed client #2's breakfast and supper meals in a blender. During both observation periods client #2's meals were served in individual serving bowls of a smooth texture and consistency. Client #2 consumed her smooth textured diet mixtures with a small coated spoon.</p> <p>Client #2's record was reviewed on 6/3/15 at 10:40am. Client #2's 7/2/14 ISP (Individual Support Plan) and 4/23/15 "Physician's Order" both indicated client #2 was prescribed a "Mechanical Soft Diet." Client #2's 4/1/15 Nutritional Assessment completed by the Registered Dietician indicated client #2 was to receive a "Mechanical</p>	W 0460	W 460 The facility follows diets for the clients based on doctor's and dietician recommendations. The facility trains all staff upon hire the diets of the clients and how to properly prepare each diet. All staff have been trained on the client diets and the procedures of preparation of those diets per order of the doctor. The training includes verifying the type of diet with the correct texture to the diet order per client. The Program Coordinator will complete a meal time observation to ensure the client diets are prepared according to the order. The Program Coordinator will complete observations two times weekly for 4 weeks. The Program Coordinator will document in the weekly checklist any deficiencies. The weekly review will be checked, and signed off on by the Program Director each month. Person Responsible: Area Director, Completion Date: 7/11/15	07/11/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/11/2015	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2715 ROCKFORD LN KOKOMO, IN 46902			
(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>Soft Diet."</p> <p>On 6/3/15 at 9:05am, an interview was conducted with the QIDP/PD. The QIDP/PD stated client #2 received "a pureed diet" during both observation periods on 6/2/15 and "should have" received a mechanical soft diet as prescribed.</p> <p>On 6/3/15 at 11:30am, an interview with the agency LPN (Licensed Practical Nurse) was conducted. The LPN indicated client #2 was prescribed a mechanical soft diet.</p> <p>9-3-8(a)</p>						