

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G318	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2560 GERMAN CHURCH RD INDIANAPOLIS, IN 46229
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W 000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: February 24, 25, and 26, 2015</p> <p>Surveyor: Tim Shebel, LSW</p> <p>Facility number: 000836 Provider number: 15G318 AIM number: 100243940</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/2/15 by Ruth Shackelford, QIDP.</p>	W 000		
W 104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the facility's governing body failed to exercise general operating direction over the facility by failing to assure a couch in the living room of the facility was in good repair for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and 4 of 4 additional clients (clients #5, #6, #7, and #8.)</p>	W 104	Home Manager will remove the couch that is not in good repair. A replacement couch has been ordered to accommodate the seating needs in the living area for the clients. Area Director completed a walk-through of the home and there were no other furniture items identified as not being in good repair Program Director will complete a monthly	03/28/2015

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.

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W 249 Bldg. 00	<p>Findings include:</p> <p>The group home where clients #1, #2, #3, #4, #5, #6, #7, and #8 resided was inspected during the 2/24/15 observation period from 3:49 P.M. until 6:00 P.M. A couch in the living room had cracked and peeled material and black marks on the cushions.</p> <p>House Manager #1 was interviewed on 2/25/15 at 6:52 A.M. House Manager #1 stated, "The couch is one of our old couches. We have a new one but haven't gotten rid of the old one (couch) yet."</p> <p>9-3-1(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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. Based on observation, record review, and interview, the facility failed to implement a dental hygiene objective for 1 of 1 sampled client with a dental hygiene</p>	W 249	<p>environmental checkof the home to identify any areas requiring mechanical or cosmetic repair. These items will be identified on the Supervisory visit form and submitted to the Area Director monthly. Any areas identified in poor repair will be sent via work order to maintenance. Responsible Party: Home Manager, Program Director and Area Director</p> <p>Program Director will retrain staff on the methodology for running client #2 dental hygiene goal to ensure it is completed per dental recommendation with the needed</p>	03/28/2015	

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	<p>objective (client #2).</p> <p>Findings include:</p> <p>Client #2 was observed at the group home during the 2/25/15 observation period from 5:49 A.M. until 7:30 A.M. During the observation period, direct care staff #7 prompted client #2 to brush his teeth. Client #2 retrieved his toothbrush and entered the bathroom. Client #2 exited the bathroom after 40 seconds and gave his toothbrush back to direct care staff #7. Direct care staff #7 did not observe client #2 brush his teeth or assure client #2 brushed his teeth correctly and for at least two minutes.</p> <p>Client #2's record was reviewed on 2/25/15 at 11:46 A.M. A review of the client's 5/15/14 dental exam indicated the following: "Pt (patient - client #2) should be assisted with brushing." Review of client #2's 10/3/14 Individual Program Plan indicated client #2 had the following dental hygiene objective: "[Client #2] is to brush his teeth for at least two minutes. [Client #2] is to follow all the correct steps (in brushing his teeth.)"</p> <p>Area Director #1 was interviewed on 2/25/15 at 12:44 P.M. Area Director #1 stated, "Staff (direct care staff) should have implemented (client #2's) objective</p>		<p>assistance required for effective skills training. Program Director will re-review with staff the methodology of all clients with dental hygiene goals. Home Manager will complete active treatment observation 3 times a week for 30 days surrounding goal training to ensure they are completed per requirement. Ongoing, Home Manager will complete observations per established frequency. Responsible Party: Program Director, Home Manager</p>	

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W 369 Bldg. 00	<p>as it was written."</p> <p>9-3-4(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview, the facility failed to assure 1 of 10 administered medications were administered according to physician's orders for 1 of 4 additional clients (client #8).</p> <p>Findings include:</p> <p>Client #8 was observed during the group home observation period on 2/24/15 from 3:49 P.M. until 6:00 P.M. At 4:50 P.M., direct care staff #2 administered a 1 mg (milligram) tablet of Folic acid (nutritional supplement). Direct care staff #2 did not give or prompt client #8 to eat some food after administering the folic acid tablet to client #8. Client #8 did not eat anything during the observation period.</p> <p>Client #8's record was reviewed on</p>	W 369	<p>Program Nurse will retrain staff on administering client #8 medications that requires food to be taken with administering. Program Nurse will retrain staff on following clients' physician orders as written Home Manager will complete medication administration observations on a rotation until all staff have been observed passing medications per regulation. Ongoing, Home Manager will complete medication administration observations per established frequency. Responsible Party: Program Nurse, Home Manager</p>	03/28/2015

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W 376 Bldg. 00	<p>2/25/15 at 7:16 A.M. Review of client #8's 1/15/15 physician's orders indicated the following order: "Folic Acid 1 mg tablet, take one tablet by mouth once daily with food."</p> <p>Area Director #1 was interviewed on 2/25/15 at 12:44 P.M. Area Director #1 stated, "[Client #8's] Folic acid should have been administered according to his physician's orders."</p> <p>9-3-6(a)</p> <p>483.460(k)(8) DRUG ADMINISTRATION The system for drug administration must assure that drug administration errors and adverse drug reactions are reported immediately to a physician. Based on record review and interview, the facility failed to have evidence of immediately reporting a medication error to the physician for 1 of 4 sampled clients (client #4).</p> <p>Findings include: The facility's records were reviewed on 2/24/15 at 12:37 P.M. A review of incident reports from 4/1/14 to 2/24/15</p>	W 376	Nursing supervisor retrained the Program Nurse on 3.11.15 on documentation requirements; including noting consumer follow-up and resolutions in nursing notes and monthlies summaries. Medical Monthly Summaries will be given and reviewed by the Program Director for signature when filed in the consumers' nursing book. Program Director will also document on the Incidentreporting Quality	03/28/2015

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W 455 Bldg. 00	<p>indicated the following medication error:</p> <p>"Date: 10/02/2014, Name: [Client #4], Narrative: [Client #4] received another client's 8 pm medications on 10/02/14. [Client #4] was monitored and her vitals were taken every two hours throughout the night per group home nurse request. [Client #4] did not show any reactive side effects from the medication error." Further review of the 10/2/14 medication error report failed to indicate the client's physician was immediately notified of the medication error.</p> <p>Nurse #1 was interviewed on 2/25/15 at 7:21 A.M. When asked if client #4's physician was notified of the 10/2/14 medication error, nurse #1 stated, "No, I have no documentation to show that I contacted [client #4's] physician about the med (medication) error."</p> <p>9-3-6(a)</p> <p>483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview, the facility failed to assure direct care staff removed soiled gloves prior to</p>	W 455	<p>Management and medical follow up resulting from a BDDsreportable incident. Responsible Party: Nursing Supervisor, Program Director Program Nurse</p> <p>Program Nurse will retrain staff on infection control related to medication administration procedures in between</p>	03/28/2015			

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	<p>administering medications for 1 of 4 additional clients (client #8).</p> <p>Findings include:</p> <p>Client #8 was observed during the 2/24/15 group home observation period from 3:49 P.M. until 6:00 P.M. During the observation, direct care staff #2 had put on sterile gloves to administer medications to client #8. While preparing client #8's medications for administration, direct care staff #2 removed the paper covering from a drinking straw and put it in the trash can. After putting the paper cover in the trash can, direct care staff #2 used her gloved hand to push the trash down to the bottom of the trash can. Direct care staff #2 continued to administer client #8's medications without removing the soiled gloves from her hands.</p> <p>Area Director #1 was interviewed on 2/25/15 at 12:44 P.M. Area Director #1 stated, "Staff (direct care staff #2) should have changed gloves before continuing with medication administration."</p> <p>9-3-7(a)</p>		<p>administering medications to the consumers. Home Manager will complete medication administration observations on a rotation until all staff have been observed passing medications per regulation. Ongoing, Home Manager will complete medication administration observations per established frequency. Responsible Party: Program Nurse, Home Manager</p>	