

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G712	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2014
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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8337 N COLLEGE AVE INDIANAPOLIS, IN 46240
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W000000	<p>This visit was for a pre-determined full annual recertification and state licensure survey.</p> <p>Dates of Survey: 10/28/14, 10/29/14, 10/30/14, 11/3/14 and 11/5/14.</p> <p>Facility Number: 001089 Provider Number: 15G712 AIMS Number: 100239940</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed November 10, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000104	<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 record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the governing body failed to exercise</p>	W000104	The Home Manager and Program Director will complete an audit of all consumers finances, to determine if anyone's account	12/05/2014

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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	<p>general policy, budget and operating direction over the facility to ensure clients #1, #2, #3 and #4's personal finances were not in excess of the predetermined maximum amount allowed by Medicaid.</p> <p>Findings include:</p> <p>1. Client #1's financial record was reviewed on 10/29/14 at 2:37 PM. Client #1's facility based cluster account dated 8/14/14 through 10/29/14 indicated an ending balance of \$2,508.79. Client #1's personal community based checking account ledger dated 8/14/14 through 10/29/14 indicated an ending balance of \$672.71. The review indicated client #1's personal finances/resources exceeded \$2,000.00.</p> <p>2. Client #2's financial record was reviewed on 10/29/14 at 2:40 PM. Client #2's facility based cluster account dated 7/1/14 through 10/29/14 indicated an ending balance of \$2,643.88. The review indicated client #2's personal finances/resources exceeded \$2,000.00.</p> <p>3. Client #3's financial record was reviewed on 10/29/14 at 2:45 PM. Client #3's facility based cluster account dated 7/1/14 through 10/29/14 indicated an ending balance of \$1,724.62. Client #3's</p>		<p>balance is in excess of the allowable amount. If any consumers account balances are in excess of the allowable amount the Home Manager and Program Director will work with the Social Worker and Client Finance Specialist to spend the money in an appropriate manner to get the balance below the allowable amount.</p> <p>The Home Manager and Program Director will receive retraining on consumers' finances including ensuring that all consumers' accounts are below the allowable amount.</p> <p>Ongoing the Client Finance Specialist will provide a record monthly to the Area Director of all consumers that have an account balance in excess of the allowable amount. The Area Director will ensure that the Program Director and Home Manager are notified so they can work with the Social Worker and Client Finance Specialist to spend the money in an appropriate manner to get the balance below the allowable amount.</p> <p>Responsible Party: Home Manager, Program Director, Area Director, Client Finance Specialist</p>	

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W000154	<p>personal community based checking account ledger dated 8/14/14 through 10/29/14 indicated an ending balance of \$909.59. The review indicated client #3's personal finances/resources exceeded \$2,000.00.</p> <p>4. Client #4's financial record was reviewed on 10/29/14 at 2:50 PM. Client #4's facility based cluster account dated 7/1/14 through 10/29/14 indicated an ending balance of \$3,003.55. The review indicated client #4's personal finances/resources exceeded \$2,000.00.</p> <p>AD (Area Director) #1 was interviewed on 10/29/14 at 2:15 PM. AD #1 indicated the maximum amount predetermined by Medicaid for client finances/resources was \$2,000.00.</p> <p>9-3-1(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 2 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed, the facility failed to complete a thorough investigation regarding client #1's pneumonia.</p>	W000154	The Program Director will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough	12/05/2014

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	<p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 10/28/14 at 3:00 PM. The review indicated the following:</p> <p>-BDDS report dated 5/3/14 indicated, "On 5/2/14, about 5:00 PM in the afternoon, [client #1's] father picked him up from the group home, (sic) for a family visit. It was reported back at the group home, by the father that he had taken [client #1] to the ER (Emergency Room) because he felt that something was wrong with [client #1]. The staff reported this to his supervisor and the group home nurse was notified. At the hospital, [client #1] was accessed (sic) by the medical staff. [Client #1] was admitted to the hospital for pneumonia. [Client #1] was intubated and (a) CAT scan (diagnosis tool) completed. Test results showed his left lung only functioning at 30 percent. [Client #1] was sent to surgery where CV tube was inserted into his central line and a chest tube was inserted."</p> <p>-Investigation dated 5/6/14 indicated HM (Home Manager) #1 and RN (Registered Nurse) #1 were interviewed. The</p>		<p>investigation can be completed.</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 Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director</p>	
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W000214	<p>investigation did not indicate documentation of additional staff, clients or client #1's father being interviewed to determine if signs and symptoms of illness were present and/or addressed.</p> <p>AD (Area Director) #1 was interviewed on 10/29/14 at 2:15 PM. AD #1 indicated client #1 could verbally express pain and report illness. AD #1 indicated client #1 had attended day services prior to his 5/2/14 incident. AD #1 indicated there was not additional documentation of interviews being conducted with day service staff, group home staff working with client #1, client #1's housemates, client #1 or client #1's father to determine if signs and symptoms of illness were present and/or addressed. AD #1 indicated investigations of alleged neglect should be thorough.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. Based on record review and interview for 1 of 4 sampled clients (#4), the facility failed to re-assess/identify client #4's specific behavior management needs</p>	W000214	Program Director will work with Behavior specialist to complete an assessment to determine if any specific behavior management needs are	12/05/2014

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	<p>regarding physical aggression.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 10/29/14 at 8:46 AM. Client #4's BPRNN (Behavior Progress Report Narrative Notes) dated 1/23/14 indicated, "[Client #4] attempted hitting a female staff in the kitchen area. [Client #4] was verbally redirected to his room by another staff for yelling and calling staff names and saying [expletive] you! [Client #4] was calm. [Client #4] came into the kitchen and became very physical with staff. [Client #4] was PIA (physical management technique) (sic) for hitting staff and been (sic) physical." Client #4's BPRNN dated 8/26/14 indicated, "[Client #4] was preparing for afternoon shower. [Client #4] was yelling at another staff that he would kill her. [Staff #1] spoke with [client #4] to apologize (sic). [Client #4] threw glasses and broke them and spat on [staff #1] and other staff. [Client #4] proceeded to attack [staff #1]. Stopped him from attacking restrained and bagged off (sic)." Client #4's BSP (Behavior Support Plan) dated 9/2014 indicated, "The recommendations and instructions which follow are designed to reduce the occurrence of concerning behaviors and increase abilities that will further reduce the likelihood of these</p>		<p>appropriate to add to Client #4 Behavior support Plan. Client #4 Behavior Support Plan will be updated as needed. Staff will receive retraining on any changes to Client #4 Behavior Support Plan.</p> <p>Staff will receive retraining to ensure they are tracking all consumers' behaviors, targeted and not targeted to determine if any changes to the Behavior Support plan need to be made. The Program Director will receive retraining to include ensuring that all new behaviors are tracked and assessed to determine if any changes/updates to consumers Behavior Support Plans need to be made.</p> <p>Ongoing, the Program Director and Behavior Specialist will review Behavior tracking sheets a minimum of twice monthly to note if any new behaviors are present and assess to determine if any changes/updates to consumers Behavior Support Plans need to be made.</p> <p>Responsible Party, Home Manager, Program Director, Behavior Specialist</p>				

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W000331	<p>concerns. This plan will be revised in accordance with changes in circumstances, needs, and progress." Client #4's BSP did not indicate documentation of assessment, recommendations or revisions regarding client #4's physical aggression.</p> <p>PD (Program Director) #1 was interviewed on 10/29/14 at 1:28 PM. PD #1 indicated physical aggression was not a targeted behavior for reduction in client #4's 9/2014 BSP. PD #1 indicated the behavior consultant should assess client #4's incidents of physical aggression to determine if recommendations or revisions were needed to specifically address client #4's behavioral needs.</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 record review and interview for 1 of 4 sampled clients (#1), the facility nurse failed to met the health needs of client #1.</p> <p>Findings include:</p>	W000331	<p>Program Nurse will receive retraining to include ensuring that all clients receive all necessary assessments for all medical needs within the first 30 days following admission. Program Nurse will receive retraining to include ensuring that all recommendations for follow up</p>	12/05/2014

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	<p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 10/28/14 at 3:00 PM. The review indicated the following:</p> <p>-Investigation dated 5/6/14 narrative interview with RN (Registered Nurse) #1 indicated, "[RN #1] stated when [client #1] was admitted (9/4/13) he had a homemade CPAP machine that his father made him. [RN #1] said [client #1's] father was informed [client #1] could not use the machine as there was no order, it was not regulated and did not provided (sic) information needed on its use from the attending physician. [RN #1] said [client #1] had a sleep study, which he had not ever received (sic) (results) in February 2014."</p> <p>Client #1's record was reviewed on 10/29/14 at 12:04 PM. Client #1's medical appointment form dated 2/12/14 indicated client #1 was seen by his PCP (Primary Care Physician) for assessment of sleep apnea. Client #1's medical appointment form dated 2/13/14 indicated client #1 had completed a sleep study to be assessed for sleep apnea. Client #1's medical appointment form dated 4/1/14 indicated client #1 had received a CPAP machine for treatment of obstructive sleep apnea. Client #1's</p>		<p>from any medical appointments are reviewed, scheduled and/or completed as needed as soon as possible after the medical appointment.</p> <p>Ongoing, the Program Nurse will review all consumers' medical appointment forms within 48 hours of the appointment to determine if any follow up treatment is needed. If any follow up is needed the Program nurse will work with the Home Manager and/or Program Director to ensure that appointments are scheduled, medications are ordered, etc.</p> <p>Responsible Party: Program Nurse, Home manager, Program Director</p>	

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W009999	<p>record did not indicate documentation of assessment or PCP evaluation of client #1's sleep apnea needs from his date of admission on 9/4/13 through 2/12/14.</p> <p>RN #1 was interviewed on 10/29/14 at 1:55 PM. RN #1 indicated client #1 was assessed for sleep apnea on 2/12/14.</p> <p>9-3-6(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division...</p> <p>(19) Use of any physical or manual restraint regardless of: (a) planning; (b) human rights committee approval; (c) informed consent.</p> <p>This state rule was not met as evidenced by:</p>	W009999	<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>Program Director will receive retraining to include ensuring that all reportable incidents are documented and BDDS reports are filed within 24 hours of knowledge of the incident.</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</p>	12/05/2014

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	<p>Based on record review and interview for 2 of 2 incidents of use of physical restraint reviewed, the facility failed to immediately notify the BDDS (Bureau of Developmental Disabilities Services) within 24 hours in accordance with state law regarding 2 incidents of physical restraints being used on client #4.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 10/29/14 at 8:46 AM. Client #4's BPRNN (Behavior Progress Report Narrative Notes) dated 1/23/14 indicated, "[Client #4] attempted hitting a female staff in the kitchen area. [Client #4] was verbally redirected to his room by another staff for yelling and calling staff names and saying [expletive] you! [Client #4] was calm. [Client #4] came into the kitchen and became very physical with staff. [Client #4] was PIA (physical management technique) (sic) for hitting staff and been (sic) physical." Client #4's BPRNN dated 8/26/14 indicated, "[Client #4] was preparing for afternoon shower. [Client #4] was yelling at another staff that he would kill her. [Staff #1] spoke with [client #4] to apologize (sic). [Client #4] threw glasses and broke them and spat on [staff #1] and other staff. [Client #4] proceeded to attack [staff #1].</p>		<p>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 Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of twice weekly for 30 days to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines. After the 30 days, the Home Manager and/or Program Director will review the DSRs and Behavior tracking records a minimum of once per week to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, Program Director and/or Area Director within the designated reporting guidelines.</p> <p>Responsible Party: Home Manager, Program Director</p>	

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	<p>Stopped him from attacking restrained and bagged off (sic)."</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 10/28/14 at 3:00 PM. The review did not indicate documentation of client #4's 1/24/14 or 8/26/14 incidents involving the use of physical restraint techniques by facility staff being reported to the BDDS.</p> <p>PD (Program Director) #1 was interviewed on 10/29/14 at 1:28 PM. PD #1 indicated the use of physical restraints should be reported to the BDDS within 24 hours.</p> <p>9-3-1(b)</p>				