

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G433		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/22/2013	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3938 PRANGE AVE LAFAYETTE, IN 47905			
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W000000	<p>This visit was for a PCR (Post Certification Revisit) to the investigation of complaint #IN00136427 completed on 9/26/13.</p> <p>Complaint #IN00136427: Not Corrected.</p> <p>Dates of Survey: November 21, and 22, 2013.</p> <p>Facility Number: 000947 Provider Number: 15G433 AIMS Number: 100244580</p> <p>Surveyors: Susan Eakright QIDP-TC Amber Bloss QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed December 2, 2013 by Dotty Walton, QIDP.</p>	W000000					

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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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (client C), the facility failed to provide sufficient staff to supervise and to implement client C's Individual Support Plan (ISP) and Behavior Support Plan (BSP).</p> <p>Findings include:</p> <p>Observations were conducted on 11/21/13 from 2:00pm until 3:15pm, and on 11/21/13 from 3:30pm until 5:12pm. On 11/21/13 at 4:00pm, the van with clients B, C, and H arrived at the group home with one (1) Group Home Staff (GHS #2). From 4:00pm until 4:30pm, clients B and H were assisted from the van to inside the group home and client C was left locked inside the van alone. From 4:00pm until 4:30pm, client C unlatched his seat belt, crawled over the van seat, and hit the van windows with his hands without staff redirection. At 4:30pm, GHS #1</p>	W000186	W 189:The facility provides sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. The facility schedules direct support staff per licensure of home in two week increments to ensure appropriate supervision of the clients in the home.The written schedule in the home provided a total of four direct support staff to supervise the clients. Due to miscommunication all four staff did not report to work at the appropriate time. The Home Manager will re-train the staff to follow the appropriate shift coverage system to alert the supervisor in the future to ensure that there is always sufficient numbers of staff in the home. The home manager will train all staff on Client C Behavioral support plan, Individual Support Plan and Supervision Protocol including the Physical Intervention Alternative section in the Plan. In addition the home manager will review the protocol for van transport of the clients to ensure	12/22/2013	

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	<p>entered the group home, located GHS #2, obtained the keys to the van, and GHS #1 assisted client C from the van. At 5:00pm, the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) indicated there were to be three staff on duty to complete the transporting of clients from the facility day services location to the group home. The PD/QIDP indicated two group home staff should have been on the van with client C and stated client C was "one on one staff supervision at all times" when client C was awake because of client C's SIB (Self Injurious Behavior) and physically aggressive behaviors.</p> <p>Client C's records were reviewed on 11/21/13 at 11:03am. Client C's record and 9/18/13 ISP (Individual Support Plan) and 9/21/13 BSP (Behavior Support Plan) both indicated client C had SIB of banging his head and physical aggression.</p> <p>Client C's 9/21/13 Behavior Support Plan (BSP) indicated client C's behaviors included resistance, temper outbursts, property destruction, physical assault and self-injurious behavior (SIB). The BSP indicated, "...[Client C] knows how to appropriately get attention, but he seems to have learned</p>		<p>that no clients are left without a staff present while the client is in the vehicle. To ensure adequate supervision, in the future, the home manager will complete the schedule in advance with Program Director input. The facility home manager will observe daily in the home. Additionally, observations by other supervisory staff will implement three observations completed per week to ensure adequate supervision of the clients and implementation of client's plans Completion Date: 12/22/13 Persons Responsible: Area Director, Program Director, Home Manager</p>				

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	<p>that the most reliable way to get attention is to have behavior problems..." The BSP indicated with the behaviors of physical assault, property destruction, SIB and temper outbursts staff were to, "Immediately implement the Area Restriction Procedure. If [client C's] behavior requires physical containment, also use the Compliance Testing Procedure." Client C's 9/21/13 BSP indicated client C "will have 1:1 (one on one) supervision due to his behavior of self injurious behavior and physical assault...The staff responsible for being [client C's] 1:1 will wear a lanyard (identification on a necklace) to indicate they are [client C's] staff...The staff must be within 12" (twelve inches) of [client C] when he is awake. Staff should be able to intervene immediately should [client C] start to have a behavior...."</p> <p>On 11/21/13 at 5:00pm, an interview was conducted with the PD/QIDP. The PD/QIDP indicated client C had SIB behaviors. The PD/QIDP stated client C should have had staff supervision "within twelve inches" of his person when client C was awake. The PD/QIDP stated client C should not have been transported on the facility van with other clients and "just one staff person." The PD/QIDP indicated client</p>						

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W000249	<p>C should not have been left alone locked on the van. The PD/QIDP indicated the facility staff failed to implement client C's BSP and ISP to supervise client C. The PD/QIDP indicated the facility failed to ensure client C had one on one supervision while client C was awake.</p> <p>This federal tag relates to complaint #IN00136427.</p> <p>This deficiency was cited on 09/26/2013. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(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 for 1 of 4 sampled clients (client C) to implement client C's Individual Support Plans (ISP) and Behavior Support Plan (BSP) as written.</p> <p>Findings include:</p>	W000249	W249: The facility currently meets with the client Interdisciplinary team to formulate an individual program plan. The group home staff are trained to implement all treatment program goals to support achievement by the specific client of such goals. The home manager will train all staff on Client C Behavioral	12/22/2013

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	<p>Observations were conducted on 11/21/13 from 2:00pm until 3:15pm, and on 11/21/13 from 3:30pm until 5:12pm. During both observations client C was not encouraged to use sign language and/or a communication book to communicate his wants/needs.</p> <p>On 11/21/13 from 2:00pm until 3:15pm, client C's one on one staff person did not wear identification to identify herself as client C's one on one staff person.</p> <p>On 11/21/13 at 4:00pm, the van with clients B, C, and H arrived at the group home with one (1) Group Home Staff (GHS #2). From 4:00pm until 4:30pm, clients B and H were assisted from the van to inside the group home and client C was left locked inside the van alone. From 4:00pm until 4:30pm, client C unlatched his seat belt, crawled over the van seat, and hit the van windows with his hands without staff redirection. At 4:30pm, GHS #1 entered the group home, located GHS #2, obtained the keys to the van, and GHS #1 assisted client C from the van.</p> <p>At 5:00pm on 11/21/13, The PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) indicated there were to be three staff on duty to</p>		<p>support plan, Individual Support Plan and Supervision Protocol including the Physical Intervention Alternative section in the Plan. The training will emphasize communication goal with staff formal and informal communication with client C using a communication book. In addition the home manager will review the protocol for van transport of the clients to ensure that no clients are left without a staff present while the client is in the vehicle. . 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 active treatment daily. The Program Director will audit active treatment by observation three times weekly to ensure clients receive training opportunities with guidance of written client plans. Responsible Person: Area Director Completion Date: 12/22/13</p>		

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	<p>complete the transporting of clients from the facility day services location to the group home. The PD/QIDP indicated two group home staff should have been on the van with client C and stated client C was "one on one staff supervision at all times" when client C was awake because of client C's SIB (Self Injurious Behavior) and physically aggressive behaviors.</p> <p>Client C's records were reviewed on 11/21/13 at 11:03am. Client D's record and 9/18/13 ISP (Individual Support Plan) both indicated client C was non-verbal, non-ambulatory, and wore a helmet to protect his head from SIB (Self Injurious Behaviors). Client C's 9/18/13 ISP indicated a goal/objective to use a communication book to indicate a picture and sign the meaning of the picture. Client C's 9/21/13 BSP (Behavior Support Plan) indicated client C had SIB of banging his head and physical aggression.</p> <p>Client C's 9/21/13 Behavior Support Plan (BSP) indicated client C's behaviors included resistance, temper outbursts, property destruction, physical assault and self-injurious behavior (SIB). The BSP indicated, "...[Client C] knows how to appropriately get attention, but he seems to have learned</p>						

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	<p>that the most reliable way to get attention is to have behavior problems..." The BSP indicated with the behaviors of physical assault, property destruction, SIB and temper outbursts staff were to, "Immediately implement the Area Restriction Procedure. If [client C's] behavior requires physical containment, also use the Compliance Testing Procedure." Client C's 9/21/13 BSP indicated client C "will have 1:1 (one on one) supervision due to his behavior of self injurious behavior and physical assault...The staff responsible for being [client C's] 1:1 will wear a lanyard (identification on a necklace) to indicate they are [client C's] staff...The staff must be within 12" (twelve inches) of [client C] when he is awake. Staff should be able to intervene immediately should [client C] start to have a behavior...."</p> <p>On 11/21/13 at 5:00pm, an interview was conducted with the PD/QIDP. The PD/QIDP indicated client C had SIB behaviors and needed to wear a helmet to protect himself from injury. The PD/QIDP indicated client C was non verbal and was to use sign to communicate. The PD/QIDP indicated not all of the facility staff had the skill to use sign language. The PD/QIDP indicated client C had a communication</p>						

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W000289	<p>book and indicated client C's communication book could not be located at this time. The PD/QIDP stated client C should have had staff supervision "within twelve inches" of his person when client C was awake. The PD/QIDP indicated the staff should have worn a lanyard to identify themselves as client C's one on one assigned staff person. The PD/QIDP indicated the facility staff failed to implement client C's BSP and ISP as written.</p> <p>This federal tag relates to complaint #IN00136427.</p> <p>This deficiency was cited on 09/26/2013. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a) 483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on record review and interview, for 1 of 2 sampled clients (client A) who had restrictive techniques employed, the facility failed to clearly define the</p>	W000289	W 289: The facility currently utilizes the use of systematic interventions to manage inappropriate client behavior as needed per client. The interventions are incorporated	12/22/2013	

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	<p>specific techniques utilized in client A's Behavior Support Plan (BSP).</p> <p>Findings include:</p> <p>Client A's records were reviewed on 11/21/13 at 11:45am. Client A's 11/7/12 ISP (Individual Support Plan) and 10/31/13 BSP (Behavior Support Plan) indicated client A's behaviors included resistance, outbursts, inappropriate nudity, and takes other persons items without permission. The BSP and undated Protocol indicated "...The staff must stay next to [client A] and use her gait belt when she is ambulating. Staff should verbally prompt her to use her wheelchair or walker when moving around the house...If [client A] should start to fall, staff should use approved PIA (Physical Intervention Alternative) moves to keep her from falling...." The plan failed to indicate and define specifically what PIA techniques were to be used.</p> <p>On 11/21/13 at 5:00pm, an interview was conducted with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional). The PD/QIDP indicated client A's BSP and Protocol did not state and/or define the specific techniques used for client A.</p>		<p>into the client's individual program plan by the behavioral specialist. The behavior consultant has revised the behavior support plan for client A. This includes more specific guidelines related to specifically how to address self abusive behaviors, and a revised protocol for client A. The protocol also specifies which, specific techniques should be used if needed using Physical Intervention Alternatives, program. The home manager will retrain the direct support staff, to utilize the revision of the behavior support plan for client A. The specific use of physical intervention is outlined in the behavior plan. In the future, the facility will ensure the behavior plans specifically state what techniques the staff will implement when following the behavior plan of all clients. The home manager will review the behavior plans of client monthly to ensure the plans are clear and suited to the client. The home manager will observe daily. The Program Director will observe in the home three times weekly to ensure the staff are following the techniques written in the client behavior plans. Completion Date: 12/22/13 Persons Responsible: Area Director, Program Director, Home Managers</p>		

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W000436	<p>This federal tag relates to complaint #IN00136427.</p> <p>This deficiency was cited on 09/26/2013. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-5(a)</p> <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 sample clients (clients C and D) who used adaptive equipment, the facility failed to ensure adaptive equipment was available and functional.</p> <p>Findings include:</p> <p>1. During observations on 11/21/13 from 2:00pm until 3:15pm, and on 11/21/13 from 3:30pm until 5:12pm, client D sat in his wheelchair with his head bent over during the entire observation periods. Client D's shoulders did not touch the back of the wheelchair and his head did not touch</p>	W000436	<p>W436 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. The facility had in place the appropriate equipment of a Hoyer lift for client D. The Program Director will retrain the day program staff on the use of client D's Hoyer lift and transfer protocol. The Program Director has scheduled wheelchair repair for client's D and C wheelchairs. The program director replaced the cracked helmet at the time of the survey. Client C has been</p>	12/22/2013			

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	<p>the headrest. Client D was non verbal and did not communicate his wants/needs to staff. No communication system was observed available for facility staff to use to communicate with client D.</p> <p>During observations on 11/21/13 from 2:00pm until 3:15pm, client D sat in his wheelchair and his shoulders did not touch the back of the wheelchair. At 2:50pm, client D began to hit and slap the top of his lap tray on his wheelchair. Client D began to scream, cry, and the staff were unable to comfort him. At 2:50pm, two staff wheeled client D into the movie room at the facility owned day program, one staff lifted client D's legs and one staff lifted client D under his arms, and the two staff transferred client D onto a floor mat inside the room. From 2:50pm until 3:15pm, client D laid on the mat with facility staff, and cried, screamed, and yelled. At 3:10pm, Workshop Staff (WKS) #1 stated she was not sure what client D was upset about and "it's hard because he doesn't talk." WKS #1 indicated staff transfer client D back and forth from his wheelchair and the day service does not have a Hoyer Lift available. WKS #1 indicated client D was non verbal and did not have a communication system to communicate his wants and needs.</p>		<p>wearing the new helmet. The Program director will train residential and day program staff on the newly written communication goal for Client D. In the future, The Home Manager will ensure the staff check the client adaptive equipment on a weekly basis to ensure good working order. The home manager will immediately schedule and order repairs as needed. The Program Director will review all client goals monthly to ensure implementation and monitor the progress of the client. Person Responsible: Area Director Completion Date: 12/22/13</p>		

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	<p>Client D's records were reviewed on 11/21/13 at 10:37am. Client D's record and 2/20/13 ISP (Individual Support Plan) both indicated client D was admitted on 01/26/13, was non-verbal, non-ambulatory, and used a wheelchair for transportation. Client D's 9/16/13 "Risk Plan" indicated client D was at risk for falls and client D "staff should always use the Hoyer Lift" to transfer client D into and out of his wheelchair. Client D's Risk Plan indicated he was non verbal and did not indicate a communication system for client D to communicate his wants/needs. A Medical Appointment Form dated 07/4/13 indicated client D was assessed and fitted for a different wheelchair.</p> <p>On 11/21/13 at 5:00pm, an interview was conducted with the Program Director (PD). The PD indicated client D's wheelchair did not fit him properly and he bent forward, his shoulders did not touch the back of his chair and his head did not touch the headrest. She indicated he had not received his new wheelchair. The PD indicated client D's wheelchair was on order. The PD indicated client D did not have a communication system to communicate his wants/needs to staff. The PD indicated she was not aware the facility</p>			

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(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>owned day service did not have a Hoyer Lift.</p> <p>2. During observations on 11/21/13 from 2:00pm until 3:15pm, and on 11/21/13 from 3:30pm until 5:12pm, client C sat in his wheelchair. Both wheelchair right and left arm rests had the padding and finish torn away which exposed bare metal against client C's skin. Client C's helmet was ripped, torn, and moved loosely on his head. During both observations client C was not encouraged to use sign language and/or a communication book to communicate his wants/needs.</p> <p>Client C's records were reviewed on 11/21/13 at 11:03am. Client D's record and 9/18/13 ISP (Individual Support Plan) both indicated client C was non-verbal, non-ambulatory, wore a helmet to protect his head from SIB (Self Injurious Behaviors), and used a wheelchair for transportation. Client C's 9/18/13 ISP indicated a goal/objective to use a communication book to indicate a picture and sign the meaning of the picture. Client C's 9/21/13 BSP (Behavior Support Plan) indicated client C had SIB of banging his head and physical aggression. Client B's BSP indicated he wore a helmet to protect his head from injuries during his identified</p>						

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	<p>behaviors. Client C's 9/18/13 Risk Plan indicated client C was at risk for falls. Client C's Risk Plan indicated he was non verbal, used a wheelchair, and did indicate client C should use sign language and/or a communication book to communicate his wants/needs to facility staff.</p> <p>On 11/21/13 at 5:00pm, an interview was conducted with the Program Director (PD). The PD indicated client C's wheelchair did not fit him properly. The PD indicated client C's helmet was ripped, torn, and did not fit him properly. The PD indicated client C had SIB behaviors and needed to wear a helmet to protect him from injury. The PD pulled a new helmet from a box and gave it to client C to replace his ripped, torn, and loose fitting helmet. The PD indicated client C had not received his new wheelchair. The PD indicated client C's wheelchair was on order since July, 2013. The PD indicated client C was non verbal and was to use sign to communicate. The PD indicated not all of the facility staff had the skill to use sign language. The PD indicated client C had a communication book and indicated client C's communication book could not be located at this time.</p> <p>This federal tag relates to complaint</p>			
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	#IN00136427. This deficiency was cited on 09/26/2013. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-7(a)				