

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G466	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/08/2012
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1926 W 75TH PL INDIANAPOLIS, IN 46260		
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W0000	<p>This visit was for the PCR (Post Certification Revisit) for the investigation of complaint #IN00112797 which had resulted in Immediate Jeopardy, completed on 8/24/12.</p> <p>This visit was done in conjunction with a predetermined full annual recertification and state licensure survey.</p> <p>Complaint #IN00112797: Not corrected.</p> <p>Dates of Survey: 10/1/12, 10/2/12, 10/3/12 and 10/8/12.</p> <p>Facility Number: 000980 Provider Number: 15G466 AIMS Number: 100244620</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed October 15, 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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W0104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 3 of 3 sampled clients (A, B and C) plus three additional clients (D, E and F), the governing body failed to exercise general policy, budgeting and operating direction over the facility to ensure clients A and B's finances were not in excess of predetermined maximum amounts allowed by Medicaid. The governing body failed to exercise general policy, budgeting and operating direction over the facility to assure a full and complete accounting of client's A, B, C, D, E, and F's finances and failed to reimburse missing funds (clients D, E, and F). The governing body failed to exercise general policy, budgeting and operating direction over the facility by failing to ensure their nursing services provided clients B and C with necessary adaptive equipment and training/methodologies in their program plans.</p> <p>Findings include:</p> <p>1. Client A's financial record was reviewed on 10/2/12 at 11:48 AM. Client A's facility based cluster account ledger, kept by administrative staff in the agency office, dated 8/20/12 through 10/2/12</p>	W0104	<p>1. The Home Manager and Program Director will complete an audit of all consumers finances, to determine if anyone's account 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>2. The Home Manager and Program Director will complete an audit of all consumers finances to ensure that petty cash ledgers are updated and maintained for all clients.</p> <p>3. Paperwork has been completed for Client D, E and F to get reimburse for missing funds. Area Director will follow up with Accounting Department to check on the status of consumers getting reimbursed for missing money.</p> <p>The Home Manager and Program Director will receive retraining on consumers finances including ensuring that all consumers</p>	11/07/2012			

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	<p>indicated the following:</p> <p>-8/20/12, RBW (Room and Board Withdrawal), \$28.00 with an ending balance in the amount of \$5,358.04</p> <p>-8/20/12, RBW, \$28.00 with an ending balance in the amount of \$5,330.04</p> <p>-9/11/12, RBW, \$28.00 with an ending balance in the amount of \$5,302.04</p> <p>Client B's financial record was reviewed on 10/2/12 at 11:48 AM. Client B's facility based cluster account ledger dated 7/17/12 through 10/2/12 indicated the following:</p> <p>-7/17/12, SSD (Social Security Deposit), \$6,187.00 with an ending balance in the amount of \$9,361.54</p> <p>-7/17/12, SSD, \$465.00 with an ending balance in the amount of \$9,826.54</p> <p>-7/17/12, RBW, \$1,089.00 with an ending balance in the amount of \$8,737.54</p> <p>-8/3/12, SSD, \$93.00 with an ending balance in the amount of \$8,830.54</p> <p>-8/3/12, SSD, \$1,239.00 with an ending balance in the amount of \$10,069.54</p>		<p>accounts are below the allowable amount and that Petty cash ledgers are up to date and are maintained monthly for all consumers financial transactions.</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 the 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. Ongoing, the Home manager will review the clients finances a minimum of weekly to ensure that Petty cash ledgers are up to date. The Program Director will review and reconcile the finances a minimum of monthly to ensure that all records are up to date and accurate.</p> <p>Responsible Party: Home Manager, Program Director, Area Director, Client Finance Specialist</p>		

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	<p>-8/20/12, RBW, \$1,089.00 with an ending balance in the amount of \$8,980.54</p> <p>-8/31/12, SSD, \$93.00 with an ending balance in the amount of \$9,073.54</p> <p>-8/31/12, SSD, \$1,239.00 with an ending balance in the amount of \$10,312.54</p> <p>-9/11/12, RBW, \$1,089.00 with an ending balance in the amount of \$9,223.54</p> <p>2. Client A's financial record was reviewed on 10/2/12 at 11:48 AM. Client A's financial record did not indicate a group home maintained petty cash ledger for August 2012, September 2012 and/or through 10/2/12/date of review.</p> <p>Client B's financial record was reviewed on 10/2/12 at 11:49 AM. Client B's financial record did not indicate a group home maintained petty cash ledger for August 2012, September 2012 and/or through 10/2/12/date of review.</p> <p>Client C's financial record was reviewed on 10/2/12 at 11:50 AM. Client C's financial record did not indicate a group home maintained petty cash ledger for August 2012, September 2012 and/or through 10/2/12/date of review.</p> <p>3. The facility's BDDS (Bureau of</p>			

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	<p>Developmental Disabilities Services) reports and investigations were reviewed on 10/2/12 at 8:50 AM. The review indicated the following:</p> <p>-BDDS report dated 9/11/12 indicated, "Money was given to staff on the evening of 9/7/12 and put in a lock box. Later that evening staff took some of the consumers to the gas station. The next morning when staff went to take the consumers out [client D] was missing \$5.00..., [client E] was missing \$5.00 and [client F] was missing \$5.00."</p> <p>AS (Administrative Staff) #1 was interviewed on 10/2/12 at 11:48 AM. AS #1 indicated the maximum allowable amount was \$1,500.00. AS #1 indicated the account balances for client A and client B were in excess of the allowable amount. AS #1 indicated client's D, E and F had not been reimbursed their missing money. AS #1 indicated the clients' needed to be reimbursed the missing money. AS #1 stated, "We do not have a full accounting of funds (clients' cash kept in the group home). We switched home managers, it was a mess... not accounted for. We have been in the process of reconciling funds and ledgers."</p> <p>The governing body failed to exercise general policy, budgeting and operating</p>						

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	<p>direction over the facility by failing to ensure their nursing services provided clients B and C with necessary adaptive equipment and training/methodologies in their program plans. Please see W331.</p> <p>This federal tag relates to complaint #IN00112797.</p> <p>This deficiency was cited on 8/24/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>				

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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 2 of 3 sampled clients (B and C), the facility nursing services failed to develop a fall prevention protocol for client B. The facility's nursing services failed to ensure clients B and C had recommended adaptive equipment.</p> <p>Findings include:</p> <p>1. Client B's record was reviewed on 10/2/12 at 10:08 AM. Client B's Quarterly Nursing Assessment indicated the following:</p> <p>-3/30/11 note indicated, "abnormal gait" with fall at work reported.</p> <p>-6/7/11 note indicated, "abnormal gait."</p> <p>-9/13/11 note indicated, "abnormal gait."</p> <p>-12/1/11 note indicated, "abnormal gait" with one fall reported.</p> <p>-3/13/12 note indicated one fall reported while in the shower due to an, "abnormal gait."</p> <p>-6/11/12 noted indicated client B had two falls this quarter and was receiving</p>	W0331	<p>1. Client B Fall Risk Protocol has been completed. The Program Nurse will be retrained on ensuring that protocols are developed as needed based on consumers risk and needs. Ongoing, the Program Nurse will ensure that protocols are developed as needed based on consumers documented risks and needs. Program Nurse will ensure that all staff are trained on any protocols that are developed based on consumers risks and needs.</p> <p>2. Training goals have been developed for Client B to prompt her to wear her eyeglasses and use her walker. All Direct Support Staff will receive training on implementing Client B's training goals for her adaptive equipment. Program nurse will follow up on the recommendation for Client C for use of a Occlusal Mouthguard and Rigid Orthotics for her feet. Program nurse will ensure this adaptive equipment has been obtained and staff are trained on the use of this adaptive equipment. The Program Director will receive retraining to include the need to ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment. Ongoing, the Program Director</p>	11/07/2012	

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	<p>physical therapy for strength, flexibility and balance.</p> <p>-9/11/12 note indicated, "... had falls this past month. Roller walker ordered and delivered today."</p> <p>Client B's Medical Appointment form dated 5/9/12 indicated, "Evaluate and treat for a small fracture lower spine, scoliosis, frequent falls and pain management. Seen for PT (Physical Therapy) evaluation regarding low back pain and gait abnormality."</p> <p>2. Observations were conducted at the group home on 10/1/12 from 4:51 PM through 6:00 PM. Client B and client C were observed in the home throughout the observation period. Client B did not utilize a rolling walker, wear eyeglasses or hearing aids during the observation period. Client C did not utilize a mouth guard or foot orthotic device.</p> <p>Observations were conducted at the group home on 10/2/12 from 6:00 AM through 8:00 AM. Client B and client C were observed in the home throughout the observation period. Client B did not utilize a rolling walker, wear eyeglasses or hearing aids during the observation period. Client C did not utilize a mouth guard or foot orthotic device.</p>		<p>will ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment. The Area Director will review the next 3 ISPs submitted by this Program Director to ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment.</p> <p>Responsible Party: Program Nurse, Nursing Supervisor , Program Director, Area Director</p>				

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	<p>Client B's record was reviewed on 10/2/12 at 10:08 AM. Client B's vision medical appointment form dated 6/8/11 indicated the recommendation for full time prescription use. Client B's hearing appointment form dated 3/22/11 indicated the recommendation for full time use of hearing aids. Client B's dental examination form dated 2/27/12 indicated the recommendation for use of a bite guard. Client B's Quarterly Nursing Assessment dated 9/11/12 indicated client B had an PCP (Primary Care Physician) prescription order for a rolling walker. Client B's Quarterly Nursing assessment dated 9/11/12 indicated client B had received the rolling walker for full time use. Client B's ISP (Individual Support Plan) dated 3/23/12 did not indicate formal/informal training or supports to assist client B to use eyeglasses, hearing aids or the rolling walker.</p> <p>Client C's record was reviewed on 10/2/12 at 1:09 PM. Client C's physicians order form dated 8/27/12 indicated the use of Rigid Orthotic daily (plantar fasciitis) and Occlusal Mouthguard (TMJ/Temporomandibular Joint Disorder). Client C's Monthly Health Care Coordination form dated August 2012 indicated client C should be using a</p>			

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	<p>mouthguard and have orthotics for her feet.</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1 on 10/3/12 at 10:15 AM indicated client B's guardian had concerns regarding her ambulation and requested the walker. QMRP #1 stated, "... [client B] sometimes has issues with balance." When asked if client B had a history of falls, QMRP #1 stated, "[Client B] has had a few, two or three since I've been here. I've been here a couple of months." QMRP #1 indicated client B did not have a fall risk prevention plan. QMRP #1 indicated client B should wear eyeglasses, hearing aids and use her rolling walker. QMRP #1 indicated client B refused to wear her eyeglasses and use her walker. QMRP #1 indicated client B's hearing aids were being adjusted due to not fitting properly and falling out. QMRP #1 indicated client B did not have a formal goal to train/assist her to use her eyeglasses or walker. QMRP #1 indicated client B did not have a mouthguard. QMRP #1 indicated client C did not have a mouthguard or orthotics for her feet.</p> <p>Interview with nurse #1 on 10/3/12 at 10:30 AM indicated client B had a history of falls. Nurse #1 indicated client B's PCP (Primary Care Physician) had written a</p>			

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	<p>prescription for client B to use a rolling walker while ambulating. Nurse #1 indicated client B needed a falls risk plan.</p> <p>This federal tag relates to complaint #IN00112797.</p> <p>This deficiency was cited on 8/24/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>			