

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G432	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/27/2015
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3606 HIGHWOODS DR N INDIANAPOLIS, IN 46222
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W 0000 Bldg. 00	<p>This visit was for a predetermined full annual recertification and state licensure survey.</p> <p>Dates of Survey: 8/17/15, 8/18/15, 8/19/15, 8/20/15, 8/26/15 and 8/27/15.</p> <p>Facility Number: 000946 Provider Number: 15G432 AIMS Number: 100244570</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed by #09182 on 9/03/2015.</p>	W 0000		
W 0159 Bldg. 00	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 4 additional clients (#5, #6, #7 and #8), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients #1, #2, #3, #4, #5, #6, #7 and #8's active treatment program by</p>	W 0159	The Program Director/QIDP will be retrained on Indiana MENTOR's policy and procedures regarding completing monthly reviews for each client's individualized support plan. This training will include, but not limited to, ensuring that each individualized goal is monitored and amended based on the results of	09/26/2015

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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	<p>failing to monitor/review clients #1, #2, #3 and #4's ISP (Individual Support Plan) training objectives for progression/regression of skills, failed to ensure the facility's IDT (Interdisciplinary Team) reviewed and made recommendations to address client #3's oral hygiene needs/refusals, to ensure client #6 was offered the opportunity to choose his preferred food during the evening meal, to ensure client #1 had a current active treatment schedule, to ensure the HRC (Human Rights Committee) reviewed, approved and monitored client #1's use of psychotropic medications used for behavior management, to ensure the facility's HRC ensured clients #1 and #4's use of psychotropic medication for behavior management was conducted with the written informed consent of the client and to ensure staff provided training in meal preparation when formal and informal training opportunities existed for clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 8/19/15 at 10:52 AM. Client #1's ISP dated 11/10/14 indicated client #1's formal training objectives should be monitored monthly and reviewed quarterly for progression/regression of</p>		<p>completions versus trials.</p> <p>1.The Program Director will gather data and complete monthly summaries for June, July, and August 2015 for client #1. Based on the results of the data that is gathered, the Program Director will work with the team to address any changes that are needed.</p> <p>2.The Program Director will gather data and complete monthly summaries for June, July, and August 2015 for client #2. Based on the results of the data that is gathered, the Program Director will work with the team to address any changes that are needed.</p> <p>3.The Program Director will gather data and complete monthly summaries for June, July, and August 2015 for client #3. Based on the results of the data that is gathered, the Program Director will work with the team to address any changes that are needed.</p> <p>1.The Program Director will convene the IDT for client #3 to discuss the refusals for oral hygiene.</p> <p>2.The Program Nurse, in conjunction with the IDT for client 3, will create a protocol for the poor oral hygiene.</p> <p>3.The Behavior Specialist will work with the Program Director and Program Coordinator to address client #3's ongoing refusals for oral hygiene.</p> <p>4.The Program Director will gather data and complete monthly summaries for June, July, and August</p>	

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	<p>skills. Client #1's ISP dated 11/10/14 indicated client #1 had formal training objectives regarding medication administration, money management, leisure skills, oral hygiene, meal preparation and domestic chores. Client #1's record did not indicate documentation of monthly goal review/monitoring for the months of June 2015 and July 2015.</p> <p>2. Client #2's record was reviewed on 8/19/15 at 12:23 PM. Client #2's ISP dated 11/10/14 indicated client #2's formal training objectives should be monitored monthly and reviewed quarterly for progression/regression of skills. Client #2's ISP dated 11/10/14 indicated client #2 had formal training objectives regarding medication administration, money management, exercise, showering and cleaning his room. Client #2's record did not indicate documentation of monthly goal review/monitoring for the months of May 2015, June 2015 and July 2015.</p> <p>3. Client #3's record was reviewed on 8/19/15 at 11:48 AM. Client #3's Physician's Order Form (POF) dated 7/22/15 indicated, "Assist with brushing and flossing (teeth) three times daily."</p> <p>Client #3's Dental Examination Report</p>		<p>2015 for client #4. Based on the results of the data that is gathered, the Program Director will work with the team to address any changes that are needed.</p> <p>5. Please see W247</p> <p>1. The Direct Support Staff will be retrained on ensuring that each client is offered choice in daily decisions and self-management. This training will include but is not limited to client's rights and responsibilities. Upon hiring a new Program Coordinator, he/she will be trained on ensuring that each client is offered choice in daily decisions and self-management. This training will include but is not limited to client's rights and responsibilities.</p> <p>2. For the first four weeks, the Program Nurse and/or Program Director (QIDP) will complete 3 meal time observations per week to ensure that the menu is being followed according to each client's dining plan, and that the client is offered appropriate choices. After the initial four weeks, the Program Nurse and/Program Director (QIDP) will complete no less than 1 meal observation per week ongoing.</p> <p>1. Ongoing, the DSPs will ensure that they follow the client specific menus and offer choices at all times.</p> <p>1. Please see W250</p> <p>1. The Program Director will be retrained on completing active treatment schedules, and reviewing them no less than annually, but</p>	

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	<p>dated 7/8/15 indicated client #3 had poor hygiene related to her teeth and gums. The 7/8/15 Dental Examination Report indicated, "Needs help brushing."</p> <p>Client #3's Dental Examination Report dated 3/8/15 indicated client #3 had poor hygiene related to her teeth and gums. The 3/8/15 Dental Examination Report indicated, "Assist with brushing three times per day."</p> <p>Client #3's Dental Examination Report dated 12/10/14 indicated client #3 had poor hygiene related to her teeth and gums. The 12/10/14 Dental Examination Report indicated, "Generalized heavy plaque and material all (sic)."</p> <p>Client #3's Medication Administration Record (MAR) dated 4/1/15 through 4/30/15 indicated client #3 refused to brush her teeth on 4/3/15, 4/6/15, 4/26/15, 4/27/15 and 4/28/15. Client #3's MAR dated 6/1/15 through 6/30/15 indicated client #3 refused to brush her teeth on 6/1/15, 6/3/15, 6/4/15, 6/5/15, 6/8/15, 6/10/15, 6/12/15, 6/13/15, 6/14/15, 6/15/15, 6/17/15, 6/18/15 and 6/19/15. Client #3's MAR dated 7/1/15 through 7/31/15 indicated client #3 refused to brush her teeth on 7/6/15, 7/7/15, 7/8/15, 7/10/15, 7/11/15, 7/12/15, 7/14/15, 7/15/15, 7/16/15, 7/17/15,</p>		<p>more as needed, per client.</p> <p>2.The Program Director will complete an updated active treatment schedule for client #1.</p> <p>3.The Program Director will review active treatment schedules for clients 2, 3, 4, 5, 6, 7, and 8 to ensure that they accurately address each client's needs and properly show the client's daily activities.</p> <p>4.Ongoing, the Program Director will ensure that each client's active treatment schedule is reviewed no less than annually by the team, and will make all changes necessary when needed.</p> <p>2.Please see W262</p> <p>1.The Program Director will work with the team for Client #1 to ensure all appropriate approvals are in place for the use of the behavior controlling medication, Trazadone.</p> <p>2.Once the appropriate informed consent is in place for client #1, the Program Director will meet with the Human Rights Committee for approval of continued use.</p> <p>3.The Program Director will work with the team, and the HRC, to review the notes from the use of the behavior controlling medications to ensure that it is proving to be effective with continued use.</p> <p>4.The Program Director and Program Nurse will work together to ensure adequate information is given to the Human Rights Committee for approval during each review.</p>	

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	<p>7/18/15, 7/19/15, 7/20/15, 7/21/15, 7/22/15, 7/24/15, 7/25/15, 7/26/15 and 7/27/15.</p> <p>Client #3's Monthly Summary report dated May 2015 indicated, "Zero percent (progress) in personal hygiene which consisted (of) brushing her teeth with 2 verbal prompts in 90% of trials. Data for June 2015 and July 2015 was not available for review.</p> <p>Client #3's record did not indicate documentation of IDT review or recommendations to address client #3's oral hygiene refusals.</p> <p>Client #3's ISP dated 10/15/14 indicated client #3's formal training objectives should be monitored monthly and reviewed quarterly for progression/regression of skills. Client #3's 10/15/14 ISP indicated client #3 had formal training objectives regarding medication administration, money management, making her bed, personal hygiene/tooth brushing and physical exercise.</p> <p>Client #3's record did not indicate documentation of monthly goal review/monitoring for the months of June 2015 and July 2015.</p> <p>4. Client #4's record was reviewed on</p>		<p>5.The Area Director will participate in all quarterly Human Rights Committee meetings to ensure adequate information is provided to the team and that required approvals are in place.</p> <p>3.Please see W263</p> <p>a. The Program Director will be trained on the correct process for retrieving the appropriate approvals for the Behavior Support Plans, behavior controlling medications, and the use of sedatives before appointments. This includes but is not limited to the informed consent.</p> <p>b. The Program Director will seek guardian approvals for all psychotropic medications and the Behavior Support Plan for client #1 and 4.</p> <p>c. Ongoing, the Program Director will correctly retrieve the approvals for all future Behavior Controlling/Sedatives from the Guardian/Health Care Representative first, then once received, will get the appropriate approval from the Human Rights Committee, before implementing.</p> <p>d. Ongoing, the Area Director will complete random quarterly audits to ensure that all of the proper approvals are in place from the IDTs.</p> <p>1.Please see W488</p> <p>1.The Direct Support Professionals will be retrained on completing formal and informal active treatment opportunities for each client at any given teaching moment. This training will include</p>	

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	<p>8/19/15 at 11:33 AM. Client #4's ISP dated 10/21/14 indicated client #4's formal training objectives should be monitored monthly and reviewed quarterly for progression/regression of skills. Client #4's ISP dated 10/21/14 indicated client #4 had formal training objectives regarding medication administration, money management, bathing, domestic chores, oral hygiene and meal preparation. Client #4's record did not indicate documentation of monthly goal review/monitoring for the months of June 2015 and July 2015.</p> <p>5. The QIDP failed to integrate, coordinate and monitor client #6's active treatment program by failing to ensure client #6 was offered the opportunity to choose his preferred food during the evening meal. Please see W247.</p> <p>6. The QIDP failed to integrate, coordinate and monitor client #1's active treatment program by failing to ensure client #1 had a current active treatment schedule. Please see W250.</p> <p>7. The QIDP failed to integrate, coordinate and monitor client #1's active treatment program by failing to ensure the HRC reviewed, approved and monitored client #1's use of psychotropic medications used for behavior</p>		<p>but not limited to the meal preparation times.</p> <p>2.The Program Director and/or Home Manager will complete 2 weekly active treatment observations for 4 weeks, and then 1 per week afterwards to ensure that all formal and informal training opportunities are being completed as expected.</p>				

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W 0247 Bldg. 00	<p>management. Please see W262.</p> <p>8. The QIDP failed to integrate, coordinate and monitor clients #1 and #4's active treatment programs by failing to ensure the facility's HRC ensured clients #1 and #4's use of psychotropic medication for behavior management was conducted with the written informed consent of the clients. Please see W263.</p> <p>9. The QIDP failed to integrate, coordinate and monitor clients #1, #2, #3, #4, #5, #6, #7 and #8's active treatment program by failing to ensure staff provided training in meal preparation when formal and informal training opportunities existed for clients #1, #2, #3, #4, #5, #6, #7 and #8. Please see W488.</p> <p>9-3-3(a)</p> <p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. Based on observation and interview for 1 additional client (#6), the facility failed to ensure client #6 was offered the opportunity to choose his preferred food during the evening meal.</p>	W 0247	The Direct Support Staff will be retrained on ensuring that each client is offered choice in daily decisions and self-management. This training will include but is not limited to client's rights and	09/26/2015			

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W 0250 Bldg. 00	<p>Findings include:</p> <p>Observations were conducted at the group home on 8/18/15 from 4:40 PM through 6:00 PM. At 5:40 PM, client #6 participated the home's evening meal. The home's evening meal consisted of pot roast, creamed corn, tossed salad, rolls and mashed potatoes. Client #6 indicated he did not like creamed corn and did not want to eat it. Staff #2 stated, "Oh, yeah [client #6] doesn't like creamed corn." Client #6 was not offered an alternative preferred vegetable for the evening meal.</p> <p>Home Manager #1 was interviewed on 8/19/15 at 1:10 PM. Home Manager #1 indicated client #6 indicated he did not like creamed corn during the evening meal on 8/18/15. Home Manager #1 indicated client #6 was not offered an alternative preferred vegetable. Home manager #1 indicated client #6 should be offered a choice of preferred vegetables.</p> <p>9-3-4(a)</p> <p>483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p>		<p>responsibilities. Upon hiring a new Program Coordinator, he/she will be trained on ensuring that each client is offered choice in daily decisions and self-management. This training will include but is not limited to client's rights and responsibilities. For the first four weeks, the Program Nurse and/or Program Director (QIDP) will complete 3 meal time observations per week to ensure that the menu is being followed according to each client's dining plan, and that the client is offered appropriate choices. After the initial four weeks, the Program Nurse and/Program Director (QIDP) will complete no less than 1 meal observation per week ongoing.</p> <p>Ongoing, the DSPs will ensure that they follow the client specific menus and offer choices at all times.</p>	

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	<p>Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1 had a current active treatment schedule.</p> <p>Findings include:</p> <p>Home Manager (HM) #1 was interviewed on 8/18/15 at 5:03 PM. HM #1 indicated client #1 was not currently attending a day services due to recent psychological/behavioral incidents. HM #1 indicated client #1 had been in the hospital from 5/4/15 through 5/29/15 and had not been released from his doctor to return to day services. HM #1 indicated client #1 stayed home during the day and would go on appointments and transport his housemates to and from work.</p> <p>Client #1's record was reviewed on 8/19/15 at 10:52 AM. Client #1's Health Care Coordination/Monthly Health Review (HCC/MHR) dated May 2015 indicated client #1 was admitted to the hospital on 5/4/15 regarding confusion, aggression and psychosis. Client #1's HCC/MHR dated May 2015 indicated client #1 was discharged from the hospital on 5/29/15 and returned to the group home. Client #1's active treatment schedule dated 3/8/11 indicated client #1 attended day services on Monday through Friday during the week from 9:00 AM</p>	W 0250	<p>The Program Director will be retrained on completing active treatment schedules, and reviewing them no less than annually, but more as needed, per client.</p> <p>The Program Director will complete an updated active treatment schedule for client #1.</p> <p>The Program Director will review active treatment schedules for clients 2, 3, 4, 5, 6, 7, and 8 to ensure that they accurately address each client's needs and properly show the client's daily activities.</p> <p>Ongoing, the Program Director will ensure that each client's active treatment schedule is reviewed no less than annually by the team, and will make all changes necessary when needed.</p>	09/26/2015			

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W 0262 Bldg. 00	<p>through 2:00 PM. Client #1's active treatment schedule did not indicate documentation of update/revision since 3/8/11.</p> <p>AD (Area Director) #1 was interviewed on 8/19/15 at 1:10 PM. AD #1 indicated client #1's active treatment schedule should be updated to reflect his current programming needs.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure the HRC (Human Rights Committee) reviewed, approved and monitored client #1's use of psychotropic medications used for behavior management.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/19/15 at 10:52 AM. Client #1's Physician's Order Form (POF) dated</p>	W 0262	<p>The Program Director will work with the team for Client #1 to ensure all appropriate approvals are in place for the use of the behavior controlling medication, Trazadone. Once the appropriate informed consent is in place for client #1, the Program Director will meet with the Human Rights Committee for approval of continued use.</p> <p>The Program Director will work with the team, and the HRC, to review the notes from the use of the behavior controlling medications to ensure that it is proving to be</p>	09/26/2015

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W 0263 Bldg. 00	<p>7/22/15 indicated client #1's medications included, but were not limited to, Trazodone (depression/anxiety) 50 milligram tablet. Client #1's record did not indicate documentation of HRC review or approval of client #1's use of Trazodone for behavior management.</p> <p>AD (Area Director) #1 was interviewed on 8/19/15 at 1:10 PM. AD #1 indicated the facility's HRC should review, approve and monitor client #1's use of psychotropic medications used for behavior management.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#1 and #4), the facility's HRC (Human Rights Committee) failed to ensure clients #1 and #4's use of psychotropic medication for behavior management was conducted with the written informed consent of the client.</p> <p>Finding include:</p>	W 0263	<p>effective with continued use. These reviews will be no less than quarterly, but more as needed, or when changes are made.</p> <p>The Program Director and Program Nurse will work together to ensure adequate information is given to the Human Rights Committee for approval during each review.</p> <p>The Area Director will participate in all quarterly Human Rights Committee meetings to ensure adequate information is provided to the team and that required approvals are in place.</p> <p>Ongoing, the Program Director will ensure that all required approvals are in place before use.</p> <p>The Program Director will be trained on the correct process for retrieving the appropriate approvals for the Behavior Support Plans, behavior controlling medications, and the use of sedatives before appointments. This includes but is not limited to the informed consent.</p> <p>The Program Director will seek guardian approvals for all psychotropic medications and the Behavior Support Plan for client #1</p>	09/26/2015

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	<p>1. Client #1's record was reviewed on 8/19/15 at 10:52 AM. Client #1's ISP (Individual Support Plan) dated 11/10/14 indicated client #1 was emancipated. Client #1's Physician's Order Form (POF) dated 7/22/15 indicated client #1 received Clozapine (schizophrenia) 50 milligram tablet, Trazodone (depression/anxiety) 50 milligram tablet and Fluoxetine (schizophrenia/depression) 10 milligram tablet. Client #1's record did not indicate documentation of client #1's written informed consent for the use of Clozapine, Trazodone or Fluoxetine.</p> <p>2. Client #4's record was reviewed on 8/19/15 at 11:33 AM. Client #4's ISP dated 10/21/14 indicated client #4 was an emancipated adult with a HCR (Health Care Representative). Client #4's POF dated 7/22/15 indicated client #4 received Abilify (psychosis) 10 milligrams daily. Client #4's record did not indicate documentation of client #4's written informed consent for the use of Abilify for the management of client #4's psychosis or behavior.</p> <p>AD (Area Director) #1 was interviewed on 8/19/15 at 1:10 PM. AD #1 indicated the facility's HRC should ensure clients #1 and #4's s use of psychotropic medications used for behavior</p>		<p>and 4. Ongoing, the Program Director will correctly retrieve the approvals for all future Behavior Controlling/Sedatives from the Guardian/Health Care Representative first, and then once received, will get the appropriate approval from the Human Rights Committee, before implementing.</p>	

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W 0312 Bldg. 00	<p>management was conducted with their written informed consent.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 3 of 4 sampled clients (#1, #3 and #4), the facility failed to ensure clients #1, #3 and #4 use of psychotropic medications for behavior management was included in a plan of titration or active treatment program to reduce or eliminate the need for the medications.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 8/19/15 at 10:52 AM. Client #1's Physician's Order Form (POF) dated 7/22/15 indicated client #1 received Clozapine (schizophrenia) 50 milligram tablet, Trazodone(depression/anxiety) 50 milligram tablet and Fluoxetine (schizophrenia/depression) 10 milligram tablet. Client #1's record did not indicate documentation of a plan of titration or active treatment program to reduce or</p>	W 0312	<p>The Program Director will also be retrained on ensuring that titration plans are included in the Behavior Support Plans when applicable. The Behavior Specialist will add in the plan of titration for the psychotropic medications for client 1, 3, and 4's current Behavior Support Plan(s). Ongoing, the Program Director, in conjunction with the team, will ensure that the plan(s) of titration is/are included in the Behavior Support Plan for each client when applicable. Ongoing, the Program Director will correctly retrieve the approvals for all future Behavior Controlling medications and the titration plans, from the Guardian/Health Care Representative first, then once received, will get the appropriate approval from the Human Rights Committee, before implementing. Ongoing, the Area Director will</p>	09/26/2015

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	<p>eliminate the need for the use of Clozapine, Trazodone or Fluoxetine.</p> <p>2. Client #3's record was reviewed on 8/19/15 at 11:48 AM. Client #3's POF dated 7/22/15 indicated client #3 received Seroquel (psychosis) 400 milligram tablet, Depakote (psychosis/depression) ER (Extended Release) 500 milligram tablet, Zoloft (psychosis) 100 milligram tablet, Clonazepam (psychosis) 0.5 milligram tablet, and Haloperidol (psychosis) 1 milligram tablet. Client #3's record did not indicate documentation of a plan of titration or active treatment program to reduce or eliminate client #3's need for Seroquel, Depakote, Clonazepam, Zoloft or Haloperidol.</p> <p>3. Client #4's record was reviewed on 8/19/15 at 11:33 AM. Client #4's POF dated 7/22/15 indicated client #4 received Abilify (psychosis) 10 milligrams daily. Client #4's BSP dated 1/15/15 indicated client #4 received Abilify but did not specify the purpose of the medication. Client #4's 1/15/15 BSP did not indicate documentation of a plan of titration to reduce or eliminate client #4's need for Abilify for behavior management.</p> <p>AD (Area Director) #1 was interviewed on 8/19/15 at 1:10 PM. AD #1 indicated the facility should ensure clients #1, #3</p>		complete random quarterly audits to ensure that all of the proper approvals are in place from the IDTs.	

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W 0331 Bldg. 00	<p>and #4 use of psychotropic medications for behavior management was included in a plan of titration or active treatment program to reduce or eliminate the need for the medications.</p> <p>9-3-5(a)</p> <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 1 of 4 sampled clients (#1), the facility nursing services failed to met the health needs of client #1.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/19/15 from 6:15 AM through 8:00 AM. At 7:10 AM, client #1 was seated at the medication administration table. During the administration of client #1's medications client #1 took a drink of water from his cup and then slumped down in the seat with his head down and held the position for 15 seconds. Staff #3 asked client #1 if he was okay and encouraged him to finish drinking his water. Client #1 did not initially respond to staff #3's verbal prompts then looked at staff #3 while</p>	W 0331	<p>The Interdisciplinary team will meet to discuss Client #1 and his signs and symptoms that should be noted on his high risk and nursing plans for changes in his mental status. The Program Nurse will update Client #1's nursing care plan to include signs and/or symptoms of changes mental status regarding confusions or delusions and when nursing assistance should be sought out. The Program Director will update Client #1's high risk plan to include signs and/or symptoms of changes in mental status regarding confusions or delusions and when assistance should be sought out. The Direct Support Staff will be retrained on client #1's changes to the high risk plan and nursing protocols. The Program Nurse and Program Director will be retrained on updating each client's high risk plans</p>	09/26/2015

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	<p>holding the cup of water in his hand but not drinking. Client #1 then looked back down and was again asked if he was okay and encouraged to finish drinking his water. Client #1 again stayed in this slumped over position with his head down for another 10 seconds. Staff #3 asked client #1 if he was okay and client #1 abruptly sat up straight in his chair, made eye contact with staff #3 and stated, "Oh, sorry. Sorry." Client #1 then finished drinking his water and resumed the mornings activities.</p> <p>Home Manager (HM) #1 was interviewed on 8/18/15 at 5:03 PM. HM #1 indicated client #1 was not currently attending a day services due to recent psychological/behavioral incidents. HM #1 indicated client #1 had been in the hospital from 5/4/15 through 5/29/15. HM #1 indicated client #1's psychotropic medications had been changed and client #1 was being monitored while his doctors re-assessed his dosage amounts.</p> <p>HM #1 was interviewed on 8/19/15 at 1:15 PM. HM #1 indicated she had noticed client #1's behavior during the 8/19/15 medication administration. HM #1 stated, "The staff told me about it. He has some incidents like that and we keep an eye on him. I was going to call the doctor." HM #1 indicated the nurse had</p>		<p>and nursing protocols when being discharged from the hospital or when other changes occur. When an incident occurs, the Program Director and/or Program Nurse will submit a copy of the changes of each client's ISP/high risk plan to the Area Director as requested.</p> <p>The Area Director and/or Quality Assurance Specialist will complete random quarterly audits to ensure that the Program Director and Nurse are updating high risk plans as needed.</p> <p>Ongoing the Program Director and the Program Nurse will continue to monitor and update each client specific plans as needed.</p>	

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	<p>not been notified of client #1's behavior. HM #1 indicated client #1 did not have a change of mental status plan or instructions regarding when the facility nurse should be notified when client #1 was confused or disorientated or had other unusual behaviors.</p> <p>Client #1's record was reviewed on 8/19/15 at 10:52 AM. Client #1's Health Care Coordination/Monthly Health Review (HCC/MHR) dated April 2015 indicated, "4/13/15, noted [client #1] was in bed, unable to lift head, arms or legs, lethargic and wet to touch. Blood pressure 103/62. 911 called. [Client #1] was transported via ambulance to [hospital] ER (Emergency Room) where he was later admitted for Pneumonia." Client #1's HCC/MHR dated April 2015 indicated, "4/29/15, [client #1] was discharged from [hospital] to group home." Client #1's HCC/MHR dated April 2015 indicated, "[Former Home Manager #1] reported that [client #1] is very confused and doesn't remember anyone. States he thinks that his mother is deceased."</p> <p>Client #1's HCC/MHR dated May 2015 indicated client #1 was admitted to the hospital on 5/4/15 regarding confusion, aggression and psychosis. Client #1's HCC/MHR dated May 2015 indicated</p>			

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W 0368 Bldg. 00	<p>client #1 was discharged from the hospital on 5/29/15 and returned to the group home. Client #1's HCC/MHR dated May 2015 indicated, "[Client #1] returned to group home on 5/29/15. Remains confused and delusional at times."</p> <p>Client #1's record did not indicate documentation of a nursing care plan/risk plan for staff to identify signs or symptoms of changes in client #1's mental status regarding confusion or delusions and when nursing should be notified.</p> <p>Nurse #1 was interviewed on 8/19/15 at 1:30 PM. Nurse #1 indicated client #1's psychotropic medications were being adjusted following his hospitalization due to delusional and aggressive behavior with confusion. Nurse #1 indicated there was not a risk plan regarding client #1's mental status identifying signs or symptoms of a change or altered mental status and reporting instructions.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in</p>			

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	<p>compliance with the physician's orders. Based on observation, record review and interview for 1 of 4 sampled clients (#2), the facility failed to ensure client #2's physician's orders were followed.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/19/15 from 6:15 AM through 8:00 AM. At 6:39 AM, staff #1 administered client #2's morning medications which included, but were not limited to, Levothyroxine (hypothyroidism) 50 micrograms tablet. At 6:50 AM, client #1 ate his morning meal which consisted of cereal with milk and a doughnut.</p> <p>Client #2's pharmacy packaged Levothyroxine was reviewed on 8/19/15 at 6:39 AM. The pharmacy package indicated client #2 should wait 30 minutes after taking the medication before eating.</p> <p>Staff #1 was interviewed on 8/19/15 at 6:40 AM. Staff #1 indicated client #2 took his medications before eating but was not aware of any time restrictions before eating after taking his medication.</p> <p>Client #2's record was reviewed on 8/19/15 at 12:23 PM. Client #2's</p>	W 0368	<p>All staff at this group home will be retrained on medication administration according to the Indiana MENTOR policy and procedures for medication administration.</p> <p>For the first four weeks, the Program Coordinator, Program Director, and/or Program Nurse will complete three (3) weekly medication administration observations to ensure that the medication goals are being completed with each client as specified for four (4) weeks. These will then be reviewed by the Program Director ensuring that there are no further training needs.</p> <p>After the initial four (4) weeks, the Home Manager and/or Program Director will complete two (2) weekly medication administration observations for four (4) additional weeks, and will ensure that all needed retrainings will be completed.</p> <p>After the additional four (4) weeks, the Home Manager and/or Program Director will complete weekly medication administration observations ongoing, and will ensure that all needed retrainings will be completed.</p> <p>Ongoing, all staff will complete medication administration according to the Indiana MENTOR policy and procedures.</p>	09/26/2015

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W 0488 Bldg. 00	<p>Physician's Order form dated 7/22/15 indicated, "Levothyroxine 50 micrograms tablet. Take one tablet by mouth once daily at least 30 minutes prior to breakfast for Hypothyroidism."</p> <p>Nurse #1 was interviewed on 8/19/15 at 2:13 PM. Nurse #1 indicated client #2's medication should be administered as prescribed by the physician's orders.</p> <p>9-3-6(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) plus 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure staff provided training in meal preparation when formal and informal training opportunities existed for clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/18/15 from 4:40 PM through 6:00 PM. At 4:40 PM, client #4 assisted staff #2 set the dining room table</p>	W 0488	The Direct Support Professionals will be retrained on completing formal and informal active treatment opportunities for each client at any given teaching moment. This training will include but not limited to the meal preparation times. The Program Director and/or Home Manager will complete 2 weekly active treatment observations for 4 weeks, and then 1 per week afterwards to ensure that all formal and informal training opportunities are being completed as expected. Ongoing, the Area Director will complete quarterly pop in visits to ensure that all policies and procedures are being followed.	09/26/2015

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	<p>for the evening meal. Client #4 then left the area and sat down in the living room. Staff #2 returned to the kitchen area and continued meal preparation. Staff #2 buttered biscuits, stirred pots cooking on the stove, checked items cooking in the oven, cleaned counters, put away clean dishes and placed dirty dishes in the sink. Client #4 was not encouraged to return to assist with the evening meal preparation. Clients #1, #2, #3, #5, #6, #7 and #8 who were also present in the home were not encouraged to participate in the meal preparation. At 5:25 PM. staff #2 placed a serving bowl of tossed salad and rolls on the table, placed servings of salad dressing into souffle cups, transferred gravy from the cooking pot to a serving bowl and placed it on the table. Staff #2 placed the serving bowl of mashed potatoes, creamed corn and pot roast on the table. At 5:36 PM, client #4 placed the milk on the table.</p> <p>Home Manager #1 was interviewed on 8/19/15 at 1:10 PM. Home Manager #1 indicated staff #2 should encourage clients #1, #2, #3, #4, #5, #6, #7 and #8 to participate in the preparation of the home's evening meal to the extent of their capabilities.</p> <p>9-3-8(a)</p>			

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W 9999 Bldg. 00	<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: (11.) An emergency intervention for the individual resulting from : (a.) a physical symptom; (b.) a medical or psychiatric condition; (c.) any other event."</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 2 incidents of emergency intervention utilization reviewed, the facility failed to immediately notify the BDDS (Bureau of Developmental Disabilities Services) regarding an incident of police intervention regarding client #1.</p>	W 9999	<p>The Program Director (QIDP) will be retrained on BDDS reportable incidents. This training will include the 24 hour timeline for the incidents to be reported.</p> <p>The Program Director (QIDP) will complete all incidents within the 24 hour timeline and if unable to do so, he/she will initiate conversations with the Area Director/Administrator to assist. Ongoing, the Program Director will complete the all future incidents within the 24 hour timeline.</p>	09/26/2015

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	<p>Findings include:</p> <p>Client #1's record was reviewed on 8/19/15 at 10:52 AM. Client #1's Health Care Coordination/Monthly Health Review form dated May 2015 indicated, "5/4/15, [Former Home Manager #1], reported that [client #1] had become violent this AM and the police were called. [Client #1] was transported to [hospital] ER (Emergency Room). [Doctor] was called and appointment had to be canceled. [Client #1] was awake during the night and very confused in the AM. [Client #1] was transferred and admitted to [hospital] psych ward."</p> <p>Former Home Manager #1 was interviewed on 8/18/15 at 1:30 PM. Former Home Manager #1 indicated the police had been called to the group home on 5/4/15 after client #1 had become physically aggressive toward staff and clients in the home. Former Home Manager #1 indicated the police placed client #1 in handcuffs after making verbal threats toward the police and then removed client #1 from the home and transported him to the hospital ER. Former Home Manager #1 indicated client #1 was then transferred to a different/second hospital and admitted to the psych ward.</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G432	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/27/2015
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3606 HIGHWOODS DR N INDIANAPOLIS, IN 46222
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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>The facility's BDDS reports were reviewed on 8/18/15 at 10:18 AM. The review indicated the following:</p> <p>-BDDS report dated 5/6/15 indicated, "Staff report that [client #1] was aggressing towards them and talking incoherently. [Client #1] was seen at the ER and placed in the psych ward."</p> <p>The 5/6/15 BDDS report did not indicate documentation of the 5/4/15 police involvement or client #1 being placed in handcuffs as an emergency intervention by the police.</p> <p>AD (Area Director) #1 was interviewed on 8/18/15 at 1:45 PM. AD #1 indicated she was not aware of the 5/4/15 police involvement with client #1. AD #1 indicated the 5/4/15 incident of police involvement and use of handcuffs as an emergency intervention should have been reported to BDDS.</p> <p>9-3-1(b)</p>			