

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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
W 0000  Bldg. 00	<p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Dates of Survey: 9/22, 9/23, 9/24, 9/25, 9/28, 9/29, and 9/30/2015.</p> <p>Facility Number: 000754 Provider Number: 15G230 AIM Number: 100243370</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 10/7/15.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the governing body failed to exercise operating direction over the facility to complete maintenance and repairs for clients #1, #3, #4, #5, #6, #7, and #8's group home.</p>	W 0104	<p>The facility has policies in place to ensure the home receives maintenance and repairs as needed to remain safe and welcoming for all individuals residing there. The bathroom remodel has been approved to correct the cracked tiles, broken drawer handles, and chipped soap holder. Any items that may pose a safety risk have been covered or removed pending the bathroom remodel.</p>	10/30/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>Findings include:</p> <p>Observation and interview were conducted on 9/23/15 from 3:05pm until 6:35pm and on 9/24/15 from 5:40am until 7:55am, at the group home with clients #1, #2, #3, #4, #5, #6, #7, and #8. During both observation periods clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed to access bathroom #1.</p> <p>On 9/23/15 at 5:25pm, the Residential Manager (RM) stated bathroom #1 was "due for a remodel" and identified the following:</p> <ul style="list-style-type: none"> <li>-The shower/tub was stained and discolored.</li> <li>-Eighteen (18) of twenty (20) five inch by five inch (5" x 5") tile squares surrounding the tub/shower were "cracked and chipped" and exposed jagged edges of tile.</li> <li>-One of three (1 of 3) drawers under the bathroom sink were missing hardware to open the drawer and one of three drawers under the bathroom sink were "missing half" the handle and exposed a "jagged" edge.</li> <li>-The shower/tub's porcelain soap holder was "broken, chipped, and had exposed jagged edges."</li> </ul>		<p>Moving forward the Program Coordinator will continue to do weekly inspections of the home to ensure all maintenance issues are addressed and rectified. Any issue that presents a safety risk for injury will be immediately addressed.</p> <p>Date of Completion: October 30, 2015</p> <p>Person Responsible: Area Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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
W 0149 Bldg. 00	<p>-The RM stated the "cabinet drawers" under the sink and built into the wall would not open for the clients to access the drawers.</p> <p>On 9/25/15 at 12:15pm, an interview was conducted with the Area Director (AD). The AD stated the group home bathroom was "approved" to be repaired in the future. The AD provided a "9/3/15 Invoice" for "Complete remodel of bathroom." No projected dates were available for review for the work to be done. The AD indicated no further information was available for review.</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and for 4 additional clients (clients #5, #6, #7, and #8), the facility neglected to immediately report client #4's injury of unknown source; neglected to ensure staff were on duty at the group home and clients #1, #2, #3, #4, #5, #6, #7, and #8 were not left alone and without staff supervision;</p>	W 0149	<p>The facility has policies and procedures in place that prohibit mistreatment, neglect, or abuse of the individual. Staff are trained on these policies upon hire and at least annually thereafter.</p> <p>Additionally, the facility has policies to immediately report injuries of unknown origin, ensure staff are on duty for individuals requiring 24 hour supervision, and that individuals are not subjected to staff mistreatment.</p>	10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>and neglected to ensure client #1 was not subjected to continued staff mistreatment.</p> <p>Findings include:</p> <p>1. The facility's reportable incidents and investigations for the Bureau of Developmental Disabilities Services (BDDS) from 9/2014 through 9/22/2015 were reviewed on 9/22/15 at 2:30pm, and on 9/22/15 at 8:00pm, and did not indicate a unknown injury for client #4:</p> <p>Observation and interview were conducted on 9/23/15 from 3:05pm until 6:35pm and on 9/24/15 from 5:40am until 7:55am, at the group home, and on 9/24/15 from 9:50am until 10:57am, at the contracted workshop. On 9/23/15 at 4:45pm, client #4 was observed with a "quarter" sized red area on the inside crease of his left elbow. On 9/24/15 at 10:10am, client #4 was non verbal and provided one on one staff supervision at the contracted workshop. At 10:10am, WKS (Workshop Staff) #1 stated client #4's crease inside his left elbow had a "bright red" skin area "bigger than a half dollar." WKS #1 indicated the area was observed by the workshop staff on 9/22/15 and stated "the area was getting larger." WKS #1 indicated the workshop staff notified the group home staff on duty on 9/22/15. At 10:15am, WKS #2</p>		<p>The staff and QIDP will be retrained on the need to immediately report any injury of unknown origin so that an investigation can be completed into the injury and treatment can be sought accordingly.</p> <p>Furthermore, the staff will be retrained on the facility's policy prohibiting abuse, neglect, or mistreatment of the individuals, including the need for 24 hour awake supervision and the need to immediately report any instance of abuse, neglect, or mistreatment to the on-call supervisor. The QIDP will also be retrained on the components of a thorough investigation.</p> <p>A member of management will complete observations at least three times weekly for a minimum of 30 days to monitor for signs of abuse and/or neglect, as well as discussing the facility's abuse/neglect policy with staff members working. If continuous and complete compliance has been achieved, observations will continue at least weekly for an additional 30 days. If continuous and complete compliance remains, observations will be completed as needed moving forward.</p> <p>Date of Completion: October 30, 2015 Person Responsible: Area Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>stated client #4's skin area "began as a bump and has gotten worse without treatment." WKS #2 stated the area was "bright red" in color.</p> <p>On 9/24/15 at 1:35pm, client #4's record was reviewed. Client #4's record did not include documentation of a "bright red" skin area inside the crease to his left elbow.</p> <p>On 9/25/15 at 12:15pm, an interview with the agency's Area Director (AD) was conducted. The AD indicated the facility followed the BDDS reporting guidelines for reportable incidents and investigations. The AD indicated the facility staff did not immediately report client #4's injury of unknown origin to his left elbow.</p> <p>2. On 9/22/15 at 2:30pm and on 9/22/15 at 8:00pm, the facility's reportable incidents and investigations for the Bureau of Developmental Disabilities Services (BDDS) from 9/2014 through 9/22/15 were reviewed and indicated the following allegation of staff neglect:</p> <p>-An 8/4/15 BDDS report for an incident on 8/4/15 at 12:15am indicated "The overnight staff had contacted the on call supervisor and stated that she needed to leave due to a family emergency. The on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>call supervisor then arrived at the home and it appeared that the overnight staff had already left the home before she had arrived to take over. All consumers were found to be fine and sleeping."</p> <p>-An 8/5/15 "Summary of Internal Investigation Report" indicated "On 8/4/15 Program Coordinators [names of supervisors] arrived at [group home] to relieve staff member [Discharged Staff #1] who threatened to leave the clients unattended if someone didn't come to relieve her so she could take her child asthma medicine...It was reported that [Discharged Staff #1] had already left the premises" and the Discharged Staff #1 was suspended pending an investigation.</p> <p>-The investigation indicated "Factual Findings...[Agency Supervisors] got there (at the group home) at 12:15pm...no vehicles were in the driveway or in front of the house...[Name of Supervisor] clocked in 12:15am on 8/4/15... [Discharged Staff #1] clocked out at 12:21am on 8/4/15 but had been gone for the entire time [Agency Supervisor Name] was there...."</p> <p>-The investigation indicated a witness statement from PC (Program Coordinator) #1 who "reported the following...[Discharged Staff #1]" tried</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>to contact the PC, the Residential Manager (RM), and multiple staff members from the group home on 8/3/15 from 11:08pm until 11:21pm. The statement indicated Discharged Staff #1 called PC #1 again and PC #1 "tried to problem solve with [Discharged Staff #1] by asking if other people could pick up the medication and deliver it to her son... [Discharged Staff #1] became very argumentative and started yelling... [Discharged Staff #1] told [PC #1] she was going to leave the clients since no one was coming in to allow her to leave. [PC #1] told her that if she left the clients she could be arrested and/or reported for abandonment at which point [Discharged Staff #1] hung up on [PC #1]...[PC #1] missed calls at 11:45pm and 11:58pm but [Discharged Staff #1] left voicemails saying 'she didn't care and would leave the clients' if no one was there by 12:30am...[PC #1] said she answered the phone at 11:59pm...[Discharged Staff #1] continued being really angry...[PC #1] pulled up, [PC #2] was already there and saw the main door open (to the group home)...[PC #1] stated (the two supervisors) entered the (group home) at 12:15am...."</p> <p>-The investigation indicated a witness statement from Discharged Staff #1 who "reported the following...stated she was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>really angry and got very angry to [PC #1] on the phone...stated she was furious that [PC #1] threatened her with calling the police if [Discharged Staff #1] left the clients unattended before someone got there...stated she then went out for a smoke and to call her boyfriend to tell him she was being told she would be fired if she left when [PC #1] 'came peeling up to the home' in her car...stated [PC #1] started yelling at her and told her she was fired and to get off the premises...stated [PC #1] called her a crack head b---- and got in her face...stated she left to take the medicine to her son and went back to the group home within 15 minutes, stating she left at 12:21am on 8/4/15 and was back 15 minutes later at 12:36am...When asked about going back to [name] of group home, [Discharged Staff #1] then said she did not go back but that she would have been able to make it back in around 15 minutes...."</p> <p>-The Investigation indicated "Corrective Action...an employee cannot leave the shift until a replacement has arrived...Conclusion: Evidence supports [Discharged Staff #1] did attempt multiple times to get someone to relieve her from her shift. Evidence supports that [Discharged Staff #1] did leave the premises before anyone was able to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>relieve her, which left [clients #1, #2, #3, #4, #5, #6, #7, and #8] unattended. Evidence does support that [Discharged Staff #1] falsified her time sheet on 8/4/15...."</p> <p>On 9/25/15 at 12:15pm, an interview with the agency's Area Director (AD) was conducted. The AD indicated the facility followed the BDDS reporting guidelines for reportable incidents and investigations. The AD indicated the Discharged Staff #1 incident on 8/4/15 was substantiated staff neglect for clients #1, #2, #3, #4, #5, #6, #7, and #8. The AD indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 had the identified need for 24 hour a day staff supervision.</p> <p>3. On 9/22/15 at 2:30pm and on 9/22/15 at 8:00pm, the facility's reportable incidents and investigations for the Bureau of Developmental Disabilities Services (BDDS) from 9/2014 through 9/22/15 were reviewed and indicated the following allegation of staff to client abuse:</p> <p>-A 6/28/15 BDDS report for an incident on 6/27/15 at 7:30am indicated staff "reported [GHS #10] went into the living room and something was heard to hit the floor. When other staff [GHS #12] turned around [client #1] was on the floor</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>on her back in front of her chair. [GHS #10] returned to kitchen and was heard telling [client #1] to lay back down 2-3 times. [Client #1] independently returned to chair after 15 minutes and continued to watch TV...Staff suspended pending investigation...."</p> <p>-A 7/6/15 "Summary of Internal Investigation Report" indicated witness statements by GHS #12 "...stated she was relieved by [GHS #10] and [GHS #2] on 6/27/15...somewhere between 7:30am and 7:45am [GHS #10] told [GHS #12] to stay right there and to not turn around and then [GHS #10] rushed to the living room and [GHS #12] heard something that sounded like something hit the floor...."</p> <p>-GHS #2's witness statement indicated client #1 "wanted to come to the kitchen and [GHS #10] asked her if she would go back in to the living room because [client #1] constantly wants to be in the kitchen to try to gain access to snacks or money... [client #1] began to hit her legs...[GHS #10] wheeled [client #1] back to the living room...[client #1] trying to hit another client...[GHS #10] went to the living room to intervene and [client #1] just dropped to the floor...[GHS #10] did tell [client #1] that she could just lay down but [GHS #10] did not make</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>her...."</p> <p>-"Conclusion...Evidence supports that [client #1] likely had a behavioral outburst...Evidence supports that [client #1] ended up on the ground however there is conflicting information as to how she ended up on the floor...Evidence could not be found to support the allegation of abuse."</p> <p>-A 11/20/14 BDDS report for an incident on 11/19/14 at 3:00pm indicated "Staff reported to the [Residential Manager (RM)] that they witnessed [client #1] being restrained inappropriately by another staff [Group Home Staff #10]. Staff were immediately suspended pending an investigation."</p> <p>-A 11/20/14 "Summary of Internal Investigation Report" indicated GHS #3 "reported on 11/19/14 that on 11/15/14 Saturday that [GHS #10] was using PIA (Physical Intervention Alternatives) on [client #1] and had a blanket over [client #1's] head."</p> <p>-A witness statement from the RM (Residential Manager) indicated: "stated that" on 11/19/14 GHS #3 "told [the RM] that [GHS #11] told [GHS #3] on Sunday (11/16/14) that she walked into the living room and [client #1] was on the floor</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>covered with a fleece blanket...[client #1] was saying stop, [GHS #10], please stop, [client #1] just wanted to get up."</p> <p>-A witness statement from GHS #11 indicated "when [GHS #11] came in on Saturday 11/15/14 around 3:00pm... [client #1] was on the floor and [GHS #10] had a blanket over [client #1's] head...[GHS #11] said [GHS #10] was not hurting [client #1]...."</p> <p>-A witness statement from GHS #3 indicated GHS #11 told her on 11/16/14 that GHS #10 had client #1 wrapped up in a blanket when GHS #11 arrived on shift on 11/15/14 and that "[client #1] has more significant behaviors when [GHS #10] is working...".</p> <p>-A witness statement from GHS #10 indicated "no PIA was used on [client #1]" on 11/15/14. GHS #10 indicated he "grabbed a blanket and knelt down beside [client #1's] head to put the blanket under her head because she was trying to bang her head."</p> <p>-"Additional Information...[Client #1's] behavior plan was not found in the home...Conclusion: Evidence could not be found to support any abuse or inappropriate PIA. Evidence supports that not all staff have been trained on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>[client #1's]" BSP (Behavior Support Plan). The investigation was not thorough in that the witness statements, factual findings, and conclusion did not indicate why staff did not immediately report an allegation of abuse, neglect, and/or mistreatment.</p> <p>On 9/25/15 at 12:15pm, an interview with the agency's Area Director (AD) was conducted. The AD indicated the facility followed the BDDS reporting guidelines for reportable incidents and investigations. The AD indicated GHS #10 had two (2) incidents of potential abuse, neglect, and/or mistreatment for client #1. The AD indicated the two investigations were not thorough in that the investigation did not include why the facility did not investigate staff not immediately reporting allegations of abuse, neglect, and/or mistreatment. The AD indicated no further information was available for review.</p> <p>On 9/22/15 at 2:30pm, the facility's policy and procedures were reviewed. The facility's 4/2011 Quality and Risk Management policy indicated "Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services thorough oversight of management procedures and company operations,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2015	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905			
(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
W 0153  Bldg. 00	<p>close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The 4/2011 Quality and Risk Management Policy indicated failure to provide appropriate supervision, care or training was considered neglect. The 4/2011 Quality and Risk Management Policy indicated, "Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. (1.) Investigation findings will be submitted to the AD (Area Director) for review and development of further recommendations as needed within 5 days of the incident."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, record review, and interview, for 1 of 1 injury of unknown origin (client #4), the facility failed to immediately report to the facility's administrator and to BDDS (Bureau of Developmental Disabilities Services) per</p>			W 0153	<p>The facility has policies that ensure all allegations of abuse, neglect, or mistreatment, as well as injuries of unknown origin, are immediately reported. The facility then reports any of these instances to the Bureau of</p>		10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 client #4's injury of unknown origin.</p> <p>Findings include:</p> <p>The facility's reportable incidents and investigations for the Bureau of Developmental Disabilities Services (BDDS) from 9/2014 through 9/22/2015 were reviewed on 9/22/15 at 2:30pm, and on 9/22/15 at 8:00pm, and did not indicate a unknown injury for client #4:</p> <p>Observation and interview were conducted on 9/23/15 from 3:05pm until 6:35pm and on 9/24/15 from 5:40am until 7:55am, at the group home, and on 9/24/15 from 9:50am until 10:57am, at the contracted workshop. On 9/23/15 at 4:45pm, client #4 was observed with a "quarter" sized red area on the inside crease of his left elbow. On 9/24/15 at 10:10am, client #4 was non verbal and provided one on one staff supervision at the contracted workshop. At 10:10am, WKS (Workshop Staff) #1 stated client #4's crease inside his left elbow had a "bright red" skin area "bigger than a half dollar." WKS #1 indicated the area was observed by the workshop staff on 9/22/15 and stated "the area was getting larger." WKS #1 indicated the workshop staff notified the group home staff on</p>		<p>Developmental Disabilities Services (BDDS) and Adult Protective Services (APS). The QIDP will be retrained on the need to report any injuries of unknown injury to the BDDS and APS within 24 hours. The Area Director and Quality Improvement Specialist will ensure the next three BDDS reportable incidents are reported to BDDS and APS within 24 hours. The Area Director will continue to monitor the timeliness of all BDDS reportable incidents moving forward.</p> <p>Date of Completion: October 30, 2015</p> <p>Person Responsible: Area Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2015
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905		
(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	
W 0154 Bldg. 00	<p>duty on 9/22/15. At 10:15am, WKS #2 stated client #4's skin area "began as a bump and has gotten worse without treatment." WKS #2 stated the area was "bright red" in color.</p> <p>On 9/24/15 at 1:35pm, client #4's record was reviewed. Client #4's record did not include documentation of a "bright red" skin area inside the crease to his left elbow.</p> <p>On 9/25/15 at 12:15pm, an interview with the agency's Area Director (AD) was conducted. The AD indicated the facility followed the BDDS reporting guidelines for reportable incidents and investigations. The AD indicated the facility staff did not immediately report client #4's injury of unknown origin to his left elbow.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 2 of 2 allegations of staff to client mistreatment (client #1), the facility failed to thoroughly investigate staff to client mistreatment.</p>	W 0154	<p>The facility has policies and procedures that ensure all incidents of abuse, neglect, or exploitation will be thoroughly investigated. The QIDP will be retrained on the components completing a</p>	10/30/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2015	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905			
(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>Findings include:</p> <p>On 9/22/15 at 2:30pm and on 9/22/15 at 8:00pm, the facility's reportable incidents and investigations for the Bureau of Developmental Disabilities Services (BDDS) from 9/2014 through 9/22/15 were reviewed and indicated the following allegation of staff to client abuse:</p> <p>1. A 6/28/15 BDDS report for an incident on 6/27/15 at 7:30am indicated staff "reported [GHS #10] went into the living room and something was heard to hit the floor. When other staff [GHS #12] turned around [client #1] was on the floor on her back in front of her chair. [GHS #10] returned to kitchen and was heard telling [client #1] to lay back down 2-3 times. [Client #1] independently returned to chair after 15 minutes and continued to watch TV...Staff suspended pending investigation...."</p> <p>-A 7/6/15 "Summary of Internal Investigation Report" indicated witness statements by GHS #12 "...stated she was relieved by [GHS #10] and [GHS #2] on 6/27/15...somewhere between 7:30am and 7:45am [GHS #10] told [GHS #12] to stay right there and to not turn around and then [GHS #10] rushed to the living</p>		<p>thorough investigation that includes historical information as well staff reporting timeliness. The Area Director and Quality Improvement Specialist will ensure the next three investigations for thoroughness. The Area Director will continue to monitor the thoroughness of all investigations moving forward. Date of Completion: October 30, 2015 Person Responsible: Area Director</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>room and [GHS #12] heard something that sounded like something hit the floor...."</p> <p>-GHS #2's witness statement indicated client #1 "wanted to come to the kitchen and [GHS #10] asked her if she would go back in to the living room because [client #1] constantly wants to be in the kitchen to try to gain access to snacks or money... [client #1] began to hit her legs...[GHS #10] wheeled [client #1] back to the living room...[client #1] trying to hit another client...[GHS #10] went to the living room to intervene and [client #1] just dropped to the floor...[GHS #10] did tell [client #1] that she could just lay down but [GHS #10] did not make her...."</p> <p>-"Conclusion...Evidence supports that [client #1] likely had a behavioral outburst...Evidence supports that [client #1] ended up on the ground however there is conflicting information as to how she ended up on the floor...Evidence could not be found to support the allegation of abuse." The investigation did not address the history of GHS #10 inappropriately restraining client #1.</p> <p>2. A 11/20/14 BDDS report for an incident on 11/19/14 at 3:00pm indicated "Staff reported to the [Residential</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>Manager (RM)] that they witnessed [client #1] being restrained inappropriately by another staff [Group Home Staff #10]. Staff were immediately suspended pending an investigation."</p> <p>-A 11/20/14 "Summary of Internal Investigation Report" indicated GHS #3 "reported on 11/19/14 that on 11/15/14 Saturday that [GHS #10] was using PIA (Physical Intervention Alternatives) on [client #1] and had a blanket over [client #1's] head."</p> <p>-A witness statement from the RM (Residential Manager) indicated: "stated that" on 11/19/14 GHS #3 "told [the RM] that [GHS #11] told [GHS #3] on Sunday (11/16/14) that she walked into the living room and [client #1] was on the floor covered with a fleece blanket...[client #1] was saying stop [GHS #10], please stop, [client #1] just wanted to get up."</p> <p>-A witness statement from GHS #11 indicated "when [GHS #11] came in on Saturday 11/15/14 around 3:00pm... [client #1] was on the floor and [GHS #10] had a blanket over [client #1's] head...[GHS #11] said [GHS #10] was not hurting [client #1]...."</p> <p>-A witness statement from GHS #3</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>indicated GHS #11 told her on 11/16/14 that GHS #10 had client #1 wrapped up in a blanket when GHS #11 arrived on shift on 11/15/14 and that "[client #1] has more significant behaviors when [GHS #10] is working..."</p> <p>-A witness statement from GHS #10 indicated "no PIA was used on [client #1]" on 11/15/14. GHS #10 indicated he "grabbed a blanket and knelt down beside [client #1's] head to put the blanket under her head because she was trying to bang her head."</p> <p>-"Additional Information...[Client #1's] behavior plan was not found in the home...Conclusion: Evidence could not be found to support any abuse or inappropriate PIA. Evidence supports that not all staff have been trained on [client #1's]" BSP (Behavior Support Plan). The investigation was not thorough in that the witness statements, factual findings, and conclusion did not indicate why staff did not immediately report an allegation of abuse, neglect, and/or mistreatment.</p> <p>On 9/25/15 at 12:15pm, an interview with the agency's Area Director (AD) was conducted. The AD indicated the facility followed the BDDS reporting guidelines for reportable incidents and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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
W 0249 Bldg. 00	<p>investigations. The AD indicated GHS #10 had two (2) incidents of potential abuse, neglect, and/or mistreatment for client #1. The AD indicated the two investigations were not thorough in that the investigation did not include why the facility did not investigate staff not immediately reporting allegations of abuse, neglect, and/or mistreatment. The AD indicated no further information was available for review.</p> <p>9-3-2(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.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (client #4), the facility failed to implement client #4's communication objective/goal when opportunities existed.</p> <p>Findings include:</p> <p>Observation and interview were conducted on 9/23/15 from 3:05pm until</p>	W 0249	<p>The facility ensures active treatment of individuals by developing an Individualized Support Plan (ISP) with the participation and input from an Interdisciplinary Team (IDT). The ISP includes interventions and goals to assist and support the individual to achievement of objectives.</p> <p>The staff will be retrained on performing active treatment, as well as utilizing any opportunity possible to engage an individual</p>	10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>6:35pm and on 9/24/15 from 5:40am until 7:55am, at the group home, and on 9/24/15 from 9:50am until 10:57am, at the contracted workshop. During the three (3) observation periods client #4 walked around throughout each room and was non verbal. During the three (3) observation periods client #4 was not taught and/or encouraged to use sign language and/or a communication system to communicate his wants and needs. During the three observation periods client #4 scraped the inside of his dishes during meals and was not offered more food to eat. During the three observation periods client #4 pulled different staff members by the arm and hand once staff asked him what he wanted after he made noises and screams. During the three observation periods no listed sign language words were observed available for client #4. On 9/23/15 at 6:35pm, the RM (Residential Manager) indicated the staff let client #4 take them to what he wants.</p> <p>On 9/24/15 at 1:35pm, client #4's record was reviewed. Client #4's 1/28/15 ISP (Individual Support Plan) indicated he was non verbal and had a communication goal to "practice listed signs of please, drink, and more." Client #4's 1/20/2009 Speech Therapy assessment indicated he was non verbal and staff were to use sign</p>		<p>towards completion or involvement of their goal. Staff will be retrained on Client #4's communication objective/goal and the need to implement this whenever opportunities exist. A member of management will complete observations at least three times weekly for a minimum of 30 days to ensure active treatment is being performed, particularly for Client #4's communication goal. If continuous and complete compliance has been achieved, observations will continue at least weekly for an additional 30 days. If continuous and complete compliance remains, observations will be completed as needed moving forward. Person Responsible: Area Director Date of Completion: October 30, 2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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
W 0268 Bldg. 00	<p>language to communicate.</p> <p>On 9/25/15 at 12:15pm, an interview was conducted with the AD (Area Director) and PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) #2. The AD and PD/QIDP #2 both indicated client #4's communication goal should be implemented during formal and informal opportunities. PD/QIDP #2 indicated client #4's objective/goal was to sign more, drink, and please.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation and interview, for 1 of 4 sampled clients (client #3) and 1 additional client (client #5), the facility failed to ensure clients #3 and #5's dignity in regard to their personal appearances.</p> <p>Findings include:</p> <p>Observation and interview were conducted on 9/23/15 from 3:05pm until 6:35pm and on 9/24/15 from 5:40am until 7:55am, at the group home, and on</p>	W 0268	<p>The facility has policies and procedures to promote growth, development, and independence of each individual, including personal dignity in regard to appearance.</p> <p>The staff will be retrained on ensuring the personal dignity of each individual, in particular Client #3's wearing clean clothing and Client #5 wearing and/or being encouraged to wear a belt.</p> <p>To ensure these items are being done, taught, and/or encouraged, a member of management will complete observations at least three times weekly for a minimum</p>	10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>9/24/15 from 9:50am until 10:57am, at the contracted workshop for clients #3 and #5.</p> <p>On 9/23/15 at 4:30pm, client #3 arrived home on the facility van with two facility staff. From 4:30pm until 6:35pm, client #3 wore a blue sweatshirt that had dried rings of food and liquid from the front collar/neck area extending to her waist of the sweatshirt. At 6:15pm, client #3 ate supper wearing the same soiled sweatshirt. At 6:35pm, client #3 wore the same soiled sweatshirt.</p> <p>On 9/24/15 from 6:40am until 7:55am, client #7 was observed to wear large blue jeans which fell down his legs to expose three to four (3-4 inches) of his underwear under the blue jeans. PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) #2, the RM (Residential Manager), and two group home staff observed client #5's pants sagging down his legs and client #5 pulling up his pants. Client #5 was not taught and/or encouraged to wear a belt.</p> <p>On 9/24/15 from 9:50am until 10:57am, client #5 was observed at the contracted workshop, wore the oversized blue jeans, and did not wear a belt. When client #5 stood up to walk his pants sagged down his legs to expose his underwear.</p>		<p>of 30 days. If continuous and complete compliance has been achieved, observations will continue at least weekly for an additional 30 days. If continuous and complete compliance remains, observations will be completed according to policy moving forward. Person Responsible: Area Director Date of Completion: October 30, 2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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
W 0289 Bldg. 00	<p>On 9/25/15 at 12:15pm, an interview was conducted with the AD (Area Director), PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) #1, and PD/QIDP #2. PD/QIDP #2 and AD both indicated client #3 should have been assisted by the facility staff to change her soiled clothing. Both staff indicated client #5 should have been taught and encouraged to wear a belt to hold up his pants for personal dignity.</p> <p>9-3-5(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>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 observation, record review, and interview, for 1 of 4 sampled clients (client #4), the facility failed to ensure client #4's behavioral intervention of staff supervision was incorporated into his ISP (Individual Support Plan) and/or BSP (Behavior Support Plan).</p> <p>Findings include:</p> <p>Observation and interview were conducted on 9/23/15 from 3:05pm until</p>	W 0289	<p>The facility has policies and procedures to ensure the use of systematic interventions to manage inappropriate behavior by individuals is incorporated into each individual's Behavioral Support Plan (BSP) and/or Individualized Support Plan (ISP), including the use of intensive staff supports.</p> <p>The ISP and BSP for Client #4 will be updated to include the specific behavioral intervention required for intensive staff supports. The QIDP will be</p>	10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2015	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905			
(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>6:35pm and on 9/24/15 from 5:40am until 7:55am, at the group home of client #4. Client #4 walked throughout each room of the group home independently, interacted with his housemates and staff, and client #4 did not have one on one staff supervision. On 9/23/15 at 4:30pm, the Residential Manager (RM) stated no clients living in the group home were one on one staff supervision and/or "required special (staff) supervision."</p> <p>On 9/24/15 from 9:50am until 10:57am, client #4 was observed at the contracted workshop. At 10:15am, client #4 sat next to Workshop Staff (WKS) #1 at a table. At 10:15am, WKS #1 and Workshop Supervisor both stated client #4 "was one on one" staff supervision at the workshop. The Workshop Supervisor indicated client #4's BSP and/or ISP did not include written guidelines for client #4's one on one staff supervision intervention and stated workshop staff were to "be within one arm's reach" of client #4 "at all times." WKS #1 indicated she was client #4's one on one staff supervision because of his behaviors of physical aggression, property destruction, and AWOL (Absent Without Leave). The Workshop Supervisor stated client #4 had been one on one staff supervision intervention "over" six (6) months.</p>		<p>retrained on the need to ensure the ISP and BSP include the specific behavioral interventions required to manage an individual's inappropriate behavior. Additionally, the residential and day service staff will be retrained on the updated plans.</p> <p>The Area Director will review the next three ISP's and BSP's to confirm inclusion of specific behavioral interventions/needs are incorporated into the program plans.</p> <p>Person Responsible: Area Director Date of Completion: October 30, 2015</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>Client #4's record was reviewed on 9/24/15 at 1:35pm. Client #4's 1/28/15 ISP and 5/2015 BSP both indicated client #4 had "targeted behaviors" which included: Aggressive outburst combined with Physical Aggression, Inappropriate Nudity, Stealing Food, AWOL (Absent Without Leave), and Resistance to instruction defined as "escape avoidance." Client #4's ISP indicated he required twenty-four hour a day staff supervision. Client #4's ISP, BSP, and/or record did not include a behavioral intervention to define the level of staff supervision that client #4 needed.</p> <p>On 9/25/15 at 12:15pm, an interview was conducted with the AD (Area Director) and QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) #2. QIDP/PD #2 stated client #4 did not recognize danger, "required" twenty-four hour staff supervision, and did not have one on one staff supervision at the group home. QIDP/PD indicated client #4's record did not include a behavioral intervention to define the level of staff supervision that client #4 needed. The AD indicated the facility knew that the workshop was providing client #4 one on one staff supervision for his behaviors as an intervention to prevent client #4's behaviors.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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
W 0369 Bldg. 00	<p>9-3-5(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview, for 2 of 9 medications administered (for clients #1 and #7) during the evening medication administration, the facility failed to administer medication without error for clients #1 and #7.</p> <p>Findings include:</p> <p>1. On 9/23/15 at 4:55pm, GHS (Group Home Staff) #3 selected client #1's "Calcium Tablet Chew 500mg (milligrams), Chew 1 tablet three times daily with meals" for Osteopenia (reduced bone mass). GHS #3 dispensed the tablet into a medication cup, client #1 took the medication, and no food or a meal was provided. At 6:15pm, client #1 consumed her first bite of food. At 6:15pm, GHS #3 and the RM (Residential Manager) both indicated client #1's first bite of food was at 6:15pm.</p>	W 0369	<p>The facility has policies and procedures to ensure medications are administered without error as designated by Physician's Orders.</p> <p>The staff will be retrained on proper medication administration techniques, including following Physician's Orders that require certain medications be taken with food. Staff will be retrained on Client #1 and Client #7's need for specific medications to be administered with meals or food. A member of management or the facility nurse will complete a medication administration observation at least three times weekly for a minimum of 30 days.</p> <p>If continuous and complete compliance has been achieved, medication administration observations will continue at least weekly for an additional 30 days.</p> <p>If continuous and complete compliance remains, medication administration observations will be completed as needed moving forward.</p> <p>Person Responsible: Area Director Date of Completion: October 30,</p>	10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>On 9/24/15 at 2:30pm, client #1's 9/2015 MAR (Medication Administration Record) and 6/2015 "Physician's Order" both indicated "Calcium Tablet Chew 500mg (milligrams), Chew 1 tablet three times daily with meals" for Osteopenia (reduced bone mass).</p> <p>2. On 9/23/15 at 5:08pm, client #7 was observed at the group home with GHS #3. At 5:08pm, GHS #3 administered client #7's "Oyster Calcium 500mg, take 1 tablet by mouth three times daily with meals" for Osteoporosis (loss of bone health). Client #7 took the medication with water, left the medication area, and no food and/or a meal was provided. At 6:15pm, client #7 took her first bite of the food which was her supper meal. At 6:15pm, GHS #3 and the RM both indicated client #7's first bite of food was at 6:15pm.</p> <p>On 9/25/15 at 8:25am, client #7's 9/2015 MAR and 6/2015 "Physician's Order" both indicated "Oyster Calcium 500mg, take 1 tablet by mouth three times daily with meals" for Osteoporosis (loss of bone health).</p> <p>On 9/24/15 at 1:00pm, an interview with the agency nurse was conducted. The agency nurse indicated staff should ensure client #1 and #7's physician's</p>		2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>orders were followed for administering medications with food and/or a meal. The agency nurse indicated the facility followed the Core A/Core B training for medication administration and the facility's policy and procedure for medication administration. The agency nurse indicated staff did not follow physician's orders.</p> <p>On 9/25/15 at 12:15pm, an interview was conducted with the AD (Area Director), PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) #1, and PD/QIDP #2. PD/QIDP #1 indicated client #1 and #7's medications should be administered according to physician's orders. PD/QIDP #1 and the AD both indicated the facility followed Core A/Core B Medication Administration Training.</p> <p>On 9/24/15 at 1:30pm, a review was conducted of the facility's 4/2011 "Health" policy and procedures and the 4/2011 "Medication Administration Handbook" both of which indicated each client's physician orders should be followed.</p> <p>On 9/24/15 at 1:30pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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
W 0381 Bldg. 00	<p>"Core Lesson 3: Principles of Administering Medication" medications should be administered according to physician's orders.</p> <p>9-3-6(a)</p> <p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. Based on observation, record review, and interview, for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8), the facility failed to ensure medication storage closets were kept secured for clients #1, #2, #3, #4, #5, #6, #7, and #8's medication.</p> <p>Findings include:</p> <p>On 9/23/15 from 4:50pm until 5:25pm, GHS #3 administered client #1, #2, #3, and #7's medications from two of two medication storage closets side by side in the front hallway. At 4:50pm, GHS #3 unlocked two of two medication closets. During the medication observation period, GHS #3 left the eye sight of both medication storage closets which were unlocked and unsecured when clients #1, #2, #3, and #7's medication administration was completed. At 5:25pm, GHS #3 relocked the two</p>	W 0381	<p>The facility has policies and procedures in place to ensure medications are stored properly and securely. Staff will be retrained on the need to ensure medication administration cabinets are locked and that the keys to these cabinets are kept secured by staff at all times. A member of management or the facility nurse will complete an observation at least three times weekly for a minimum of 30 days to ensure the medication administration cabinet is locked and that staff have the key properly secured. If continuous and complete compliance has been achieved, observations will continue at least weekly for an additional 30 days. If continuous and complete compliance remains, observations will be completed as needed moving forward. Person Responsible: Area Director Date of Completion: October 30,</p>	10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>medication closets. From 4:50pm until 5:25pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 walked up and down the hallway to the bathrooms, client bedrooms, kitchen, and living rooms walking past the unlocked and unsecured medication storage closets. At 5:25pm, GHS #3 indicated she had left the closets unlocked and unsecured between administering clients #1, #2, #3, and #7's medications. GHS #3 indicated she unlocked two of two closets at 4:50pm and relocked the closets at 5:25pm.</p> <p>On 9/25/15 at 12:15pm, an interview was conducted with the AD (Area Director), PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) #1, and PD/QIDP #2. PD/QIDP #1 indicated clients #1, #2, #3, #4, #5, #6, #7, and #8's medications were stored inside the medication cabinet. PD/QIDP #1 and the AD both indicated the facility followed Core A/Core B Medication Administration Training.</p> <p>On 9/24/15 at 1:30pm, a review was conducted of the facility's 4/2011 "Health" policy and procedures and the 4/2011 "Medication Administration Handbook" both of which indicated the medication cabinet should be kept secured by the facility staff.</p>		2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2015	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905			
(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			
W 0382 Bldg. 00	<p>On 9/24/15 at 1:00pm, an interview with the agency nurse was conducted. The agency nurse indicated medication cabinets should be kept secured when medications were not administered. The agency nurse indicated the facility followed "Living in the Community" for medication administration.</p> <p>On 9/24/15 at 1:30pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications keys should be kept secured.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who resided in the home, the facility failed to keep medication secure when not being administered for clients #1, #2, #3, #4, #5, #6, #7, and #8.</p> <p>Findings include:</p>	W 0382	The facility has policies and procedures in place to ensure all medications are locked, except for when being prepared for administration. This includes topical ointments, creams, and other prescribed medications. Staff will be retrained on the need to ensure all prescribed medications are locked/secured when not being administered. To ensure compliance, a member of management or the facility nurse	10/30/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2015	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905			
(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>On 9/23/15 from 3:05pm until 6:35pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed in the group home with three (3) facility staff on duty, accessed two of two bathrooms, and clients #1, #2, #3, #4, #5, #6, #7, and #8's prescribed creams and prescribed toothpaste tubes were observed in two of two bathrooms. At 5:25pm, the Residential Manager (RM) walked through the group home with the surveyor. At 5:25pm, the RM indicated the following medications with pharmacy labels were unsecured sitting in totes on the bathroom counter inside bathroom #1 for clients #1, #3, #6, and #7:</p> <p>-For client #1: One (1) eight ounce bottle with a pharmacy label "Ammonium Lactate 12% TO (Topical) Lot (Lotion), apply to topically to hands...after first dampening with water dry skin" for dry skin at 9:00pm.</p> <p>-For client #3: One (1) sixteen ounce bottle with a pharmacy label "Lubrisoft TO Lot, apply to the affected area twice daily as needed," one (1) four (4) ounce bottle of "Ammonium Lactate 12% TO Lot, apply as needed for dry skin," and two (2) 1.8 ounce (oz.) tubes with a pharmacy label indicating "Prevident 5000 Plus 1.1% PO (oral) cream, use to brush teeth twice daily and rinse" for</p>		<p>will complete an observation at least three times weekly for a minimum of 30 days to ensure no medications are left unlocked. If continuous and complete compliance has been achieved, observations will continue at least weekly for an additional 30 days. If continuous and complete compliance remains, observations will be completed as needed moving forward. Person Responsible: Area Director Date of Completion: October 30, 2015</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>Fluoride Therapy toothpaste.</p> <p>-For client #6: One (1) 16 oz. bottle of "Ammonium Lactate 12% TO Lot, apply as needed for dry skin."</p> <p>-For client #7: One (1) tube of "Metronidazole" 45grams cream, an antibiotic cream used for bacterial infections of the skin.</p> <p>On 9/23/15 at 5:45pm, the RM indicated the following medications were observed to have pharmacy labels, unsecured inside totes on the bathroom counter, and located inside bathroom #2 for clients #2, #4, #5, and #8:</p> <p>-For client #2: One (1) 30 grams "Tazorac 0.05% TO cream, apply to the affected area once daily at 8am for Acne" and one (1) 8oz. bottle of "Ammonium Lactate 12% TO Lot" apply to dry skin as needed.</p> <p>-For client #4: One (1) 8oz. bottle of "Ammonium Lactate 12% TO Lot" apply to dry skin as needed.</p> <p>-For client #5: One (1) 8oz. bottle of "Ammonium Lactate 12% TO Lot" apply to dry skin as needed and two (2) 1.8 ounce (oz.) tubes with a pharmacy label indicating "Prevident 5000 Plus 1.1% PO</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
---	--

(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>(oral) cream, use to brush teeth twice daily and rinse" for Fluoride Therapy toothpaste.</p> <p>-For client #8: One (1) 1.57oz. tube of Bacitracin Ointment 500U (units)/1 gm (gram) TO Oint., for minor cuts was area well with soap and water and apply topically twice daily and cover," two (2) 8oz. bottle of "Ammonium Lactate 12% TO Lot" apply to dry skin as needed, and two (2) 1.8 ounce (oz.) tubes with a pharmacy label indicating "Prevident 5000 Plus 1.1% PO (oral) cream, use to brush teeth twice daily and rinse" for Fluoride Therapy used for Gingivitis toothpaste.</p> <p>On 9/25/15 at 12:15pm, an interview with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) was conducted. The PD/QIDP indicated medications should be kept locked and secured when not being administered. The PD/QIDP indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 9/24/15 at 1:00pm, an interview with the agency nurse was conducted. The agency nurse indicated medications should be kept secured when medications were not administered. The agency nurse</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2015
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905		
(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>indicated the facility followed "Living in the Community" for medication administration.</p> <p>On 9/24/15 at 1:30pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be kept secured when not being administered.</p> <p>9-3-6(a)</p>				