

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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
W000000	<p>This visit was for an annual recertification and state licensure survey.</p> <p>Dates of survey: January 16, 17, 21, 22 and 24, 2014.</p> <p>Facility Number: 001113 AIM Number: 100245610 Provider Number: 15G599</p> <p>Surveyor: Christine Colon, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/10/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview, the governing body failed for 7 of 8 clients who resided at the group home (clients #1, #2, #3, #4, #6, #7 and #8), to exercise general operating direction in a manner to provide oversight to ensure their abuse and neglect policy was implemented in regards to documentation of incident reports, preventing client to client aggression</p>	W000104	<p>The governing body is committed to maintaining the health and safety of all the clients we serve. The facility currently has policies in place to make sure the individuals rights are being adhere to and that all needs are being met under the state regulations while living in the facility. Additionally, the facility is committed to prohibiting abuse, neglect and exploitation. All staff</p>	02/23/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410		
(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 financial exploitation and to ensure the facility took sufficient/effective corrective measures to prevent repeated episodes of client to client aggression and financial exploitation.</p> <p>Findings include:</p> <p>1. A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports was conducted on 1/17/14 at 4:00 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 1/14/13 indicated client #2 bit client #7 on the arm while sitting on the couch.</p> <p>-BDDS report dated 2/27/13 indicated \$20.00 was missing from client #2's personal petty cash funds kept at the group home.</p> <p>-BDDS report dated 4/16/13 indicated client #8 hit client #2 in the face while on the van causing redness to her face.</p> <p>-BDDS report dated 6/14/13 indicated a day program peer hit client #6 on her face.</p> <p>-BDDS report dated 6/15/13 indicated client #2 bit a day program peer while on the day service van and the peer</p>		<p>are trained upon hire and annually on the abuse, neglect and exploitation policy. All staff are also trained on the behavior support plan of each client and how to implement the plan to make sure the environment is appropriate for all who receive services. All staff will be retrained on the abuse, neglect and exploitation policy. All staff will be retrained on the Behavior Support Plan for client's #1,2,3,4,6,7, and 8 how to implement techniques described in the plan to assist and protect all clients. The Home Manager will monitor environment of the home by reviewing documentation and completing observations 3 times weekly for one month and then weekly. The Program Director will also be retrained to monitor the environment of the home by reviewing documentation and doing observations weekly one month and then monthly. The Program Director will also be trained to utilize each clients IDT as needed to engage in a teamings to to determine if additional support should be put in place for the clients to be safe and healthy in the home or other environment in which they are served. All staff will be retrained on the process of how to manage and document the client's petty cash daily. Staff will also be retrained on incident reporting when issues arise</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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>scratched client #2 on the left cheek.</p> <p>-BDDS report dated 7/31/13 indicated client #2 bit client #1 on the upper arm.</p> <p>-BDDS report dated 8/8/13 indicated client #1 scratched client #3 on both of his arms above the wrist area causing bleeding.</p> <p>-BDDS report dated 9/10/13 indicated client #2 scratched client #8.</p> <p>-BDDS report dated 10/10/13 indicated client #2 was punched by a day program peer on the day service van.</p> <p>-BDDS report dated 10/16/13 indicated client #2 had a fall with injury causing a bruise near her eyebrow.</p> <p>-BDDS report dated 11/13/13 indicated client #2 "grabbed" client #6's hair and pulled hair out. Client #6 scratched client #2 on the neck.</p> <p>-BDDS report dated 12/5/13 indicated client #4 was missing \$20.00 from his personal petty cash funds kept at the group home. The report further indicated client #7 was missing \$10.00 and client #3 was missing \$10.00.</p> <p>-BDDS report dated 12/31/13 indicated</p>		<p>regarding the client's funds. The Home Manager will be trained to review and ensure that the clients funds are accounted for on a daily basis at various times on all shifts for one month and then weekly thereafter. The Program Director will be trained to review and manage the clients funds weekly for the one month and then monthly thereafter. Responsible Party: Area Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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 #2 "attacked" client #8 while riding on the group home van.</p> <p>Further review of the above incidents failed to indicate internal incident reports were documented.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/22/14 at 5:15 P.M.. The QIDP indicated staff should follow the facility's abuse/neglect policy. The QIDP indicated all incidents of abuse and neglect are to be immediately reported by telephone to the on call person, a written incident report is to be completed by the staff involved in the incident and then investigated.</p> <p>A review of the facility's "Operating Practices-Supervised Group Living Services" policy, no date noted, was conducted on 1/17/14 at 7:30 P.M.. Review of the policy indicated:</p> <p>"...All incidents that require a report to the Bureau of Developmental Disabilities Services, or internal incident reports will be entered into a database maintained by The Mentor Network."</p> <p>2. Please refer to W149: The facility failed for 4 of 4 sampled clients and 3</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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>additional clients (clients #1, #2, #3, #4, #6, #7 and #8), to implement written policy and procedures regarding alleged abuse and neglect.</p> <p>3. Please refer to W157: The facility failed for 4 of 4 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #6, #7 and #8), to take sufficient/effective corrective measures to prevent repeated episodes of client to client aggression and financial exploitation.</p> <p>9-3-1(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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
W000130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, the facility failed for 1 of 4 sampled clients and 1 additional client (clients #4 and #8), to promote their privacy by not ensuring their beds were not put together.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/16/14 from 4:50 P.M. until 7:20 P.M.. At 6:00 P.M., clients #4 and #8's twin size beds were observed to be put together, making a full size bed. Direct Support Professionals #1, #2 and #3 walked past clients #4 and #8 checking on the clients as they lay on their bed.</p> <p>A morning observation was conducted at the group home on 1/17/14 from 6:30 A.M. until 8:10 A.M.. During the entire observation period, clients #4 and #8's beds were observed to be put together.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/22/14 at 5:15 P.M.. The QIDP indicated clients</p>	W000130	<p>The facility is committed to ensuring the client's rights are being adhered to at all times. All staff are trained upon hire and annually on client rights. All staff will be retrained on the clients rights and making sure that the the client's right to privacy is being protected and promoted. As a corrective measure the rooms and been rearranged so that client #8 does not push his bed next to client #4. The Home manager will monitor the environment of the home daily for one month to ensure the clients rights and privacy is being maintained and then weekly thereafter. The PD will be retrained to monitor the home weekly for one month to ensure the environment of home and to make sure the clients rights are being maintained and then monthly thereafter. Responsible Party: Area Director</p>	02/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410			
(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			
W000149	<p>#4 and #8's beds should be separate to ensure their personal privacy.</p> <p>9-3-2(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 record review and interview, the facility failed for 4 of 4 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #6, #7 and #8), to implement written policy and procedures to prevent alleged abuse and neglect in regards to client to client aggression and financial exploitation.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports was conducted on 1/17/14 at 4:00 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 1/14/13 indicated client #2 bit client #7 on the arm while sitting on the couch.</p> <p>-BDDS report dated 2/27/13 indicated</p>	W000149	<p>The facility currently has policies in place to make sure the individuals rights are being adhered to and that all needs are being met under the state regulations while living in the facility. Additionally, the facility is committed to prohibiting abuse, neglect and exploitation. All staff are trained upon hire and annually on the abuse, neglect and expolitation policy. All staff are also trained on the behavior support plan of each client and how to implement the plan to make sure the environment is appropriate for all who receive services. All staff will be retrained on the abuse, neglect and exploitation policy. All staff will be retrained on the Behavior Support Plan for client's #1,2,3,4,6,7, and 8 how to implement techniques deccribed in the plan to assist and protect all clients. The Home Manager will monitor environment of the home by</p>	02/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410			
(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>\$20.00 was missing from client #2's personal petty cash funds kept at the group home.</p> <p>-BDDS report dated 4/16/13 indicated client #8 hit client #2 in the face while on the van causing redness to her face.</p> <p>-BDDS report dated 6/14/13 indicated a day program peer hit client #6 on her face.</p> <p>-BDDS report dated 6/15/13 indicated client #2 bit a day program peer while on the day service van and the peer scratched client #2 on the left cheek.</p> <p>-BDDS report dated 7/31/13 indicated client #2 bit client #1 on the upper arm.</p> <p>-BDDS report dated 8/8/13 indicated client #1 scratched client #3 on both of his arms above the wrist area causing bleeding.</p> <p>-BDDS report dated 9/10/13 indicated client #2 scratched client #8.</p> <p>-BDDS report dated 10/10/13 indicated client #2 was punched by a day program peer on the day service van.</p> <p>-BDDS report dated 10/16/13 indicated client #2 had a fall with injury causing a</p>		<p>reviewing documentation and completing observations 3 times weekly for one month and then weekly. The Program Director will also be retrained to monitor the environment of the home by reviewing documentation and doing observations weekly one month and then monthly. The Program Director will also be trained to utilize each clients IDT as needed to engage in a teamings to to determine if additional support should be put in place for the clients to be safe and healthy in the home or other environment in which they are served. All staff will be retrained on the process of how to manage and document the client's petty cash daily. Staff will also be retrained on incident reporting when issues arise regarding the client's funds. The Home Manager will be trained to review and ensure that the clients funds are accounted for on a daily basis at various times on all shifts for one month and then weekly thereafter. The Program Director will be trained to review and manage the clients funds weekly for the one month and then monthly thereafter. Responsible Party: Area Director</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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>bruise near her eyebrow.</p> <p>-BDDS report dated 11/13/13 indicated client #2 "grabbed" client #6's hair and pulled hair out. Client #6 scratched client #2 on the neck.</p> <p>-BDDS report dated 12/5/13 indicated client #4 was missing \$20.00 from his personal petty cash funds kept at the group home. The report further indicated client #7 was missing \$10.00 and client #3 was missing \$10.00.</p> <p>-BDDS report dated 12/31/13 indicated client #2 "attacked" client #8 while riding on the group home van.</p> <p>A review of the facility's "Operating Practices-Supervised Group Living Services" policy, no date noted, was conducted on 1/17/14 at 7:30 P.M.. Review of the policy indicated:</p> <p>"Indiana Mentor has a fundamental responsibility to protect and promote the rights of the persons served...The following actions are prohibited by employees of Indiana Mentor: abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds; or violation of an individual's rights....Practices prohibited include the following: ...hitting...A</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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>proactive intervention that denies an individual of any of the following without a physicians order: ...medical care or treatment....Quality and Risk Management: Indiana MENTOR promotes a high quality of service and seeks to protect individuals receiving Indiana MENTOR services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed....Alleged, suspected or actual abuse, neglect, or exploitation of an individual...."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/22/14 at 5:15 P.M.. The QIDP indicated staff should follow the facility's abuse/neglect policy. When asked how the facility addressed the client to client aggression on the day program van, the QIDP indicated the clients do not sit by each other while transporting. The QIDP further indicated the clients' money was missing but there was no evidence leading to a particular staff. The QIDP further indicated the money was missing due to staff not double counting the petty cash.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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
W000157	<p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, for 4 of 4 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #6, #7 and #8), the facility failed to take sufficient/effective corrective measures to prevent repeated episodes of client to client aggression and financial exploitation.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports was conducted on 1/17/14 at 4:00 P.M.. Review of the records</p>	W000157	The facility currently has policies in place to ensure the individuals rights are being adhere to and that all needs are being met under the state regulations while living in the facility. Additionally, the facility is committed to prohibiting abuse, neglect and exploitation. All staff are trained upon hire and annually on the abuse, neglect and exploitation policy. When violations do occur the facility should take appropriate corrective actions to resolve the issue. All staff are also trained on the behavior support plan of each client and how to implement the	02/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410		
(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:</p> <p>-BDDS report dated 1/14/13 indicated client #2 bit client #7 on the arm while sitting on the couch.</p> <p>-BDDS report dated 2/27/13 indicated \$20.00 was missing from client #2's personal petty cash funds kept at the group home.</p> <p>-BDDS report dated 4/16/13 indicated client #8 hit client #2 in the face while on the van causing redness to her face.</p> <p>-BDDS report dated 6/14/13 indicated a day program peer hit client #6 on her face.</p> <p>-BDDS report dated 6/15/13 indicated client #2 bit a day program peer while on the day service van and the peer scratched client #2 on the left cheek.</p> <p>-BDDS report dated 7/31/13 indicated client #2 bit client #1 on the upper arm.</p> <p>-BDDS report dated 8/8/13 indicated client #1 scratched client #3 on both of his arms above the wrist area causing bleeding.</p> <p>-BDDS report dated 9/10/13 indicated client #2 scratched client #8.</p>		<p>plan to make sure the environment is appropriate for all who receive services. All staff will be retrained on the abuse, neglect and exploitation policy. All staff will be retrained on the Behavior Support Plan for client's #1,2,3,4,6,7, and 8 how to implement techniques decribed in the plan to assist and protect all clients. The Home Manager will monitor environment of the home by reviewing documentation and completing observations 3 times weekly for one month and then weekly. The Program Director will also be retrained to monitor the environment of the home by reviewing documentation and doing observations weekly one month and then monthly. The Program Director will also be trained to utilize each clients IDT as needed to engage in a teaming to to determine if additional support should be put in place for the clients to be safe and healthy in the home or other environment in which they are served. All staff will be retrained on the process of how to manage and document the client's petty cash daily. Staff will also be retrained on incident reporting when issues arise regarding the client's funds. The Home Manager will be trained to review and ensure that the clients funds are accounted for on a daily basis at various times on all shifts for one</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410			
(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>-BDDS report dated 10/10/13 indicated client #2 was punched by a day program peer on the day service van.</p> <p>-BDDS report dated 10/16/13 indicated client #2 had a fall with injury causing a bruise near her eyebrow.</p> <p>-BDDS report dated 11/13/13 indicated client #2 "grabbed" client #6's hair and pulled hair out. Client #6 scratched client #2 on the neck.</p> <p>-BDDS report dated 12/5/13 indicated client #4 was missing \$20.00 from his personal petty cash funds kept at the group home. The report further indicated client #7 was missing \$10.00 and client #3 was missing \$10.00.</p> <p>-BDDS report dated 12/31/13 indicated client #2 "attacked" client #8 while riding on the group home van.</p> <p>Further review of the reports failed to indicate the facility took effective/sufficient corrective action to prevent recurrence.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/22/14 at 5:15 P.M.. When asked how the facility</p>		<p>month and then weekly thereafter. The Program Director will be trained to review and manage the clients funds weekly for the one month and then monthly thereafter. Also the Area Director will review and monitor the finances bi-weekly for the one month and then monthly thereafter. The Area Director will review incidents and investigaitons to make sure appropriate corrective actions have been put in place when violations have occurred.</p> <p>Responsible Party: Area Director</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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
W000218	<p>addressed the client to client aggression on the day program van, the QIDP indicated the clients do not sit by each other while transporting. The QIDP indicated staff sign off on each client's personal petty cash sheet for each shift and the group home manager reviews the record. The QIDP indicated there was no documentation to indicate any further measures were put in place to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review and interview for 3 of 4 sampled clients and 2 additional clients (clients #1, #2, #4, #5 and #6), the facility failed to obtain sensorimotor assessments.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/16/14 from 4:50</p>	W000218	The facility coordinates and implements the clients goals and objectives with client and team input as well as assessments which are completed to determine the level of skills the client is capable of in a particular area. Included in the assessment is sensorimotor development assessments. The PD will be trained to ensure that the required information is included in the ISP/CFA specifically the area	02/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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>P.M. until 7:20 P.M.. During the entire observation period clients #5 and #6 utilized a wheelchair for mobility. Clients #1 and #2 were observed to have an unsteady gait. Client #4 was observed reaching to feel his way through his home.</p> <p>An interview with Direct Support Professional (DSP) #1 was conducted on 1/16/14 at 6:00 P.M.. DSP #1 stated "[Client #4] just recently lost his eyesight from glaucoma, that's why he feels his way around the house."</p> <p>A morning observation was conducted at the group home on 1/17/14 from 6:30 A.M. until 8:10 A.M.. During the entire observation period clients #5 and #6 utilized a wheelchair for mobility. Clients #1 and #2 were observed to have an unsteady gait. Client #4 was observed reaching to feel his way through his home.</p> <p>A facility owned day program observation was conducted on 1/21/14 from 12:45 P.M. until 1:55 P.M.. During the entire observation period clients #5 and #6 utilized a wheelchair for mobility. Clients #1 and #2 were observed to have an unsteady gait.</p> <p>A review of client #1's record was</p>		<p>of sensorimotor development and skills. The ISP/CFA will be updated for clients #1,2,4,5, and 6. The Area Director will review and monitor the next 4 client ISP/CFA to ensure the required information is present. Responsible Party: Area Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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>conducted on 1/21/14 at 3:20 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>A review of client #2's record was conducted on 1/21/14 at 4:10 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>A review of client #4's record was conducted on 1/21/14 at 5:00 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>A review of client #5's record was conducted on 1/21/14 at 5:30 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>A review of client #6's record was conducted on 1/21/14 at 5:45 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>An interview with the Nurse was conducted on 1/22/14 at 5:30 P.M.. The Nurse indicated clients #5 and #6 used a wheelchair for ambulation, clients #1 and #2 had an unsteady gait and client #4 recently lost his eye sight. The Nurse indicated clients #1, #2, #4, #5 and #6 did not have a sensorimotor assessment completed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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
W000220	<p>9-3-4(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development.</p> <p>Based on observation, record review and interview, the facility failed for 3 of 4 sampled clients and 2 additional clients (clients #1, #2, #4, #6 and #7) to ensure a speech assessment was completed for clients who need assistance with communication skills.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/16/14 from 4:50 P.M. until 7:20 P.M.. During the entire observation clients #1, #2, #4 and #7 were non-verbal in communication in that the clients did not speak. Client #6 could not be understood by this surveyor, staff and peers when speaking.</p> <p>A morning observation was conducted at</p>	W000220	<p>The facility coordinates and implements the clients goals and objectives on client and team input as well as assessments. Included in the assessments is speech and language development. The PD will be trained to ensure that the required information is included in the ISP/CFA specifically the area of speech and language development. The ISP/CFA will be updated for clients #1,2,4,5, and 6. The Area Director will review and monitor the next 4 client ISP/CFA to ensure the required information is present. The PD will also be trained that if information that is gathered from the speech and language assessment determines a deficit a communication goal will be written and implemented to address this need. The PD will develop communication goals for</p>	02/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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 group home on 1/17/14 from 6:30 A.M. until 8:10 A.M.. During the entire observation clients #1, #2, #4 and #7 were non-verbal in communication in that the clients did not speak. Client #6 could not be understood by this surveyor, staff and peers when speaking.</p> <p>A review of client #1's record was conducted on 1/21/14 at 3:20 P.M.. Review of client #1's record indicated she was non-verbal and did not indicate the client's speech and/or language skills had been assessed.</p> <p>A review of client #2's record was conducted on 1/21/14 at 4:10 P.M.. Review of client #2's record indicated she was non-verbal and did not indicate the client's speech and/or language skills had been assessed.</p> <p>A review of client #4's record was conducted on 1/21/14 at 5:00 P.M.. Review of client #4's record indicated he required assistance with communication and did not indicate the client's speech and/or language skills had been assessed.</p> <p>A review of client #6's record was conducted on 1/21/14 at 5:30 P.M.. Review of client #6's record indicated she required assistance with</p>		<p>clients #1,2,4, 6, and 7. All staff will be trained on the new goals and to implement them at all opportunities where training can occur. The Area Director will review next 4 ISPs to ensure that the required information is included and where their are deficits, a training goal or plan is in place. Responsible Party: Area Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410			
(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			
W000227	<p>communication and did not indicate the client's speech and/or language skills had been assessed.</p> <p>A review of client #7's record was conducted on 1/22/14 at 2:20 P.M.. Review of client #7's record indicated he required assistance with communication and did not indicate the client's speech and/or language skills had been assessed.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/22/14 at 5:15 P.M.. The QIDP indicated there was no documentation to indicate clients #1, #2, #4, #6 and #7's speech and/or language skills had been assessed.</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and</p>	W000227	The facility coordinates and	02/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410			
(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>interview for 1 of 4 sampled clients and 2 additional clients (clients #4, #6 and #7), the clients' Individual Support Plans (ISPs) failed to address the clients' identified communication needs.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/16/14 from 4:50 P.M. until 7:20 P.M.. During the entire observation clients #4 and #7 were non-verbal in communication in that the clients did not speak. Client #6 could not be understood by this surveyor, staff and peers while speaking.</p> <p>A morning observation was conducted at the group home on 1/17/14 from 6:30 A.M. until 8:10 A.M.. During the entire observation clients #4 and #7 were non-verbal in communication in that the clients did not speak. Client #6 could not be understood by this surveyor, staff and peers while speaking.</p> <p>An interview with Direct Support Professional (DSP) #1 was conducted on 1/16/14 at 6:00 P.M.. DSP #1 indicated clients #4 and #7 were non-verbal and client #6 talked but was hard to understand at times.</p> <p>A review of client #4's records was</p>		<p>implements the clients goals and objectives on client and team input as well as assessments. Included in the assessments is speech and language development. The PD will be trained to include in the ISP the specific objectives necessary to meet the client's needs as identified by assessments. The ISP for client #4, 6 and 7 will be updated to include a training goal for communication. All staff will be trained on the new goals and to implement the goal at formal and informal training opportunities. The Area Director will review the next 4 ISPs to ensure that any areas identified through assessments as a deficit there is a training goal or plan to address the need. Responsible Party: Area Director</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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>conducted on 1/21/14 at 5:00 P.M.. A review of the client's 8/14/13 ISP indicated he was non-verbal and failed to indicate a communication training objective to teach him to communicate with others about his wants and needs.</p> <p>A review of client #6's records was conducted on 1/21/14 at 5:30 P.M.. A review of the client's 3/28/13 ISP indicated she required assistance with her communication and failed to indicate a communication training objective to teach her to communicate with others about her wants and needs.</p> <p>A review of client #7's records was conducted on 1/22/14 at 2:20 P.M.. A review of the client's 2/21/13 ISP indicated he was non-verbal and failed to indicate a communication training objective to teach him to communicate with others about his wants and needs.</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 1/22/14 at 5:15 P.M.. The QIDP indicated clients #4, #6 and #7 did not have a communication training objective in their ISPs and further indicated they did need one implemented into their program.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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
W000247	<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, the facility failed to allow clients choice and self-management pertaining to developing of menus and eating when seated at the table, for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and for 4 additional clients (clients #5, #6, #7 and #8).</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/16/14 from 4:50 P.M. until 7:20 P.M.. At 5:20 P.M., client #5 asked this surveyor why she couldn't have fried food. When asked if she talked with the nutritionist about foods she would like on the menu, client #5 stated "She don't ask us what we want to eat. She don't listen to me, I'm sick of chicken." When asked what types of foods she would like to eat,</p>	W000247	<p>The facility provides opportunities for all the clients to make choices, encourage and teaches clients to make choices and to exercise control over their environment. Staff will be retrained to assist and encourage the clients #1,2,3 and 4 to participate in planning sessions to create a menu filled with their choices and in accordance with their diets as well as following the dieticians guidelines. The completed menus will be sent out for dietician review and will be implemented upon notification of approval. Staff and clients will review menus on a seasonal basis and make changes if desired and seek dietician approval prior to implementing.. The Home Manager will be trained to monitor the menus 3 times a week for the next 30 day and then weekly to make sure the clients choice is being adhered to. The PD will be train to monitor the menus weekly for the next 30</p>	02/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410			
(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 #6 stated "Greens, cornbread and pork chops." Client #5 stated "I want cakes and I love pasta. I like baked potatoes with sour cream and butter."</p> <p>A morning observation was conducted at the group home on 1/17/14 from 6:30 A.M. until 8:10 A.M.. At 6:45 A.M., clients #1, #2, #3, #4, #5, #6 and #7 were prompted to the dining table. Client #1 picked up her spoon and began eating her oatmeal. Direct Support Professional (DSP) #6 stated "[Client #1], you have to wait until everyone is here," and then took client #1's spoon from her hand. DSP #6 was asked why client #1 had to wait to eat. DSP #6 stated "They (the facility) want everyone at the table to eat."</p> <p>An interview with Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/22/14 at 5:15 P.M.. The QIDP indicated there was no documentation to indicate if the nutritionist involved clients #1, #2, #3, #4, #5, #6, #7 and #8 in developing menus. The QIDP further indicated clients should be allowed self choice and self management at all times.</p> <p>9-3-4(a)</p>		<p>days and then monthly to make sure the client's choice is being adhered to. Responsible Party: Area Director</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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
--------------------	--	---------------	---	----------------------

W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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, the facility failed to implement written objectives during times of opportunity for 4 of 4 sampled clients and 4 additional client (clients #1, #2, #3, #4, #5, #6, #7 and #8).</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/16/14 from 4:50 P.M. until 7:20 P.M.. During the entire observation period, clients #4, #7 and #8 stayed in their rooms with no activity or interaction. Clients #1, #2, #3, #5 and #8 sat in the living room with Direct Support Professional (DSP) #1. DSPs #2 and #3 would walk through the facility and visually check on clients #1, #2, #3, #5, #6, #7 and #8 but did not offer meaningful active treatment activities or implement client objectives.</p>	W000249	<p>The facility currently trains staff upon hire and annually on the importance of active treatment. staff are also trained on how to implement goals while interacting with the clients formally and informally. The Program Director will be retrain staff on active treatment and appropriate times to implement the goals of clients #1,2,3,4,5,6,7 and 8. The Home Manager will complete observations three times per week for one month and weekly thereafter to ensure that staff are providing active treatment and goals are being implemented at formal and informal opportunities. The Program Director will check weekly for one month to make sure goals are being implemented and documented and then monthly. If for any reasons goals are not successful or do not meet the clients needs the team will meet along with the client to determine appropriate goal choice. Responsible Party:</p>	02/23/2014
---------	---	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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>An observation was conducted at the group home on 1/17/14 from 6:30 A.M. until 8:10 A.M.. During the entire observation period, clients #4, #7 and #8 stayed in their rooms with no activity or interaction. Clients #1, #2, #3, #5 and #8 sat in the living room. DSPs #4, #5 and #6 would walk through the facility and visually check on clients #1, #2, #3, #5, #6, #7 and #8 but did not offer meaningful active treatment activities or implement client objectives. At 6:50 A.M., DSP #4 began administering the clients' medications. Client #4 did not recite his medication, client #5 did not punch out her medications and client #6 did not state the names of her medications.</p> <p>A review of client #1's record was conducted on 1/21/14 at 3:20 P.M.. Review of client #1's Individual Support Plan (ISP) dated 12/19/13 indicated the following training objectives which could have been implemented: "Will increase her communication skills by learning new site (sic) words...Will place sorted coins in staffs hands...Will exercise...Will do her laundry...Will participate in household tasks."</p> <p>A review of client #2's record was conducted on 1/21/14 at 4:10 P.M..</p>		Area Director	
--	--	--	---------------	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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>Review of client #2's record indicated an ISP dated 2/8/13 which indicated the following training objectives which could have been implemented: "Will participate in physical activity...Will exercise daily...Will do her laundry...Will increase her communication skills with the use of gestures."</p> <p>A review of client #3's record was conducted on 1/21/14 at 4:30 P.M.. Review of client #3's ISP dated 10/23/13 indicated the following training objectives which could have been implemented: "Will increase his physical activity...Will make healthy choices at mealtime...Will complete daily chores...Will complete his laundry...Will assist with making a meal."</p> <p>A review of client #4's record was conducted on 1/21/14 at 5:00 P.M.. Review of client #4's ISP dated 8/4/13 indicated the following training objectives which could have been implemented: "Will recite med...Will increase his physical activity...Will improve peer to peer interaction."</p> <p>A review of client #5's record was conducted on 1/21/14 at 3:40 P.M.. Review of client #5's ISP dated 1/14/14</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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 following training objectives which could have been implemented: "Will punch out her medications...Will learn her home address... Will increase her physical activity by exercising... Will improve her inappropriate language... Will complete her laundry."</p> <p>A review of client #6's record was conducted on 1/21/14 at 5:30 P.M.. Review of client #6's ISP dated 3/28/13 indicated the following training objectives which could have been implemented: "Will state the names of her medications... Will work out her upper body, legs and arms... Will learn to identify numbers and money... Will learn 911 and do mock fire drills."</p> <p>A review of client #7's record was conducted on 1/22/14 at 2:20 P.M.. Review of client #7's ISP dated 2/21/13 indicated the following training objectives which could have been implemented: "Will increase his physical activity... Will write his phone number and name... Will complete daily chores... Will reconcile his petty cash... Will do his laundry... Will participate in household tasks."</p> <p>A review of client #8's record was conducted on 1/22/14 at 3:20 P.M..</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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
W000323	<p>Review of client #8's ISP dated 8/14/13 indicated the following training objectives which could have been implemented: "Will increase his physical activity...Will reconcile his petty cash... Will do his laundry... Will participate in household chores."</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 1/22/14 at 5:15 P.M.. The QIDP stated client objectives should be implemented "at all times." The QIDP further indicated clients #1, #2, #3, #4, #5, #6, #7 and #8 should have been provided with meaningful active treatment activities during the observation periods.</p> <p>9-3-4(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410			
(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>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #3), to have a vision evaluation as recommended by the optometrist.</p> <p>Findings include:</p> <p>A review of client #3's record was conducted on 1/21/14 at 4:30 P.M.. Client #3's record indicated a most current vision evaluation dated 4/10/09 which indicated "Myopia and astigmatism...Follow-Up Appointment date: 2 years." Further review of the record did not indicate client #3 returned for a vision evaluation as recommended by the optometrist.</p> <p>An interview with the Nurse and Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/22/14 at 5:30 P.M.. The Nurse indicated client #3 should have gone for the follow up appointment as recommended by the optometrist. The QIDP indicated there was no evidence client #3 returned to the optometrist in two years as recommended.</p> <p>9-3-6(a)</p>	W000323	The facility is committed to maintaining the health and safety of the clients. The facility is responsible for making sure the clients medical appointments are made and completed in a timely manner. The Home Manager, Program Director and Facility Nurse will be retrained by the Area Director on maintaing client #4 health by making and keeping medical appointments. The Home Manager, Program Director and Facility Nurse will also be retrained on following the physicians orders and recommendations as precribed on the medical appointment form. If for any reason the appointments are canceled the Home Manager will reschedule the appointment immediately so the client is receiving the appropriate care while in the facility. In addition, the nurse will develop a schedule for the client appointments and share this schedule with the Program Director and Home Manager. The Home manager will monitor the appointment schedule on a weekly basis and the Program Director will monitor the schedule on a monthly basis. Responsible Party: Area Director	02/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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
--------------------	--	---------------	---	----------------------

W000331	<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, the facility failed for 4 of 4 sampled clients and 2 additional clients (clients #1, #2, #3, #4, #5 and #6), by not ensuring they received nursing services according to their medical needs.</p> <p>Findings include:</p> <p>1. An evening observation was conducted at the group home on 1/16/14 from 4:50 P.M. until 7:20 P.M.. During the entire observation period clients #5 and #6 utilized a wheelchair for mobility. Clients #1 and #2 were observed to have an unsteady gait. Client #4 was observed reaching to feel his way through his home.</p> <p>An interview with Direct Support Professional (DSP) #1 was conducted on 1/16/14 at 6:00 P.M.. DSP #1 stated "[Client #4] just recently lost his eyesight from glaucoma, that's why he feels his way around the house."</p>	W000331	<p>The facility coordinates and implements the clients goals and objectives on client and team input as well as comprehensive functional assessments which are completed to determine the level of skills the client is capable of in a particular area. Included in the assessment is sensorimotor development assessments. The PD will be retrained to update clients #1,2,3,4,5 and 6 ISP to include the CFA and sensorimotor development assessment. The Area Director will review and monitor the next 4 ISP/CFA to make sure they have the required information under the state guidelines. In addition to the Facility Nurse will be retrained to use the information gathered from the ISP and CFA assessments to make sure appropriate medical care is givens to client #1,2,3,4,5 and 6. The facility nurse will also be retrained that all doctor's recommendations should be adhered to according to the orders theat are prescribed. The Area Director will moniotr the facility nurses medical charts which include doctor's orders bi weekly for the next 30 days and then monthly. The Area Director</p>	02/23/2014
---------	--	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410			
(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>A morning observation was conducted at the group home on 1/17/14 from 6:30 A.M. until 8:10 A.M.. During the entire observation period clients #5 and #6 utilized a wheelchair for mobility. Clients #1 and #2 were observed to have an unsteady gait. Client #4 was observed reaching to feel his way through his home.</p> <p>A facility owned day program observation was conducted on 1/21/14 from 12:45 P.M. until 1:55 P.M.. During the entire observation period clients #5 and #6 utilized a wheelchair for mobility. Clients #1 and #2 were observed to have an unsteady gait.</p> <p>A review of client #1's record was conducted on 1/21/14 at 3:20 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>A review of client #2's record was conducted on 1/21/14 at 4:10 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>A review of client #4's record was conducted on 1/21/14 at 5:00 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>A review of client #5's record was</p>		<p>will review the facility nurses meidcal charts which include dotors orders bi weekly and then monthly. Staff will be retrained by the facility nurse on the use of clients #1 and 2 gait belt and protocol. Staff will also be retrained by the facility nurse on client #1 bowel tracking sheet and when to report to nurse any issues or concerns. The Home Manager will be retrained to review an monitor staff documentation for the next 30 days daily and then weekly. The Home Manager will also be retrained to do observations on the use of all adaptive equipment for clients#1 and 2 3 times a week and then weekly. The PD will be retrained to review and monitor staff documenntation weekly for the next 30 days and then monthly. The PD will also be retrained to do an observation weekly on the use of adaptive equipment weekly for the next 30 days for client #1 and 2 and then monthly. Responsible Party: Area Director</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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>conducted on 1/21/14 at 5:30 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>A review of client #6's record was conducted on 1/21/14 at 5:45 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>An interview with the Nurse was conducted on 1/22/14 at 5:30 P.M.. The Nurse indicated clients #5 and #6 used a wheelchair for ambulation, clients #1 and #2 had an unsteady gait and client #4 recently lost his eye sight. The Nurse indicated clients #1, #2, #4, #5 and #6 did not have a sensorimotor assessment completed.</p> <p>2. A review of client #3's record was conducted on 1/21/14 at 4:30 P.M.. Client #3's record indicated a most current vision evaluation dated 4/10/09 which indicated "Myopia and astigmatism...Follow-Up Appointment date: 2 years." Further review of the record did not indicate client #3 returned for a vision evaluation as recommended by the optometrist.</p> <p>An interview with the Nurse and Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/22/14 at 5:30 P.M.. The Nurse</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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 client #3 should have gone for the follow up appointment as recommended by the optometrist. The QIDP indicated there was no evidence client #3 returned to the optometrist in two years as recommended.</p> <p>3. A review of client #2's record was conducted on 1/21/14 at 4:10 P.M.. Client #2's record indicated a nursing quarterly was completed for 10/13. There was no evidence in her record to indicate nursing quarterlies were completed for 1/13 and 4/13. Client #2's most current annual physical was dated 8/22/13. Client #2's 8/14/13 Individual Support Plan (ISP) indicated client #2's diagnoses included, but were not limited to, seizure disorder, cerebral palsy, organic brain disorder and constipation. Client #2's 1/14 physician orders indicated client #2 received routine medications.</p> <p>An interview with the Nurse was conducted on 1/22/14 at 5:30 P.M.. When asked how often nursing quarterlies are to be completed, the Nurse stated "Nursing quarterlies are to be completed every three months." The Nurse further indicated she did not know why the nursing quarterlies were not in the record.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410			
(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>4. An evening observation was conducted at the group home on 1/16/14 from 4:50 P.M. until 7:20 P.M.. At 5:10 P.M., client #2 got up from the couch and walked into the kitchen. Client #2 was observed to have an unsteady gait when she walked. At 5:30 P.M., Direct Support Professional (DSP) #3 assisted client #1 off her recliner by holding her arm and walked with her down the hallway. Client #1 had an unsteady gait when she walked. DSPs #1, #2 and #3 and the Qualified Intellectual Disabilities Professional (QIDP) did not prompt and did not use a gait belt to assist clients #1 and #2 while ambulating.</p> <p>A morning observation was conducted at the group home on 1/17/14 between 6:30 A.M. and 8:10 A.M.. Clients #1 and #2 were observed the entire observation to have an unsteady gait when they walked. DSPs #4, #5, #6 and the QIDP did not use and did not prompt clients #1 and #2 to use their gait belts.</p> <p>An observation was conducted at the facility owned day program on 1/21/14 between 12:45 P.M. and 1:55 P.M.. Clients #1 and #2 were observed the entire observation to have an unsteady</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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>gait when they walked. DSPs #7, #8, #9, #10 and the QIDP did not use and did not prompt clients #1 and #2 to use their gait belts</p> <p>A review of client #1's record was conducted at the group home on 1/21/14 at 3:20 P.M.. A review of client #1's "Gait Belt PROTOCOL" dated 12/19/13 indicated: "Encourage and remind client that gait belt and assistance is needed." Review of client #1's "Bowel Movement Tracking Sheet" dated 11/13 indicated: "Notify Nurse if client does not have BM (bowel Movement) for 3 days." Further review of the record indicated client #1 did not have a bowel movement on 11/16, 11/17, 11/18, 11/19 and 11/20. There was no documentation to indicate the group home staff notified the nurse as instructed and there was no documentation to indicate the nurse assessed client #1 after the submitted documentation.</p> <p>A review of client #2's record was conducted on 1/21/14 at 4:10 P.M.. A review of client #2's "Gait Belt PROTOCOL" dated 4/11/13 indicated: "Encourage and remind client that gait belt and assistance is needed." Review of client #2's "Bowel Movement Tracking Sheet" dated 11/13 indicated: "Notify Nurse if client does not have</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410		
(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>BM (bowel Movement) for 3 days." Further review of the record indicated client #2 did not have a bowel movement the entire month. There was no documentation to indicate the group home staff notified the nurse as instructed and there was no documentation to indicate the nurse assessed client #2 after the submitted documentation.</p> <p>A review of the facility's employee records was conducted on 1/22/14 at 4:50 P.M.. Review of the employee records failed to indicate any training for any staff who worked at the group home on training and protocol on clients #1 and #2's gait belt protocols and bowel movement tracking.</p> <p>An interview with the group home nurse was conducted on 1/22/14 at 5:30 P.M.. When asked if there was protocol and documentation available for review for staff training on the use of gait belts and each client's bowel movement protocol/tracking, the nurse indicated there was not documentation.</p> <p>9-3-6(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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
W000336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview for 1 of 4 sampled clients (client #2), the facility's nursing services failed to conduct quarterly nursing assessments of the client's health status and medical needs.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 1/21/14 at 4:10 P.M.. Client #2's record indicated a nursing quarterly was completed for 10/13. There was no evidence in her record to</p>	W000336	<p>The facility is committed to maintaining the health and safety of all the clients we serve by providing appropriate medical care and keeping updated documentation. The facility nurse will be retrained by the Area Director to maintain and update quarterly assessments within the correct time frame for client#2. The Area Director will review the facility nurses quarterly assessments for the next 2 quarters to make sure all information is updated and maintained. Responsible Party: Area Director.</p>	02/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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
W000340	<p>indicate nursing quarterlies were completed for 1/13 and 4/13. Client #2's most current annual physical was dated 8/22/13. Client #2's 8/14/13 Individual Support Plan (ISP) indicated client #2's diagnoses included, but were not limited to, seizure disorder, cerebral palsy, organic brain disorder and constipation. Client #2's 1/14 physician orders indicated client #2 received routine medications.</p> <p>An interview with the Nurse was conducted on 1/22/14 at 5:30 P.M.. When asked how often nursing quarterlies are to be completed, the Nurse stated "Nursing quarterlies are to be completed every three months." The Nurse further indicated she did not know why the nursing quarterlies were not in the record.</p> <p>9-3-6(a)</p> <p>483.460(c)(5)(i) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410			
(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>Based on observation, record review and interview, the facility nursing services failed to assure staff were trained in health care needs for 2 of 4 sampled clients (clients #1 and #2).</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/16/14 from 4:50 P.M. until 7:20 P.M.. At 5:10 P.M., client #2 got up from the couch and walked into the kitchen. Client #2 was observed to have an unsteady gait when she walked. At 5:30 P.M., Direct Support Professional (DSP) #3 assisted client #1 off her recliner by holding her arm and walked with her down the hallway. Client #1 had an unsteady gait when she walked. DSPs #1, #2 and #3 and the Qualified Intellectual Disabilities Professional (QIDP) did not prompt and did not use a gait belt to assist clients #1 and #2 while ambulating.</p> <p>A morning observation was conducted at the group home on 1/17/14 between 6:30 A.M. and 8:10 A.M.. Clients #1 and #2 were observed the entire observation to have an unsteady gait when they walked. DSPs #4, #5, #6 and the QIDP did not use and did not prompt clients #1 and #2 to use their gait</p>	W000340	Currently the facility trains on the specific needs of the client and part of this training includes adaptive equipment. The Program Director and the Home Manager will be retrained to ensure that all staff receive training on each client's specific needs upon hire and when their are on any update of changes to a client's treatment or needs. All staff will be retrained in the client specific information of client 1 and 2. This training will include safe and appropriate use of the client's gait belt and training on the client's bowel protocols. Staff will be trained to report according to the protocol. Staff will be trained to ensure that they are documenting according to the protocol. The facility nurse will be trained to follow up with the Area Director when documentation has not been completed as required. The Home Manager will review the daily documentation in the medication administration record on a daily basis for one month to ensure that staff are documenting as required. Any problems noted will be documented on the Home Managers weekly checklist and reported to the Program Director. The Program Director will review the documentation in the medication administration record on a weekly basis for one month to ensure that staff are documenting as required. Responsible Party: Area Director	02/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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>belts.</p> <p>An observation was conducted at the facility owned day program on 1/21/14 between 12:45 P.M. and 1:55 P.M.. Clients #1 and #2 were observed the entire observation to have an unsteady gait when they walked. DSPs #7, #8, #9, #10 and the QIDP did not use and did not prompt clients #1 and #2 to use their gait belts</p> <p>A review of client #1's record was conducted at the group home on 1/21/14 at 3:20 P.M.. A review of client #1's "Gait Belt PROTOCOL" dated 12/19/13 indicated: "Encourage and remind client that gait belt and assistance is needed." Review of client #1's "Bowel Movement Tracking Sheet" dated 11/13 indicated: "Notify Nurse if client does not have BM (bowel Movement) for 3 days." Further review of the record indicated client #1 did not have a bowel movement on 11/16, 11/17, 11/18, 11/19 and 11/20. There was no documentation to indicate the group home staff notified the nurse as instructed and there was no documentation to indicate the nurse assessed client #1 after the submitted documentation.</p> <p>A review of client #2's record was</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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>conducted on 1/21/14 at 4:10 P.M.. A review of client #2's "Gait Belt PROTOCOL" dated 4/11/13 indicated: "Encourage and remind client that gait belt and assistance is needed." Review of client #2's "Bowel Movement Tracking Sheet" dated 11/13 indicated: "Notify Nurse if client does not have BM (bowel Movement) for 3 days." Further review of the record indicated client #2 did not have a bowel movement the entire month. There was no documentation to indicate the group home staff notified the nurse as instructed and there was no documentation to indicate the nurse assessed client #2 after the submitted documentation.</p> <p>A review of the facility's employee records was conducted on 1/22/14 at 4:50 P.M.. Review of the employee records failed to indicate any training for any staff who worked at the group home on training and protocol on clients #1 and #2's gait belt protocols and bowel movement tracking.</p> <p>An interview with the group home nurse was conducted on 1/22/14 at 5:30 P.M.. When asked if there was protocol and documentation available for review for staff training on the use of gait belts and each client's bowel movement</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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
W000436	<p>protocol/tracking, the nurse indicated there was not documentation.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 2 of 4 sampled clients who used adaptive aids and devices (clients #1 and #2), the facility failed to encourage and teach the use of a gait belt.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/16/14 from 4:50 P.M. until 7:20 P.M.. At 5:10 P.M.,</p>	W000436	The facility coordinates and implements the clients goals and objectives on client and team input as well as comprehensive functional assessments which are completed to determine the level of skills the client is capable of in a particular area. Included in the assessment is sensorimotor development assessments. The PD will be retrained to update clients #1, and2 ISP to include the CFA and sensorimotor development assessment. The Area Director will review and	02/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410			
(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 #2 got up from the couch and walked into the kitchen. Client #2 was observed to have an unsteady gait. At 5:30 P.M., Direct Support Professional (DSP) #3 assisted client #1 off her recliner by holding her arm and walked with her down the hallway. Client #1 had an unsteady gait. DSPs #1, #2 and #3 and the Qualified Intellectual Disabilities Professional (QIDP) did not prompt and did not use a gait belt to assist clients #1 and #2 while ambulating.</p> <p>A morning observation was conducted at the group home on 1/17/14 between 6:30 A.M. and 8:10 A.M.. Clients #1 and #2 were observed the entire observation to have unsteady gait. DSPs #4, #5, #6 and the QIDP did not use and did not prompt clients #1 and #2 to use their gait belts.</p> <p>An observation was conducted at the facility owned day program on 1/21/14 between 12:45 P.M. and 1:55 P.M.. Clients #1 and #2 were observed the entire observation to have unsteady gait. DSPs #7, #8, #9, #10 and the QIDP did not use and did not prompt clients #1 and #2 to use their gait belts.</p> <p>A review of client #1's record was</p>		<p>monitor the next 4 ISP/CFA to make sure they have the required information under the state guidelines. In addition to the Facility Nurse will be retrained to use the information gathered from the ISP and CFA assessments to make sure appropriate medical care is given to client #1 and 2. The facility nurse will also be retrained that all doctor's recommendations should be adhered to according to the orders that are prescribed. The Area Director will monitor the facility nurses medical charts which include doctor's orders bi weekly for the next month to make sure orders are being followed. Staff will be retrained by the facility nurse on the use of clients #1 and 2 gait belt and protocol. The Home Manager will be retrained to review and monitor staff documentation for the next 30 days 3 times a week and then weekly. The Home Manager will also be retrained to do observations on the use of all adaptive equipment for clients #1 and 2 3 times a week and then weekly. The PD will be retrained to put formal programming in place to assist client #1 and 2 with using their gait belts. The PD will be retrained to review and monitor staff documentation weekly for the next 30 days and then monthly. The PD will also be retrained to do an observation weekly on the use of adaptive equipment weekly for</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410		
(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	
W000440	<p>conducted at the group home on 1/21/14 at 3:20 P.M.. A review of client #1's "Gait Belt PROTOCOL" dated 12/19/13 indicated: "Encourage and remind client that gait belt and assistance is needed."</p> <p>A review of client #2's record was conducted on 1/21/14 at 4:10 P.M.. A review of client #2's "Gait Belt PROTOCOL" dated 4/11/13 indicated: "Encourage and remind client that gait belt and assistance is needed."</p> <p>The Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) and Nurse were interviewed on 1/22/14 at 5:20 P.M.. The Nurse indicated clients #1 and #2 had mobility risk plans which specified the use of a gait belt for mobility. The Nurse further indicated clients #1 and #2 should be using a gait belt.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation</p>	W000440	<p>the next 30 days and then monthly. Responsible Party: Area Director</p> <p>The facility is committed to maintaining the health and safety of all the clients. Staff will be</p>	02/23/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410			
(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>drills during the morning shift (8:00 A.M. to 4:00 P.M.) for the second quarter (April 1st through June 30th), morning shift and overnight shift (8:00 A.M. to 4:00 P.M. and 12:00 A.M. to 8:00 A.M.) during the third quarter (July 1st through September 30th) and for the fourth quarter (October 1st to December 31st) morning shift and evening shift (8:00 A.M. to 4:00 P.M. and 4:00 P.M. to 12:00 A.M.) of 2013 which affected 8 of 8 clients living in the facility (clients #1, #2, #3, #4, #5, #6, #7 and #8.)</p> <p>Findings include:</p> <p>The facility's records were reviewed on 1/17/14 at 7:45 A.M.. The review failed to indicate the facility held an evacuation drill for clients #1, #2, #3, #4, #5, #6, #7 and #8 in the morning for the second, third and fourth quarters of 2013, and did not conduct an evacuation drill for the overnight shift for the third quarter and evening during the fourth quarter of 2013.</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 1/22/14 at 5:15 P.M.. The QIDP indicated evacuation drills are to be conducted during each quarter for each shift.</p>		<p>retrained to review and follow the fire drill schedule and implement the schedule as written. The Home Manager and Program Director will be retrained by the Area Director to review and monitor the evacuation schedule and make sure staff are following the times as written per month. The Home Manager will also be trained to coordinate the drill by placing it on the schedule in the home. Responsible Party: Area Director</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410			
(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			
W000484	<p>9-3-7(a)</p> <p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview, the facility failed for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7 and #8) residing in the group home to provide condiments at the dining table.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group on 1/17/14 from 6:30 A.M. until 8:10 A.M.. Beginning at 7:15 A.M., clients #4, #5, #6, #7 and #8 began eating their breakfast which consisted of oatmeal, toasted bagels and juice. No sugar/sugar substitute, jelly, butter/margarine or milk were on the table for clients #1, #2, #3, #4, #5, #6, #7 and #8's use.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/22/14 at 5:15 P.M.. The QIDP, sugar/sugar substitute, butter/margarine, jelly and milk should be put on the table for the</p>	W000484	<p>The facility is committed to make sure that the individuals are provided with all the condiments needed during mealtime preparation and participating with preparing meals. Staff will be retrained to provide all condiments needed for breakfast for client#1,2,3,4,5,6, 7 and 8. The staff also will be retrained to implement the clients ISP goals and objectives formally and informally during meal times to make sure they are participating in preparing and serving their meals. The Home manager will be retrained to do various observations 3 times a week for the next 30 days and then weekly during different meal times to make sure condiments are being provided and the clients are participating in meal time preparation and serving. The Program Director will be retrained to do various observations weekly for the next 30 days and then monthly during different meal times to make sure condiments are being provided and the clients are participating in meal time preparation and</p>	02/23/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410		
(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	
W000488	<p>clients to use.</p> <p>9-3-8(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. Based on observation and interview, the facility failed to assure 8 of 8 clients residing at the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8) were involved in meal preparation and served themselves.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group on 1/17/14 from 6:30 A.M. until 8:10 A.M.. Upon entering the group home, Direct Support Professional (DSP) #6 cooked oatmeal while clients #1, #2, #3, #5 and #6 sat in the living room with no activity. Clients #4, #7 and #8 stayed in their bedrooms with no activity. At 6:45 A.M., DSP #5 served oatmeal into each client's bowls as clients #1, #2, #3, #4, #5, #6 and #7 sat at the dining table with no activity. Client #8 stayed in his room with no activity. At 7:10 A.M., DSP #5 placed bagels into the toaster and placed the</p>	W000488	<p>serving. Responsible Party: Area Director</p> <p>The facility currently trains staff upon hire and annually on the importance of active treatment during mealtime prep. Staff are also trained on how to implement goals while interacting with the clients formally and informally. The Program Director will be retrain staff on active treatment and appropriate times to implement the goals of clients #1,2,3,4,5,6,7 and 8. The Home Manager will be retrained to check 3 times a week that the goals are being implemented and documented for the next 30 days and then weekly. The Program Director will check weekly for the next 30 days to make sure goals are being implemented and documented and then monthly. If for any reasons goals are not successful or do not meet the clients needs the team will meet along with the client to determine appropriate goal choice. Responsible Party: Area Director</p>	02/23/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
---	--

(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>toasted bagels on each client's plate. Beginning at 7:15 A.M., clients #1, #2, #3, #4, #5, #6 and #7 began eating their breakfast. Clients #1, #2, #3, #4, #5, #6, #7 and #8 did not assist in meal preparation and did not serve themselves. Clients #1, #2, #3, #4, #5, #6 and #7 ate their meal independently.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/22/14 at 5:15 P.M.. The QIDP indicated clients were capable of assisting in meal preparation and serving themselves and further indicated they should be assisting in preparation and serving themselves at meal time.</p> <p>9-3-8(a)</p>			