STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	02/03/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0000	This visit was for an annual full recertification and state licensure survey. Dates of survey: January 23, 24, 26, 27 and February 2 and 3, 2012. Facility Number: 001113 AIM Number: 100245610 Provider Number: 15G599 Surveyors: Christine Colon, Medical Surveyor III/QMRP-Team Leader Tim Shebel, Medical Surveyor III/QMRP-MSW These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/17/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W0104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, the governing body failed for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7 and #8) living at the group home, to exercise general operating direction in a manner to ensure routine maintenance was completed. Findings include: An evening observation was conducted on 1/23/12 from 3:40 P.M. until 7:15 P.M.. Upon arriving at the group home one of the bedroom window mini blinds was observed to have 8 broken and missing slats. Upon entering the group home the bathroom located in the hallway next to the bedrooms was observed to not have a toilet paper holder. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/24/12 at 1:30 P.M.. The QMRP indicated the repairs need to be completed. The QMRP further indicated there were no maintenance repair request forms for this group home. No further documentation was available for review to indicate when the repairs would be completed.	W0104	**W104:** The governing body will exercise general policy, budget, and operating direction over the facility. The facility currently contracts vendors to repair physical repairs to the home as needed. The damage to the physical condition of the group home will be repaired. The Home Manager will contact a contractor to complete repairs of installing a toilet paper holder and replacement of mini blinds in the home. In the future, the Home Manager will perform weekly inspections of the home to ensure that all maintenance needs are addressed in a timely manner. The Program Director will monitor the home environment for repair needs as well as items that need replaced due to regular wear and tear. Person responsible: Program Director Completion Date: 3/4/12	03/04/2012

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	9-3-1(a)			

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W0125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review, and interview, the facility failed to assure 4 of 4 sampled clients (clients #1, #2, #3, and #4), assessed as capable of handling kitchen knives, had access to kitchen knives. Findings include: Observations of the group home where clients #1, #3, and #4 resided were conducted on 1/24/12 from 6:13 A.M. until 8:10 A.M.. During the observation period, the kitchen knives were in a basket which was locked in the medication closet. Clients #1, #2, #3, and #4 did not have access to the kitchen knives. Direct care staff #2 was interviewed on 1/24/12 at 8:11 A.M.. When asked why the kitchen knives were locked, direct care staff #2 stated, "They are locked so [client #7] can't get them." When asked if clients #1, #3, and #4 could utilize the kitchen knives, direct care staff #2 stated,	W0125	**W125**: The facility ensures the right of all clients. The facility allows and encourages each individual to exercise their rights as clients and citizens including the right to file complaints and the right to due process. The facility trained all supervisors to obtain the approval of the guardian, health care representative or family member prior to implementation of any action that would restrict client rights. The consent forms to seek approval of guardians, clients, The Interdisciplinary Team and The Human Rights Committee have been sent out with stamped return envelopes. The consents consist of seeking approval for locking sharps/knives due to client 7's behaviors and to ensure the safety of all clients in the home. The Program Director will be re-trained on client rights and approval process including Human Rights Committee format. In the future, the Program Director will ensure situations requiring approvals pertaining to client rights, will be obtained as required. Weekly, home manager will monitor the home to ensure client rights are protected. The	03/04/2012

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	"With staff assistance." Client #1's records were reviewed on 1/24/12 at 10:14 A.M.. A review of the client's 10/16/11 Individual Program Plan indicated the client was capable of utilizing kitchen knives and further review of client's record failed to indicate the client was restricted from using the kitchen knives. Client #2's records were reviewed on 1/24/12 at 10:57 A.M.. A review of the client's 8/9/11 Individual Program Plan indicated the client was capable of utilizing kitchen knives and further review of client's record failed to indicate the client was restricted from using the kitchen knives. Client #3's records were reviewed on 1/24/12 at 11:02 A.M.. A review of the client's 11/15/11 Individual Program Plan indicated the client was capable of utilizing kitchen knives and further review of client's record failed to indicate the client was restricted from using the kitchen knives. Client #4's records were reviewed on 1/24/12 at 12:07 P.M.. A review of the client's 12/6/11 Individual Program Plan indicated the client was capable of utilizing kitchen knives and further		Program Director will monitor the home monthly to ensure client rights are protected and approvals are obtained as necessary. Person Responsible: Program DirectorCompletion Date: 3/4/12	

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	review of client's record failed to indicate the client was restricted from using the kitchen knives. Program Director #1 was interviewed on 1/24/12 at 1:09 P.M.. Regional Director #1 indicated the knives were locked for client #7. Regional Director #1 further indicated clients #1, #3, and #4 did not have any assessed need which should restrict access to the facility's kitchen knives. 9-3-2(a)			

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W0208	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by other agencies serving the client is encouraged. Based on record review and interview, the facility failed for 2 of 4 sampled clients (clients #1 and #4) by not ensuring the outside day program participated in the clients' annual Individual Support Plan (ISP) meetings. Findings include: Client #2's records were reviewed on 1/24/12 at 10:57 A.M.. A review of the client's record indicated a most current ISP dated 8/9/11. Further review of the record failed to indicate participation in the client's annual ISP meeting by the outside day program provider. Client #4's records were reviewed on 1/24/12 at 12:07 P.M.. A review of the client's record indicated a most current ISP dated 12/6/11. Further review of the record failed to indicate participation in the client's annual ISP meeting by the outside day program provider. Interview with the Day Program Supervisor (DPS) was conducted on 1/27/12 at 11:10 A.M.. When asked if a representative from the day program attended the client's annual ISP meetings,	W0208	**W208:** The facility currently invites all individual team members of each client's Individual Support Team to participate by discussing, determine the needs of the client, and seek approvals for client year in the up coming year. The Program Director will contact the day program facilities for the clients to alert them to upcoming meetings and teaming to ensure they are invited to participate on those specific dates. In the future, the Program Director will ensure that a letter is sent to the day program at least 30 days in advance to alter day program agencies of the date of clients' annual Individual Support Plan teaming. Responsible Staff: Area Director Completion Date: 3/2/12	03/02/2012

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	the DPS stated "No, we are never invited." An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/3/12 at 2:20 P.M.. The QMRP indicated the day program staff are invited but never attend the clients' annual ISP meetings. 9-3-4(a)			

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W0225	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on record review and interview, the facility failed to assess the vocational needs of 4 of 4 sampled clients requiring vocational assessment (clients #1, #2, #3, and #4). Findings include: Client #1's record was reviewed on 1/24/12 at 10:14 A.M.. A review of client #1's 10/16/11 Individual Support Plan indicated the client's vocational needs and abilities had not been assessed. Client #2's record was reviewed on 1/24/12 at 10:57 A.M.. A review of client #2's 8/9/11 Individual Program Plan indicated the client's vocational needs and abilities had not been assessed. Client #3's record was reviewed on 1/24/12 at 11:02 A.M.. A review of client #3's 11/15/11 Individual Program Plan indicated the client's vocational needs and abilities had not been assessed. Client #4's record was reviewed on 1/24/12 at 12:07 P.M.. A review of client #4's 12/6/11 Individual Program Plan	W0225	**W225:** The facility currently completes assessments on all clients upon admission and annually prior to the client Individual Support Team meeting to determine the needs of the client and to establish programming goals for those needs. The Program Director has ensured that Client 1 thru 4 were assessed for vocational needed by completion of said assessments. The Home manager will ensure the assessments are placed in the client files. In addition the Program Director will ensure that needs addressed in the assessment are incorporated in the client Individual Support Plan as needed for day program. In the future, the Home Manager will ensure that each client is re-assessed vocationally annually and when client behavior or day program situation warrants the need. The Program Director will monitor the vocational progress by reviewing monthly data from day program to ensure the client is in a situation to meet his potential. Responsible Staff: Area Director Completion Date: 3/4/12	03/04/2012

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	indicated the client's vocational needs and abilities had not been assessed. Program Director #1 was interviewed on 1/24/12 at 1:09 P.M.. Program Director #1 indicated client #1, #2, #3, and #4's vocational needs and abilities had not been assessed. 9-3-4(a)			

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W0248	483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on record review, observation and interview, the facility failed to have an updated Individual Support Plan (ISP) for 2 of 2 clients observed at the outside day program (clients #1 and #4), available for all staff who worked at the day program. Findings include: A review of client #2's record was conducted at the facility's administrative office on 1/24/12 at 10:57 A.M.. A review of the client's record indicated a most current ISP dated 8/9/11. A review of client #4's record was conducted at the facility's administrative office on 1/24/12 at 12:07 P.M.. A review of the client's record indicated a most current ISP dated 12/6/11. An outside day program observation was conducted on 1/27/12 from 12:00 P.M. until 1:30 P.M.. During the observation period client #4 sat at a table with blocks. A review of client #4's record was conducted at 10:45 A.M.. A review of	W0248	**W248:** The facility currently meets with the client Interdisciplinary team to formulate an individual program plan. The group home staff are trained to implement on all treatment program goals to support achievement by the client of such goals. A copy of each client's individual plan is provided to relevant parties working with the client including other agencies providing day programming. The Program Director has provided copies of client 1 and 4 Individual Program Plan to the day program and obtained signatures of receipt of the plans. The Program Director will be re-trained on the process of distribution format of client information to other agencies as needed. In the future, the Program Director will ensure all appropriate parties receive a copy of client plans at least annually and as updates occur throughout the year. . Responsible Person: Program Director Completion Date: 3/4/12	03/04/2012

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	client #4's record indicated a most current ISP dated 12/9/09. A review of client #1's record was conducted at 11:05 A.M.. Review of the record indicated a most current ISP dated 2/10/10. Interview with the Day Program Supervisor (DPS) was conducted on 1/27/12 at 11:10 A.M.. The DPS indicated the mentioned ISP was the most current available for the day program staff. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/3/12 at 2:20 P.M.. The QMRP indicated the day program staff should have an updated ISP for clients #1 and #4. 9-3-4(a)			

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W0259	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview, the facility failed to assure a comprehensive functional assessment was reviewed at least annually for 4 of 4 sampled clients living in the group home (clients #1, #2, #3, and #4). Findings include: Client #1's record was reviewed on 1/24/12 at 10:14 A.M.. The review failed to indicate a comprehensive functional assessment had been conducted for client #1 since 1/24/11. Client #2's record was reviewed on 1/24/12 at 10:57 A.M.. The review failed to indicate a comprehensive functional assessment had conducted for client #2 since 1/24/11. Client #3's record was reviewed on 1/24/12 at 11:02 A.M.. The review indicated client #3's last comprehensive functional assessment was completed on 12/8/10. Client #4's record was reviewed on	W0259	**W259:** The facility currently completes assessments for a comprehensive functional assessment on all clients upon admission and annually. The Individual Support Team reviews the assessments at a meeting to determine the needs of the client and to establish programming goals for those needs. The Program Director has ensured that the comprehensive functional assessments have been completed for Clients 1 through 4 and sent for review by the client team. The Home manager will ensure the assessments are placed in the client files. The Program Director will be re-trained on the process of assessment completion annually for the clients. In the future, the Program Director will ensure that each client is re-assessed annually and when client situation warrants the need. The Program Director will monitor client progress by reviewing monthly data to ensure the client goals are appropriate to client needs. Responsible Staff: Area Director Completion Date: 3/4/12	03/04/2012

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	1/24/12 at 12:07 P.M.. The review failed to indicate a comprehensive functional assessment had conducted for client #4 since 1/24/11. Program Director #1 was interviewed on 1/24/12 at 1:07 P.M.. Program Director #1 indicated the facility did not have documentation of current comprehensive functional analysis being conducted for clients #1, #2, #3, and #4. 9-3-4(a)			

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W0383	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview, the facility failed for 8 of 8 clients residing at the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8), to ensure only authorized persons had access to the keys to the medication closet. Findings include: An evening observation was conducted at the group home on 1/23/12 from 3:40 P.M. until 7:15 P.M.. Throughout the observation period, the Group Home Manager and Direct Support Staff #2 and #3 were observed going into the open kitchen and retrieving the medication closet keys from the cabinet located above the microwave and placing the keys back into the cabinet after unlocking and locking the medication closet located in the hallway between the living room and open dining area. Clients #1, #2, #3, #4, #5, #6, #7 and #8 were observed during the observation entering into the kitchen and walking past the medication closet. An interview with the Registered Nurse (RN) was conducted on 1/24/12 at 12:15 P.M.. The RN indicated the keys should only be available to authorized persons,	W0383	**W383:** The facility trains all new direct support employees and supervisors to ensure only authorized persons have access to keys to the drug storage area. The Program Director trained the support staff to reiterate the procedure of staff possession and secure storage of keys to drug storage area. The home manager will complete weekly observations to ensure the staff correctly secure the keys and client medication. In the future, the Home Manager will complete weekly observations to ensure the staff are correctly securing the keys and client medication. The Program Director will complete monthly observations to ensure the staff are correctly securing the keys to the medication area. Responsible Staff: Program Director Completion Date: 3/4/12	03/04/2012

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	not put in the kitchen cabinet where anyone would have access to them. 9-3-6(a)			

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0433	483.470(f)(3) FLOORS The facility must have exposed floor surfaces and floor coverings that promote mobility in areas used by clients. Based on observation and interview for 2 of 2 clients (clients #5 and #6), who were at risk for falls, the facility failed to have floor coverings that promote mobility in areas used by clients. Findings include: An evening observation was conducted at the group home on 1/23/12 from 3:40 P.M. until 7:15 P.M.. At 4:15 P.M., clients #5 and #6 were entering into the hallway leading to their bedrooms. Client #5 used a walker. The carpeting was observed to have ripples throughout the hallway. A review of client #5's record was conducted at the facility's administrative office on 1/24/12 at 1:40 P.M.. A review of client #5's record indicated an "At Risk for Falls" protocol dated 5/12/11 and indicated: "Weakness, Unsteady gait, falls...has unsteady gait is at risk for falls and fractures...uses a walker." A review of client #6's record was conducted at the facility's administrative office on 1/24/12 at 1:50 P.M.. A review of client #6's record indicated an "Falls"	W0433	**W433:** The facility currently contracts vendors to repair physical repairs to the home as needed. The facility monitors the environment to ensure the exposed floor surfaces and floor coverings that promote mobility in all areas used by clients.The Home Manager will contact a contractor to replace the carpeting leading to the bedroom. In the future, the Home Manager will perform weekly inspections of the home to ensure that all maintenance needs are addressed in a timely manner. The Program Director will monitor the home environment for repair needs and floor covering replacement as well as items that need replaced due to regular wear and tear. Person responsible: Program DirectorCompletion Date: 3/4/12	03/04/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	02/03/2012

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	protocol dated 5/12/11 and indicated she was at risk for falls. An interview with the Registered Nurse (RN) was conducted at the facility's administrative office on 1/24/12 at 2:08 P.M.. The RN indicated clients #5 and #6 were at risk for falls. An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 2/3/12 at 2:20 P.M.. The QMRP indicated the hallway carpeting had ripples throughout. 9-3-7(a)			