PRINTED: 03/13/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DA	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COM	MPLETED
		15G599	B. WING	-	 02/	03/2012
NAME OF I	PROVIDER OR SUPPLIE	D.	STREE	T ADDRESS, CITY, STATE, ZIF	P CODE	
NAME OF	PROVIDER OR SUPPLIE.	ĸ	860 V	V 65TH LN		
REM-INI	DIANA INC		MER	RILLVILLE, IN 46410		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE HE APPROPRIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
W0000						
			W0000			
	This visit was fo		W 0000			
	recertification as	nd state licensure survey.				
	Dates of survey	: January 23, 24, 26, 27				
	and February 2					
	and February 23	and 3, 2012.				
	Facility Number	r: 001113				
	AIM Number:	100245610				
	Provider Number					
	Provider Number	E1. 13G399				
	Surveyors:					
	1	, Medical Surveyor				
	III/QMRP-Tean	•				
	Tim Shebel, Me					
	1	•				
	III/QMRP-MSV	V				
	These deficience	ies also reflect state				
		rdance with 460 IAC 9.				
	_					
		completed 2/17/12 by				
	Kuth Shackelfor	d, Medical Surveyor III.				
l						

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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 X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		15G599	B. WIN			02/03/2012	
NAME OF B	ADOLUDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			860 W	65TH LN		
	DIANA INC			MERRI	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE	
W0104	483.410(a)(1) GOVERNING BO	NUX					
		ody must exercise general					
		nd operating direction over					
	the facility.						
		ation and interview, the	W0	104	W104: The governing body wil		
		failed for 8 of 8 clients			exercise general policy, budge and operating direction over the		
	(clients #1, #2, #	3, #4, #5, #6, #7 and #8)			facility. The facility currently		
	living at the grou	p home, to exercise			contracts vendors to repair		
	general operating	g direction in a manner to		physical repairs to the home		S	
	ensure routine m	aintenance was			needed. The damage to the		
	completed.				physical condition of the group home will be repaired.		
					nome will be repaired.		
	Findings include:				The Home Manager will contact	ct a	
	C				contractor to complete repairs		
	An evening obse	rvation was conducted on			installing a toilet paper holder		
	_	0 P.M. until 7:15 P.M			replacement of mini blinds in the home.	ie	
		the group home one of			nome.		
		dow mini blinds was			In the future, the Home Manag	jer	
		8 broken and missing			will perform weekly inspections	s of	
		ring the group home the			the home to ensure that all		
	*	d in the hallway next to			maintenance needs are addressed in a timely manner.		
		is observed to not have a			The Program Director will mon		
					the home environment for repa		
	toilet paper holde	7 1.			needs as well as items that ne		
	An interview	1. 41. a O. a 1:E a 1 M 1			replaced due to regular wear a	ind	
		th the Qualified Mental			tear.		
		essional (QMRP) was			Person responsible: Program		
		24/12 at 1:30 P.M The			Director		
	-	the repairs need to be			Completion Date: 3/4/12		
	-	QMRP further indicated					
		aintenance repair request					
	_	oup home. No further					
	documentation w	as available for review					
	to indicate when	the repairs would be					
	completed.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MK7Y11

Facility ID: 001113

If continuation sheet

Page 2 of 18

PRINTED: 03/13/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G599	(X2) MULTIPLE CC A. BUILDING B. WING	00	— COM 02/0	E SURVEY PLETED 3/2012
REM-IND	PROVIDER OR SUPPLIER		860 W (ADDRESS, CITY, STATE, ZIF 85TH LN LLVILLE, IN 46410	P CÓDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	9-3-1(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MK7Y11

Facility ID: 001113

If continuation sheet Page 3 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G599	B. WING		02/03/2012	
	PROVIDER OR SUPPLIEF		860 W	ADDRESS, CITY, STATE, ZIP CODE 65TH LN ILLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)	
PREFIX		ICY MUST BE PERCEDED BY FULL	PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
W0125	The facility must clients. Therefo encourage indivi rights as clients of the United Sta	OF CLIENTS RIGHTS ensure the rights of all re, the facility must allow and idual clients to exercise their of the facility, and as citizens ates, including the right to file the right to due process.	W0125	W125 : The facility ensures the	9 03/04/2012	
	interview, the far 4 sampled client #4), assessed as kitchen knives, haves. Findings include Observations of clients #1, #3, ar conducted on 1/2 until 8:10 A.M period, the kitchen kaket which was medication close #4 did not have a knives. Direct care staff 1/24/12 at 8:11 A the kitchen knive care staff #2 stat [client #7] can't g clients #1, #3, ar	the group home where and #4 resided were 24/12 from 6:13 A.M. During the observation en knives were in a slocked in the et. Clients #1, #2, #3, and access to the kitchen #2 was interviewed on A.M When asked why es were locked, direct ed, "They are locked so get them." When asked if and #4 could utilize the		right of all clients. The facility allows and encourages each individual to exercise their right as clients and citizens includir the right to file complaints and right to due process. The facil trained all supervisors to obtain the approval of the guardian, health care representative or family member prior to implementation of any action to would restrict client rights. The consent forms to seek approving guardians, clients, The Interdisciplinary Team and The Human Rights Committee have been sent out with stamped return envelopes. The consent consist of seeking approval for locking sharps/knives due to client 7's behaviors and to ensithe safety of all clients in the home. The Program Director with the program Director will ensure situations requiring approvals pertaining client rights, will be obtained a required. Weekly, home management of the program of the pro	nts ng ithe ity iin that e al of e ve ts r sure will nd mat. to us uger	
	Findings include Observations of clients #1, #3, ar conducted on 1/2 until 8:10 A.M period, the kitch basket which wa medication close #4 did not have a knives. Direct care staff 1/24/12 at 8:11 A the kitchen knive care staff #2 stat [client #7] can't g clients #1, #3, ar	the group home where and #4 resided were 24/12 from 6:13 A.M. During the observation en knives were in a as locked in the et. Clients #1, #2, #3, and access to the kitchen #2 was interviewed on A.M When asked why es were locked, direct ed, "They are locked so get them." When asked if		the approval of the guardian, health care representative or family member prior to implementation of any action to would restrict client rights. The consent forms to seek approving guardians, clients, The Interdisciplinary Team and The Human Rights Committee have been sent out with stamped return envelopes. The consent 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 with the future, the Program Director will ensure situations requiring approvals pertaining client rights, will be obtained as	that e al of e ve ts r sure will nd mat. to as ager re	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MK7Y11

Facility ID: 001113

If continuation sheet

Page 4 of 18

PRINTED: 03/13/2012 FORM APPROVED OMB NO. 0938-0391

	f '			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING COMPLETED				
		15G599	B. WIN	G		02/03/	2012	
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
					65TH LN			
REM-IND	DIANA INC			MERRII	LLVILLE, IN 46410			
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX				PREFIX	CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE	
	"With staff assist	tance."			Program Director will monitor t			
					home monthly to ensure client rights are protected and			
	Client #1's record	ds were reviewed on			approvals are obtained as			
	1/24/12 at 10:14	A.M A review of the			necessary. Person Responsib	le:		
	client's 10/16/11	Individual Program Plan			Program DirectorCompletion			
	indicated the clie	ent was capable of			Date: 3/4/12			
		knives and further						
		record failed to indicate						
	the client was res	stricted from using the						
	kitchen knives.	Č						
	Client #2's record	ds were reviewed on						
		A.M A review of the						
		dividual Program Plan						
		ent was capable of						
		knives and further						
		record failed to indicate						
		stricted from using the						
	kitchen knives.							
	GI: JUQ							
		ds were reviewed on						
		A.M A review of the						
		Individual Program Plan						
		ent was capable of						
		knives and further						
		record failed to indicate						
	the client was res	stricted from using the						
	kitchen knives.							
	Client #4's record	ds were reviewed on						
	1/24/12 at 12:07	P.M A review of the						
	client's 12/6/11 I	ndividual Program Plan						
		ent was capable of						
		knives and further						
	l – –							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MK7Y11

Facility ID: 001113

If continuation sheet Page 5 of 18

PRINTED: 03/13/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15G599	A. BUILDING B. WING	00 <u>00</u>	HON .	COMPL 02/03/	ETED	
	PROVIDER OR SUPPLIER DIANA 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 PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TA	IX (EAC CROSS	PROVIDER'S PLAN OF CORRECTION "H CORRECTIVE ACTION SHOULD BE 5-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	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)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MK7Y11

Facility ID: 001113

If continuation sheet Page 6 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	TED
		15G599	B. WIN			02/03/2	012
NAME OF B	DOLUDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			860 W	65TH LN		
	DIANA INC				LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+-	TAG	DEFICIENCY)		DATE
W0208	client is encourag	other agencies serving the ged.	III/O				02/02/2012
		review and interview, the	W0	208	W208: The facility currently		03/02/2012
	facility failed for	2 of 4 sampled clients			invites all individual team members of each client's		
	(clients #1 and #4	4) by not ensuring the			Individual Support Team to		
	outside day prog	ram participated in the			participate by discussing,		
	clients' annual In	dividual Support Plan			determine the needs of the clie		
	(ISP) meetings.				and seek approvals for client y	/ear	
	Findings include	:			in the up coming year. The Program Director will contact t day program facilities for the clients to alert them to upcomi	ng	
	Client #2's record	ds were reviewed on			meetings and teaming to ensu		
	1/24/12 at 10:57	A.M A review of the			they are invited to participate of	on	
	client's record in	dicated a most current			those specific dates. In the future, the Program Director w	ill	
		. Further review of the			ensure that a letter is sent to the		
		ndicate participation in			day program at least 30 days i	n	
		al ISP meeting by the			advance to alter day program		
	outside day progr	• •			agencies of the date of clients annual Individual Support Plan	1	
		ds were reviewed on			teaming. Responsible Staff: Al Director Completion Date: 3/2		
		P.M A review of the					
	client's record in	dicated a most current					
	ISP dated 12/6/1	1. Further review of the					
	record failed to in	ndicate participation in					
	the client's annua	al ISP meeting by the					
	outside day progr	ram provider.					
	Interview with th	ne Day Program					
) was conducted on					
	-	A.M When asked if a					
		om the day program					
	_	nt's annual ISP meetings,					
	attended the effet	nto amidai ioi mootingo,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MK7Y11

Facility ID: 001113

If continuation sheet

Page 7 of 18

PRINTED: 03/13/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G599	(X2) MULTIPLE CC A. BUILDING B. WING	00	02/03	LETED 8/2012		
	PROVIDER OR SUPPLIER	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 PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	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)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MK7Y11

Facility ID: 001113

If continuation sheet

Page 8 of 18

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING OO COMPLE			ETED		
		15G599	B. WIN			02/03/	2012	
			P. 1121		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				65TH LN			
REM-IND	IANA INC				LLVILLE, IN 46410			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY		DATE	
W0225	483.440(c)(3)(v) INDIVIDUAL PR	OGRAM PLAN						
		sive functional assessment						
	•	applicable, vocational skills.						
			W0:	225	W225: The facility currently		03/04/2012	
	Based on record	review and interview, the			completes assessments on all			
		assess the vocational			clients upon admission and			
		ampled clients requiring			annually prior to the client Individual Support Team meet	ina		
		sment (clients #1, #2, #3,			to determine the needs of the	irig		
	and #4).	ment (chents #1, #2, #3,			client and to establish			
	and #4).				programming goals for those			
	E' 1' ' 1 1				needs. The Program Director			
	Findings include	:			has ensured that Client 1 thru	4		
					were assessed for vocational needed by completion of said			
		d was reviewed on			assessments. The Home			
		A.M A review of client			manager will ensure the			
		lividual Support Plan			assessments are placed in the	;		
	indicated the clie	ent's vocational needs and			client files. In addition the			
	abilities had not	been assessed.			Program Director will ensure the	nat		
					needs addressed in the assessment are incorporated i	n		
	Client #2's record	d was reviewed on			the client Individual Support Pl			
	1/24/12 at 10:57	A.M A review of client			as needed for day program.			
	#2's 8/9/11 Indiv	idual Program Plan			the future, the Home Manager	will		
		ent's vocational needs and			ensure that each client is	alls.		
	abilities had not	been assessed.			re-assessed vocationally annual and when client behavior or da	•		
					program situation warrants the	-		
	Client #3's record	d was reviewed on			need. The Program Director v			
		A.M A review of client			monitor the vocational progres			
		dividual Program Plan			by reviewing monthly data from			
		ent's vocational needs and			day program to ensure the clie is in a situation to meet his	rit		
	abilities had not				potential. Responsible Staff: A	rea		
	aviilles hau hot	occii assesseu.			Director Completion Date:	· -		
	Cliant #41	d was marrianned			3/4/12			
		d was reviewed on						
		P.M A review of client						
	#4's 12/6/11 Indi	vidual Program Plan						
			- 1		1			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MK7Y11

Facility ID: 001113

If continuation sheet

Page 9 of 18

PRINTED: 03/13/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G599	(X2) MULTIPLE CO A. BUILDING B. WING	00	- COM 02/0	TE SURVEY SPLETED 03/2012	
REM-INI	PROVIDER OR SUPPLIER	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 PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	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)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MK7Y11

Facility ID: 001113

If continuation sheet

Page 10 of 18

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		15G599	B. WIN			02/03/	2012
			p. ,, 11,		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				65TH LN		
REM-IND	DIANA INC				LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0248	be made availab including staff of with the client, and the client is a min Based on record interview, the fact updated Individual for 2 of 2 clients day program (clief or all staff who program. Findings include A review of clier conducted at the office on 1/24/12 review of the clier conducted at the office on 1/24/12 review of the clier conducted at the office on 1/24/12 review of the clier conducted at the office on 1/24/12 review of the clier conducted at the office on 1/24/12 review of the clier conducted at the office on 1/24/12 review of the clier conducted on 1/24/12 review of clier conducted on 1/	dient's individual plan must le to all relevant staff, other agencies who work and to the client, parents (if nor) or legal guardian. review, observation and cility failed to have an ual Support Plan (ISP) observed at the outside ents #1 and #4), available worked at the day : at #2's record was facility's administrative at 10:57 A.M A ent's record indicated a dated 8/9/11. at #4's record was facility's administrative at 12:07 P.M A ent's record indicated a	W0	248	w248: The facility currently meets with the client Interdisciplinary team to formulan individual program plan. The group home staff are trained to implement on all treatment program goals to support achievement by the client of singular 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 Individual Program Plan to the day program and obtained signatures of receipt of the plather program Director will be re-trained on the process of distribution format of client information to other agencies an eeded. In the future, the Program Director will ensure a appropriate parties receive a cofficient plans at least annually and as updates occur througher the year. Responsible Perso Program Director Completion Date: 3/4/12	ne o uch ne 1 4 ns. as as ll copy / out	03/04/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MK7Y11

Facility ID: 001113

If continuation sheet

Page 11 of 18

PRINTED: 03/13/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		15G599	A. BUILDING B. WING		02/03/2012
	PROVIDER OR SUPPLIE	R	STREET. 860 W	ADDRESS, CITY, STATE, ZIP CODE 65TH LN LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	client #4's recor ISP dated 12/9/ #1's record was Review of the recurrent ISP date Interview with the Supervisor (DP) 1/27/12 at 11:10 indicated the measurement available staff. An interview w Retardation Pro- conducted on 2/ QMRP indicate	d indicated a most current 09. A review of client conducted at 11:05 A.M ecord indicated a most			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MK7Y11

Facility ID: 001113

If continuation sheet Page 12 of 18

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDI		IDENTIFICATION NUMBER:	a. Building 00		00	COMPLETED	
15G599		B. WING			02/03/2012		
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				65TH LN		
REM-INDIANA INC					LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E	IPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	I	DATE
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.		WO			03/	04/2012
	functional assessment of each client must be reviewed by the interdisciplinary team for		WO	259	w259: The facility currently completes assessments for a comprehensive functional assessment on all clients upor admission and annually. The Individual Support Team revie the assessments at a meeting determine the needs of the clie and to establish programming goals for those needs. The Program Director has ensured that the comprehensive function assessments have been completed for Clients 1 throug 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 annual for the clients. In the future, the Program Director will ensure the each client is re-assessed annually and when client situal warrants the need. The Progricular progress by reviewing monthly data to ensure the client goals appropriate to client needs. Responsible Staff: Area Director Completion Date: 3/4	ws to ent anal lly e nat tion am are	04/2012
	Client #4's record	d was reviewed on					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MK7Y11

Facility ID: 001113

If continuation sheet

Page 13 of 18

PRINTED: 03/13/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G599		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPL 02/03	ETED		
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 PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	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)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MK7Y11

Facility ID: 001113

If continuation sheet

Page 14 of 18

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
15G599		B. WING		02/03/2012		
NAME OF B	AD CAMPED OF GUIDNI IED		STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER		860 W	65TH LN		
REM-IND	DIANA INC		MERR	ILLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	·	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
W0383	483.460(I)(2)	E AND RECORDKEEPING				
		persons may have access to				
		rug storage area.				
	-	ation and interview, the	W0383	w383: The facility trains all ne		
	facility failed for	8 of 8 clients residing at		direct support employees and		
	1	(clients #1, #2, #3, #4,		supervisors to ensure only		
		8), to ensure only		authorized persons have accerto keys to the drug storage are		
		ns had access to the keys		The Program Director trained		
	to the medication	•		support staff to reiterate the		
				procedure of staff possession		
	Findings include			secure storage of keys to drug storage area. The home mana		
	i manigs merade.			will complete weekly observat	-	
	An evening obse	rvation was conducted at		to ensure the staff correctly		
	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			secure the keys and client		
				medication. In the future, the		
				Home Manager will complete weekly observations to ensure		
				the staff are correctly securing		
				keys and client medication. T	•	
				Program Director will complete		
		eving the medication		monthly observations to ensur		
		the cabinet located above		the staff are correctly securing keys to the medication area.	tne	
		nd placing the keys back		Responsible Staff: Program		
		after unlocking and		Director Completion Date:		
	-	cation closet located in	1	3/4/12		
	_	reen the living room and				
		. Clients #1, #2, #3, #4,				
		8 were observed during				
	the observation e	entering into the kitchen				
	and walking past	the medication closet.				
	An interview wit	h the Registered Nurse				
	(RN) was conduc	cted on 1/24/12 at 12:15				
	· ·	ndicated the keys should	1			
		to authorized persons,	1			
		. ,				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MK7Y11

Facility ID: 001113

3 If continu

If continuation sheet Page 15 of 18

PRINTED: 03/13/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G599		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMP.	COMPLETED 02/03/2012	
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	(EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PERCEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	ORRECTION N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	not put in the kitchen anyone would have a					
	9-3-6(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MK7Y11

Facility ID: 001113

If continuation sheet

Page 16 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
15G599		B. WING		02/03/2012			
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				65TH LN		
REM-INDIANA INC					LLVILLE, IN 46410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE	
W0433	and floor coverin areas used by c Based on observa	POORS e facility must have exposed floor surfaces d floor coverings that promote mobility in as used by clients. ed on observation and interview for 2		W0433 W433: The facility currently contracts vendors to repair		03/04/2012	
	`	nts #5 and #6), who were			physical repairs to the home a	s	
		he facility failed to have			needed. The facility monitors t		
		hat promote mobility in			environment to ensure the		
	areas used by clie	ents.			exposed floor surfaces and flo		
	Findings include				coverings that promote mobilit all areas used by clients.The Home Manager will contact a contractor to replace the	y in	
	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				carpeting leading to the		
					bedroom. In the future, the Ho	me	
					Manager will perform weekly inspections of the home to ens	nuro.	
					that all maintenance needs are		
					addressed in a timely manner.		
	#5 used a walker	. The carpeting was			The Program Director will mon		
	observed to have	ripples throughout the			the home environment for repa	air	
	hallway.				needs and floor covering		
					replacement as well as items t	nat	
	A review of clier	nt #5's record was			need replaced due to regular wear and tear. Person		
		facility's administrative			responsible: Program		
		•			DirectorCompletion Date: 3/4/	12	
	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,						
	fallshas unstead	dy gait is at risk for falls					
	and fracturesuses a walker."						
	conducted at the office on 1/24/12	nt #6's record was facility's administrative 2 at 1:50 P.M A review ord indicated an "Falls"					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MK7Y11

Facility ID: 001113

If continuation sheet

Page 17 of 18

PRINTED: 03/13/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G599		A. BUII B. WIN	LDING	00	COMPL 02/03/	ETED		
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 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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE		
	protocol dated 5/12/11 and indicated she was at risk for falls.							
	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) protocol dated 5/12/11 and indicated she							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MK7Y11

Facility ID: 001113

If continuation sheet Page 18 of 18