

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G471	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/30/2015
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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3031 E KESSLER INDIANAPOLIS, IN 46220
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W 0000  Bldg. 00	<p>This visit was for the investigation of complaints #IN00177948 and #IN00183719.</p> <p>Complaint #IN00177948 - Substantiated. Federal/State deficiencies related to the allegations are cited at W102, W104, W122, W149, W153, W154.</p> <p>Complaint #IN00183719 - Substantiated. Federal/State deficiencies related to the allegations are cited at W102, W104, W122, W149, W153, W154.</p> <p>Dates of Survey: October 28 and 30, 2015</p> <p>Provider Number: 15G471 Aim Number: 100244650 Facility Number: 000985</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/9/15.</p>	W 0000		
W 0102  Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific</p>			

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

TITLE

(X6) DATE

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

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	<p>governing body and management requirements are met.</p> <p>Based on interview and record review for 1 of 5 clients (B) residing in the facility, the facility failed to meet the Condition of Participation: Governing Body. The Governing Body failed to exercise general policy and operating direction over the facility in that the facility failed to implement written policy and procedures to identify/prevent reoccurrence of neglect of client B (elopement), failed to ensure elopement incidents were reported within 24 hours of the incident and timely and thorough investigations were documented.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The facility's governing body failed for 1 of 5 clients (B) residing in the facility, to ensure the facility met the Condition of Participation: Client Protections, in that the facility failed to implement written policy and procedures to identify/prevent abuse/neglect, regarding a failure to report and have documentation of a thorough investigation of elopement and to prevent reoccurrence of elopement. Please see W122.</li> <li>2. The facility's governing body failed for 1 of 5 clients (B) residing in the facility to exercise general policy and operating</li> </ol>	W 0102	<p>Please see W104Please see W122The Direct Support Staff will be retrained on incident reporting requirements, including but not limited to what need to be reported, and who to report these incidents to. The Program Coordinator will be retrained on incident reporting requirements, including but not limited to reporting these incidents to the appropriate supervisor and/or administrator. The Program Director will be retrained on BDDS reports requirements. Ongoing all incidents will be appropriately reported. The Program Director will be retrained on Indiana MENTOR's policy and procedure for completing an investigation. This retraining will also include the expectation of the completion of the recommendations that are results of the completed investigation, and what is included to make a thorough investigation. To ensure that all investigations are completed accurately and thoroughly, Indiana MENTOR's Quality Assurance Specialist will assist this PD with the next three investigations. Ongoing, all investigations will be reviewed by the Area Director and the Quality Assurance Specialist to ensure that all issues are addressed, that the investigation is completed thoroughly, that recommendations are made and</p>	11/29/2015

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W 0104  Bldg. 00	<p>direction over the facility in regards to implementing written policy and procedures to ensure abuse/neglect policy was being implemented and to ensure reoccurrence of client B's elopement. Please see W104.</p> <p>This federal tag relates to complaint #IN00177948. This federal tag relates to complaint #IN00183719.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 1 of 5 clients (B) residing in the facility, the facility's governing body failed to exercise general policy and operating direction over the facility in regards to ensuring the documentation and reporting of abuse/neglect per the facility's policy and procedures.</p> <p>Findings include:</p> <p>The facility's governing body failed to implement written policy and procedures</p>	W 0104	<p>that all recommendations are completed and followed up on in a timely manner.</p> <p>The Direct Support Staff will be retrained on incident reporting requirements, including but not limited to what to report and who to report it to at all times. The Program Coordinator will be retrained on incident reporting requirements, including but not limited to reporting these incidents to the appropriate supervisor and/or administrator. The Program Director will be retrained on BDDS reports requirements. Ongoing all incidents will be appropriately reported. The Program Director</p>	11/29/2015			

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W 0122 Bldg. 00	<p>to ensure incident reporting (timely) and thorough investigations were being documented. Please see W149.</p> <p>This federal tag relates to complaint #IN00177948.</p> <p>This federal tag relates to complaint #IN00183719.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on interview and record review, the facility failed for 1 of 5 clients (B) residing in the facility to meet the Condition of Participation: Client Protections, by failing to implement written policy and procedure to prevent neglect of client B in regards to: failure to notify the administrator and the Bureau</p>	W 0122	<p>will be retrained on Indiana MENTOR's policy and procedure for completing an investigation. This retraining will also include the expectation of the completion of the recommendations that are results of the completed investigation, and what is included to make a thorough investigation. To ensure that all investigations are completed accurately and thoroughly, Indiana MENTOR's Quality Assurance Specialist will assist this PD with the next three investigations. Ongoing, all investigations will be reviewed by the Area Director and the Quality Assurance Specialist to ensure that all issues are addressed, that the investigation is completed thoroughly, that recommendations are made and that all recommendations are completed and followed up on in a timely manner. Please also see W149</p> <p>Please see W149 Please see W153The Program Coordinator will be retrained on incident reporting requirements, including but not limited to reporting these incidents to the appropriate supervisor and/or administrator. The Program Director will be retrained on BDDS reports requirements. Ongoing all</p>	11/29/2015

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	<p>of Developmental Disabilities Services (BDDS) within 24 hours of incidents of elopement/missing person, failure to document a thorough investigation for client elopement and failure to prevent a reoccurrence of client elopement.</p> <p>Findings include:</p> <p>Please see W149. The facility failed to implement written policy and procedures to ensure an incident of alleged neglect was reported within 24 hours, a thorough investigation for client elopement was documented and elopement reoccurrence was prevented.</p> <p>Please see W153. The facility failed to ensure the facility administrator and BDDS were immediately notified of an allegation of neglect (elopement).</p> <p>Please see W154. The facility failed to ensure a thorough investigation was documented in regards to client B's elopement.</p> <p>This federal tag relates to complaint #IN00177948. This federal tag relates to complaint #IN00183719.</p> <p>9-3-2(a)</p>		<p>incidents will be appropriately reported. The Program Director will be retrained on Indiana MENTOR's policy and procedure for completing an investigation. This retraining will also include the expectation of the completion of the recommendations that are results of the completed investigation, and what is included to make a thorough investigation. To ensure that all investigations are completed accurately and thoroughly, Indiana MENTOR's Quality Assurance Specialist will assist this PD with the next three investigations. Ongoing, all investigations will be reviewed by the Area Director and the Quality Assurance Specialist to ensure that all issues are addressed, that the investigation is completed thoroughly, that recommendations are made and that all recommendations are completed and followed up on in a timely manner.</p>	

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W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review, the facility failed for 2 of 4 allegations of client neglect reviewed (client B), to implement policy and procedures to ensure allegations of neglect were immediately reported to the administrator and the Bureau of Developmental Disabilities Services (BDDS) and a thorough investigation was completed/documentated and to prevent reoccurrence of elopement.</p> <p>Findings include:</p> <p>Record review of the facility's incident reports was done on 10/28/15 at 11:13a.m. The review included the following incidents for client B:</p> <p>1) An incident report on 8/30/15 indicated client B had eloped from the group home. The report indicated staff had heard the back door alarm, checked the back door area but client B was already out of sight. Staff then called the police. The report indicated the police located client B two streets from the</p>	W 0149	<p>The IDT will convene to discuss the behavior support plan that is in place for client #1 regarding his targeted behavior of elopement. The IDT will work to ensure that the behavior plan is still appropriate for client #1. Please see W153 Please see W154The Direct Support Staff will be retrained on incident reporting requirements, including but not limited to what need to be reported, and who to report these incidents to. The Program Coordinator will be retrained on incident reporting requirements, including but not limited to reporting these incidents to the appropriate supervisor and/or administrator. The Program Director will be retrained on BDDS reports requirements. Ongoing all incidents will be appropriately reported. The Program Director will be retrained on Indiana MENTOR's policy and procedure for completing an investigation. This retraining will also include the expectation of the completion of the recommendations that are results of the completed investigation, and what is included to make a thorough investigation. To ensure</p>	11/29/2015

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	<p>house and returned client B to the group home. The report indicated client B was unsupervised for 15 minutes. The facility investigation did not have documented staff interviews. The facility's 8/31/15 "Plan to Resolve" indicated an additional 1:1 (one staff to one client) staffing ratio was added to keep client B in eyesight.</p> <p>2) An incident report on 9/16/15 indicated client B had eloped across the street to a neighbor's house. The report indicated the neighbor was returning the client to the group home when staff saw them and returned client B to the group home. The 9/16/15 elopement was not reported to the administrator and the BDDS until 10/1/15. The facility investigation did not start until 10/1/15. The investigation report indicated client B had exited the group home through a window, while staff were assisting other clients, and went to the neighbor's home. The report indicated the client had entered the neighbor's home and was looking in the neighbor's refrigerator. The report indicated the police had not been called in regards to client B missing from the group home. The report indicated client B was unsupervised/missing for 10 to 15 minutes. The report indicated client B was not monitored with 1:1 supervision on 9/16/15. The report indicated the facility had installed</p>		<p>that all investigations are completed accurately and thoroughly, Indiana MENTOR's Quality Assurance Specialist will assist this PD with the next three investigations. Ongoing, all investigations will be reviewed by the Area Director and the Quality Assurance Specialist to ensure that all issues are addressed, that the investigation is completed thoroughly, that recommendations are made and that all recommendations are completed and followed up on in a timely manner.</p>	

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	<p>window alarms, changed a latch on the backyard gate (backyard fenced in) and retrained staff (on 10/2/15) on client B's behavior plan.</p> <p>Record review for client B was done on 10/30/15 at 8:15a.m. Client B's 7/13 behavior support plan (BSP) indicated client B's diagnoses included, but were not limited to, severe intellectual disability, Attention-Deficit Hyperactivity Disorder (ADHD) and Autism. The BSP indicated client B was non-verbal. Elopement was addressed in his BSP. The plan indicated staff should beware of client B's behavior, body language and tone because of client B's behavioral concerns with self injurious behaviors and elopement. The report indicated staff may be required to keep client B within line of sight for monitoring, stay with the client and prompt client B to return to the group home and physically intervene if needed for safety reasons. The plan indicated, if staff do not see client B leave the group home or lose sight of client B, staff are to immediately call the police.</p> <p>Staff #2 was interviewed on 10/28/15 at 3:10pm. Staff #2 indicated client B had eloped from the facility on 8/30/15 and again on 9/16/15. Staff #2 indicated there were no documented interviews for the</p>			

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	<p>8/30/15 elopement investigation. Staff #2 indicated he was informed by the home manager of the 9/16/15 elopement on 9/16/15 but failed to report it until 10/1/15. Staff #2 indicated the investigation for the 9/16/15 elopement did not start until 10/1/15. Staff #2 indicated client B was non-verbal and had limited pedestrian safety skills. Staff #2 indicated client B was not on any special staff monitoring on 9/16/15 (1:1 staffing/monitoring). Staff #2 indicated he was not sure when the 8/31/15 initiated 1:1 monitoring of client B for elopement had been discontinued. Staff #2 indicated there was no documentation in regards to the facility's discontinuation of the 1:1 monitoring between 8/31/15 and 9/16/15. Staff #2 indicated the police were not called during the 9/16/15 elopement.</p> <p>The facility's policy and procedures were reviewed on 10/28/15 at 9p.m. The facility's 4/11 policy and procedure "Quality and Risk Management" indicated the facility "promotes a high quality of service and seeks to protect individuals receiving 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." The</p>			

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	<p>policy indicated the BDDS should be notified of elopement of an individual that results in evasion of required supervision as described in the individual support plan for health and welfare and missing person when an individual wanders away and no one knows where they are. The policy indicated an initial report regarding an incident shall be submitted within 24 hours of the occurrence. The policy indicated the facility "is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee." The policy indicated the "investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident."</p> <p>Professional staff #1 was interviewed on 10/28/15 at 2:58p.m. Professional staff #1 indicated the facility staff had failed to follow the facility's policy and procedures in regards to client B's identified elopements. Staff #1 indicated the facility failed to have a thorough investigation of the 8/30/15 incident by having no documented interviews. Staff #1 indicated the 9/16/15 elopement should have been reported on 9/16/15 and the investigation should have begun then.</p>			

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	<p>Staff #1 indicated the facility had failed to prevent reoccurrence of client #1's elopement after the 8/30/15 elopement. Staff #1 indicated 1:1 monitoring of client B had been implemented after the 8/30/15 elopement. Staff #1 indicated there was no documentation the 1:1 staff monitoring of client B had been discontinued after the 8/30/15 elopement. Staff #1 indicated client B was not on 1:1 monitoring on 9/16/15. Staff #1 indicated on 10/2/15 facility staff were retrained on client B's behavior plan which included elopement and window alarms and fenced backyard gate latch was changed. Staff #1 indicated client B had not eloped since the 9/16/15 elopement. Staff #1 indicated client B's functioning level was severe and he was non verbal with limited pedestrian skills.</p> <p>Please see W153. The facility failed to ensure client elopement was immediately reported to the facility administrator and Bureau of Developmental Disabilities Services (client B).</p> <p>Please see W154. The facility failed to ensure a thorough investigation was documented in regards to client B's elopement.</p> <p>This federal tag relates to complaint #IN00177948.</p>			

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W 0153 Bldg. 00	<p>This federal tag relates to complaint #IN00183719.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, the facility failed for 1 of 4 facility reportable incidents (client B) reviewed, to immediately report an allegation of possible abuse/neglect (elopement) to the administrator and the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>Record review of the facility's incident reports was done on 10/28/15 at 11:13a.m. The review included the following incidents for client B:</p> <p>An incident report on 9/16/15 indicated</p>	W 0153	<p>The Program Coordinator will be retrained on incident reporting requirements, including but not limited to reporting these incidents to the appropriate supervisor and/or administrator. The Program Director will be retrained on BDDS reports requirements. Ongoing all incidents will be appropriately reported. The Program Director will be retrained on Indiana MENTOR's policy and procedure for completing an investigation. This retraining will also include the expectation of the completion of the recommendations that are results of the completed investigation, and what is included to make a thorough investigation. To ensure that all</p>	11/29/2015

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	<p>client B had eloped across the street to a neighbor's house. The report indicated the neighbor was returning the client to the group home when staff saw them and returned client B to the group home. The 9/16/15 elopement was not reported to the administrator and the BDDS until 10/1/15. The facility investigation did not start until 10/1/15. The investigation indicated client B had exited the group home through a window and went to the neighbor's home. The report indicated the client had entered the neighbor's home and was looking through the neighbor's refrigerator. The report indicated client B was unaccounted for/missing for about 10 to 15 minutes. The report indicated the facility had installed window alarms, changed a latch on the backyard gate (backyard fenced in) and retrained staff on client B's behavior plan.</p> <p>Staff #2 was interviewed on 10/28/15 at 3:10pm. Staff #2 indicated client B had eloped from the facility on 8/30/15 and again on 9/16/15. Staff #2 indicated he was informed by the home manager of the 9/16/15 elopement on 9/16/15 but failed to report it until 10/1/15. Staff #2 indicated the investigation for the 9/16/15 elopement did not start until 10/1/15.</p> <p>Professional staff #1 was interviewed on 10/28/15 at 2:58p.m. Staff #1 indicated</p>		<p>investigations are completed accurately and thoroughly, Indiana MENTOR's Quality Assurance Specialist will assist this PD with the next three investigations. Ongoing, all investigations will be reviewed by the Area Director and the Quality Assurance Specialist to ensure that all issues are addressed, that the investigation is completed thoroughly, that recommendations are made and that all recommendations are completed and followed up on in a timely manner.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G471		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/30/2015	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3031 E KESSLER INDIANAPOLIS, IN 46220			
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W 0154 Bldg. 00	<p>the 9/16/15 elopement should have been reported on 9/16/15 and the investigation should have begun on 9/16/15.</p> <p>This federal tag relates to complaint #IN00177948. This federal tag relates to complaint #IN00183719.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, the facility failed for 1 of 4 incidents of reportable incidents reviewed (client B) to ensure allegations of neglect were thoroughly investigated.</p> <p>Findings include:  Record review of the facility's incident reports was done on 10/28/15 at 11:13a.m. The review included the following incidents for client B:  An incident report on 8/30/15 indicated client B had eloped from the group home. The report indicated staff had heard the back door alarm, checked the back door</p>	W 0154	<p>The Program Coordinator will be retrained on incident reporting requirements, including but not limited to reporting these incidents to the appropriate supervisor and/or administrator. The Program Director will be retrained on BDDS reports requirements. Ongoing all incidents will be appropriately reported. The Program Director will be retrained on Indiana MENTOR's policy and procedure for completing an investigation. This retraining will also include the expectation of the completion of the recommendations that are results of the completed investigation, and what is included</p>	11/29/2015			

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	<p>area but client B was already out of sight. Staff then called the police. The report indicated the police located client B two streets from the house and returned client B to the group home. The report indicated client B was unsupervised for 15 minutes. The facility investigation did not have documented staff interviews.</p> <p>Record review for client B was done on 10/30/15 at 8:15a.m. Client B's 7/13 behavior support plan (BSP) indicated client B's diagnoses included, but were not limited to, severe intellectual disability and Autism. The BSP indicated client B was non-verbal. Elopement was addressed in his BSP.</p> <p>Staff #2 was interviewed on 10/28/15 at 3:10pm. Staff #2 indicated client B had eloped from the facility on 8/30/15 and again on 9/16/15. Staff #2 indicated there were no documented interviews for the 8/30/15 elopement investigation.</p> <p>Professional staff #1 was interviewed on 10/28/15 at 2:58p.m. Staff #1 indicated the facility failed to have a thorough investigation of the 8/30/15 incident by having no documented staff interviews.</p> <p>This federal tag relates to complaint #IN00177948. This federal tag relates to complaint</p>		<p>to make a thorough investigation. To ensure that all investigations are completed accurately and thoroughly, Indiana MENTOR's Quality Assurance Specialist will assist this PD with the next three investigations.</p> <p>Ongoing, all investigations will be reviewed by the Area Director and the Quality Assurance Specialist to ensure that all issues are addressed, that the investigation is completed thoroughly, that recommendations are made and that all recommendations are completed and followed up on in a timely manner.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

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