

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G720	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/06/2012
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 82 BENNY LN NORTH VERNON, IN47265		
(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	
W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: December 27, 28, 29, 30, 2011 and January 6, 2012</p> <p>Facility Number: 004396 Provider Number: 15G720 AIM Number: 200511360</p> <p>Surveyor: Jo Anna Scott, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on 1/17/2012 by Dotty Walton, Medical Surveyor III.</p>	W0000			

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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W0210	<p>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview for 1 of 2 sampled clients (client #2), the facility failed to ensure a comprehensive functional assessment (CFA) had been reviewed annually.</p> <p>Findings include:</p> <p>The record review for client #2 was conducted on 12/29/11 at 11:06 AM. The record included a Residential Skills Assessment dated 10/28/09. There was no indication the assessment had been reviewed and updated after 10/28/09.</p> <p>Interview with staff #1, Program Director, on 12/29/11 at 2:30 PM indicated the Residential Skills Assessment was the comprehensive functional assessment and she "missed" updating the residential skills assessment.</p> <p>9-3-4(a)</p>	W0210	<p>Program director will complete review of functional assessments annually and or as needed for client #2 and all other clients in the home. Program Director will complete weekly PD documentation checklist to ensure that all paperwork is current and up to date. Area Director will review weekly PD documentation checklist to verify that all paperwork is current and up to date. Responsible Party: Program Director Area Director</p>	01/10/2012	
W0331	<p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview for 1 of 2 sampled clients (client #2), nursing services failed to develop a</p>	W0331	<p>Facility Nurse will update aspiration protocol to include instructions for medication administration. Staff will be</p>	01/20/2012	

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	<p>protocol for staff to follow when client received his medication by low profile Mic-Key Button (enteral feeding tube) .</p> <p>Findings include:</p> <p>During the morning medication administration observation on 12/28/11 at 6:00 AM, client #2 started to receive his medication by Mic-Key Button at 6:08 AM. The residual (fluid left in tube) was checked before the medication pass was started. Staff #4 flushed the tube with water before starting the medication. Client #2, who is non-verbal, started hitting his chest while the flush was being done. Staff #5 asked client #2 if he felt like it was coming up. Client #2 proceeded to vomit a small amount of fluid. Staff #5 caught the spit-up in a plastic container and threw it and the container away. Staff #5 asked client #2 if he felt better and continued with the medication pass. Staff #5 did not document client #2 had vomited and did not contact the nurse.</p> <p>The record review for client #2 was conducted on 12/29/11 at 11:06 AM. The Quarterly Program Review dated 9/14/11 indicated his feeding schedule was changed to a night time (14 hour) bulk feeding and a 1 time a day for one hour duration feeding in July. The record</p>		<p>retrained on aspiration protocol and when to notify program director and nurse if client #2 vomits during medication administration. Facility Nurse in conjunction with Program Director will review all protocols for client #2 and all other clients to ensure that they contain accurate information for when to notify nurse/program director. Program Director in conjunction with team will review all protocols annually to ensure they are correct. Responsible Party: Facility Nurse, Program Director</p>		

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	<p>indicated the feeding was changed because client #2 was losing weight. The record indicated client #2 had an increase in weight of 9 pounds but had some vomiting. The record indicated the feeding time was shortened by 1 hour for more digestion before the morning med's/fluids in August. The Gastrostomy Feeding Protocol (undated) indicated the following for administration of medication:</p> <ol style="list-style-type: none"> "1. Crush or dissolve tablets only as ordered by physician prior to administering them through the G-tube. 2. When crushing tablets, use a pill crusher to crush the medications into a fine powder. Clean crusher prior to and after each use. 3. Mix crushed medications with 10 - 20 cc (cubic centimeter) of water. 4. Prime tube with water keeping at least 10 cc of water in the syringe before adding medications. 5. Add medications (crushed, mixed, or liquid) and then add 10 cc more water. 6. Attach feeding tube to button; open clamp so that medications go in at a rate of less that 5 minutes. 7. Add the remaining water to clear tubing. 8. Never turn your back on the medications. 9. Document." <p>There was nothing in the protocol to</p>				

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	<p>indicate what to do if the client vomited while receiving his medications. The Aspiration Protocol for client #2 dated 6/20/11 indicated the signs and symptoms of aspiration were as follows: "Breathing is rapid and difficult. Gagging/choking during meals Coughing with signs of struggle. Wheezing. Person's temp above 100. Smell of formula on the breath. Sudden change of breathing." The Aspiration Protocol indicated the feeding/eating was to stop immediately and the supervisor and nurse were to be notified and the incident was to be documented in the client's daily notes record. The Aspiration Protocol did not refer to medication passes.</p> <p>Interview with staff #3, Registered Nurse (RN), on 12/29/11 at 2:00 PM indicated she was aware client #2 had been vomiting or spitting up during the morning medication pass. Staff #3, RN, indicated staff had not told her of that morning's incident and there had not been any documentation. Staff #3, RN, indicated the client had an appointment with his doctor and the problem would be discussed at that time.</p> <p>9-3-6(a)</p>				