

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G663	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2016
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5662 N CRESTVIEW AVE INDIANAPOLIS, IN 46220
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W 0000 Bldg. 00	<p>This visit was for a recertification and state licensure survey.</p> <p>Survey Dates: February 15, 16, 17, 18, 19, 22, 23, 2016</p> <p>Facility number: 001216 Provider number: 15G663 Aim number: 100233690</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/1/16.</p>	W 0000		
W 0104 Bldg. 00	<p>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 to exercise operating direction over the facility to provide a private and safe environment for 6 of 6 clients (#1, #2, #3, #4, #5, #6) living in the group home.</p> <p>Findings include: An observation of clients #1, #2, #3, #4,</p>	W 0104	<p>The Program Coordinator and Program Director will work with the maintenance crew to ensure that the curtains and/or blinds are repaired and/or replaced as needed. This will be completed throughout the house to ensure that no other curtains and/or blinds are broken or missing. The Program Coordinator and Program Director will be retrained</p>	03/24/2016

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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W 0125 Bldg. 00	<p>#5 and #6 (at the group home) was done on 2/17/16 from 4:34p.m. to 6:14p.m. The observation included the following environmental condition: The 3 living room windows located on the front center of the group home had no window coverings. Staff #4 was interviewed on 2/17/16 at 4:52p.m. Staff #4 indicated she thought the curtains had been off of the living room windows around 2 months. Staff #4 indicated a client having a behavior had torn down the previous window covering.</p> <p>Staff #1 was interviewed on 2/22/16 at 10:34a.m. Staff #1 indicated he was not sure how long the window covering had been off of the front living room windows.</p> <p>9-3-1(a)</p> <p>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.</p> <p>Based on observation, interview and record review for 2 of 3 sampled clients (#1, #2) the facility failed to ensure the</p>	W 0125	<p>on ensuring that all maintenance issues are addressed in a timely manner and followed up on, if remaining incomplete.</p> <p>Ongoing, the Program Director will complete a monthly walk thru of the group home to ensure that no issues are noted.</p> <p>Ongoing, the Area Director will ensure that a quarterly walk-thru is completed to ensure that all maintenance issues are taken care of in a timely matter and do not remain incomplete.</p> <p>Responsible Party: Program Coordinator, Program Director, and Area Director</p> <p>The Program Director in conjunction with the IDTs, will revise the Individualized support plan for client 1 & 2 to include the restrictions to</p>	03/24/2016

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	<p>clients had the right to due process in regard to locking items (sharps and cleaning supplies) at the group home.</p> <p>Findings include:</p> <p>An observation was done at the group home on 2/17/16 from 4:34p.m. to 6:14p.m. At 4:52p.m., staff #4 indicated the the sharps and house cleaning supplies were kept locked due to client behaviors. At 6:00p.m., after supper, staff #4 opened a locked cabinet and got out some cleaning supplies for the dining room clean up.</p> <p>Record review for client #1 was done on 2/19/16 at 10:41a.m. Client #1's 1/29/16 individual support plan (ISP) did not indicate cleaning supplies and sharps were to be kept locked.</p> <p>Record review for client #2 was done on 2/19/16 at 11:53a.m. Client #2's 8/25/15 ISP did not indicate cleaning supplies and sharps were to be kept locked.</p> <p>Staff #1 was interviewed on 2/22/16 at 10:34a.m. Staff #1 indicated the group home cleaning supplies and sharps were kept locked due to client #3's behaviors. Staff #1 indicated clients #1 and #2 did not have this group home restriction addressed in their ISP and did not have</p>		<p>the locked items, including cleaning supplies and sharp objects.</p> <p>The Program Director and Program Coordinator are going through the Interdisciplinary Team and Human Right's Committee to ensure that the correct approvals are retrieved for the currently locked items to remain locked.</p> <p>The Program Director, Home Manager, and Direct Support Staff will be retrained on not locking items without approval to do so, first.</p> <p>The Direct Support Staff will be retrained on the Rights and Restrictions of Endangered Adults. Responsible Party: Home Manager and Program Director</p>	

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W 0157 Bldg. 00	<p>documented approval from clients #1 and #2.</p> <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, the facility failed for 1 of 4 investigations of alleged neglect reviewed (client #5), to ensure appropriate identified corrective action was taken.</p> <p>Findings include:</p> <p>Record review of the facility reportable incident reports was done on 2/16/16 at 11:10a.m. An incident report on 12/29/15 indicated client #5 had gone on a home visit from 12/24/15 through 12/29/15. The incident report indicated the facility staff had failed to send client #5's evening medications. The incident report indicated the facility nurse was to retrain staff on the medication packing procedure for when a client goes on overnight visits. There was no documentation this training had been completed.</p>	W 0157	<p>The Program Director will be retrained on ensuring the follow up on recommendations that are made as a result of an incident. All remaining staff at this group home will be retrained on medication administration according to the Indiana MENTOR policy and procedures for medication administration. This training will include the policy and procedures regarding packing out of house medications as well.</p> <p>For the first four weeks, the Home Manager, Program Director, and/or Program Nurse will complete three (3) weekly medication administration observations to ensure that the medication goals are being completed with each client as specified for four (4) weeks. These will then be reviewed by the Program Director ensuring that there are no further training needs.</p> <p>After the initial four (4) weeks, the</p>	03/24/2016

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W 0227 Bldg. 00	<p>Staff #2 (nurse) was interviewed on 2/22/16 at 10:34a.m. Staff #2 indicated the facility's corrective action identified for the 12/29/15 incident, had included retraining facility staff on packaging and sending medication with the clients. Staff #2 indicated the identified training had not been done.</p> <p>9-3-2(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 record review and interview, the facility failed for 2 of 3 sampled clients (#2, #3) to ensure the clients' individual support plans (ISP) had training programs in place to address their identified training needs.</p> <p>Findings include: Record review for client #2 was done on</p>	W 0227	<p>Home Manager and/or Program Director will complete two (2) weekly medication administration observations for four (4) additional weeks, and will ensure that all needed retrainings will be completed.</p> <p>After the additional four (4) weeks, the Home Manager and/or Program Director will complete weekly medication administration observations ongoing, and will ensure that all needed retrainings will be completed.</p> <p>Ongoing, all staff will complete medication administration according to the Indiana MENTOR policy and procedures. Responsible Party: Home Manager and Program Director</p> <p>The Area Director will retrain the Program Director on ensuring that trainings recommended by the Team, a medical professional, etc, are followed up on and put into place if made. The Program Director will put an exercise goal and training in place for Client 2. The Program Director will put an oral hygiene goal and training in place for Client 3.</p>	03/24/2016

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	<p>2/19/16 at 11:53a.m. Client #2 had a 2/5/16 Dietary review. The Dietician indicated client #2 had a 9 pound weight gain during the past 90 days. The Dietician recommended client #2 should exercise 30 minutes daily. Client #2's 12/28/15 physicians orders indicated "encourage increased physical activity." Client #2's 8/25/15 ISP did not have a documented exercise training program in place.</p> <p>Record review for client #3 was done on 2/19/16 at 11:18a.m. Client #3 had a 11/24/15 dental exam. The dentist indicated client #3 had "poor" oral hygiene and had "several cavities." The dentist recommended to brush twice daily. Client #3's 8/28/15 ISP did not have a documented oral hygiene training program in place.</p> <p>Staff #1 was interviewed on 2/22/16 at 10:34a.m. Staff #1 indicated client #2 has had a weight gain over the past year. Staff #1 indicated client #2's identified need to exercise was not addressed with a documented training program. Staff #1 indicated client #2 was in need of a training program to exercise 30 minutes a day. Staff #1 indicated client #3's identified dental hygiene needs had not been addressed by the facility.</p>		<p>Area Director will review all medical appointments, including all PT and OT evaluations one time per month for 3 months and then quarterly thereafter. After the review, the Area Director will follow up to be sure that all recommendations are addressed appropriately and all doctor's orders followed correctly. Responsible Party: Program Director and Program Director and Area Director</p>	

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W 0312 Bldg. 00	<p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview, the facility failed for 2 of 3 sampled clients (#1, #3) who took behavior control drugs, to ensure the behavior control medications were part of the clients' behavior support plans (BSP) which included a plan of reduction.</p> <p>Findings include:</p> <p>Review of the record of client #1 was done on 2/19/16 at 10:41a.m. Client #1's 1/28/16 BSP indicated client #1's diagnoses included, but were not limited to, Paranoid Schizophrenia and Major Depression. Physician's orders on 2/11/16 indicated client #1 received the behavior control medication Haldol. The BSP failed to include the behavior control medication in a plan which included withdrawal criteria.</p> <p>Review of the record of client #3 was done on 2/19/16 at 11:18a.m. Client #3's</p>	W 0312	<p>The Program Director will be retrained on ensuring all Behavior Support Plans include a medication titration plan upon completion. The Behavior Specialist will add in the titration plan to client #1 and 3's current Behavior Support Plan. Ongoing, the Program Director, in conjunction with the team, will ensure that the titration plan is included in the Behavior Support Plan.</p> <p>Ongoing, the Area Director will complete random quarterly audits to ensure that all of the proper approvals are in place from the IDTs. Responsible Party: Program Director and Area Director</p>	03/24/2016	

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W 0325 Bldg. 00	<p>8/28/15 BSP indicated client #3's diagnoses included, but were not limited to, Attention Deficit Disorder and Depression. Physician's orders on 12/28/15 indicated client #3 received the behavior control medications Invega and Buspar. The BSP failed to include the behavior control medications in a plan which included withdrawal criteria.</p> <p>Interview of professional staff #1 on 2/22/16 at 10:34p.m. indicated clients #1 and #3 did not have their current behavior control medications addressed in a plan of reduction.</p> <p>9-3-5(a)</p> <p>483.460(a)(3)(iii) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (#1) to ensure client #1 received routine laboratory examinations as ordered by his physician.</p> <p>Findings include:</p> <p>Record review for client #1 was done on</p>	W 0325	<p>The Area Director will retrain the Program Nurse on the ensuring that all components of the physical exams are completed, including but not limited to all requests for labs made by the physician.</p> <p>The Program Nurse will ensure the completion of the needed labs for client number 1 as soon as possible. Ongoing, the Area Director will</p>	03/24/2016

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	<p>2/19/16 at 10:41a.m. Client #1's 2/11/16 physician's orders indicated the physician had ordered CBC (complete blood count) and TSH (thyroid stimulating hormone) labs to be done annually. The most recent documented CBC and TSH labs were done on 11/25/14.</p> <p>Staff #2 (nurse) was interviewed on 2/22/16 at 10:52a.m. Staff #2 indicated the most recent documented CBC and TSH labs for client #1 were dated 11/25/14. Staff #2 indicated client #1 should have had labs completed per the physician order.</p> <p>9-3-6(a)</p>		<p>complete random quarterly audits to ensure that all proper medical care is followed up on and documented correctly.</p> <p>Responsible Party: Program Nurse and Area Director</p>		