

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G264	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 124 BLACKHAWK LN WEST LAFAYETTE, IN 47906
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W 0000 Bldg. 00	<p>This visit was for a predetermined full recertification and state licensure survey.</p> <p>Dates of Survey: 1/4, 1/5, 1/6 and 1/15/16.</p> <p>Facility number: 000784 Provider number: 15G264 AIM number: 100243500</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/22/16.</p>	W 0000		
W 0153 Bldg. 00	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS 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 interview and record review for 2 of 8 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to ensure an allegation of abuse was immediately reported to the administrator when the incident occurred for client #2, and not reporting injuries of unknown source for client #1.</p>	W 0153	<p>The facility has policies and procedures in place to ensure all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown origin, are reported immediately to the on-call supervisor.</p> <p>The facility will retrain staff on this policy and the requirement to immediately notify the on-call supervisor of any allegations of</p>	02/14/2016

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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	<p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 1/4/16 at 12:24 PM. The facility's 8/16/15 reportable incident report indicated "Staff reported that another staff may have inappropriately escorted [client #2] when she was having a behavior. Staff were immediately suspended pending investigation...."</p> <p>The facility's 8/21/15 Summary of Internal Investigation Report indicated "On August 16th, 2015 [staff #3], DSP (Direct Support Professional) reported that they heard [client #2] was inappropriately escorted to her bedroom sometime last week by [staff #4] by [staff #5], DSP and [staff #6], DSP. Both [staff #4] and [staff #5] were suspended on 8/16/15 pending the outcome of the investigation." The facility's investigation indicated staff #6 was present in the group home when the incident took place. The facility's undated interview/witness statement indicated "...He (staff #6) stated he wasn't sure if [staff #4] was yelling at [client #2], but that she was pretty loud. He stated that when [staff #5] came in that he was in the kitchen and that the next thing he saw was [staff #5] and</p>		<p>mistreatment, neglect, or abuse, as well as injuries of unknown origin. The facility will also retrain staff on BDDS reportable incidents.</p> <p>In the future, the facility staff will follow the procedure to document all known and unknown injuries, additionally to notify appropriate supervisor with all injuries of unknown origin and any allegation of abuse, neglect, or exploitation. The Program Director/QIDP will then proceed to follow BDDS guidelines for reporting the injury/allegation as needed. The Program Director will monitor the staff and documentation logs weekly to ensure that incidents that occur are reported in a timely manner in the future.</p> <p>Person Responsible: Area Director Date of Completion: February 14, 2016</p>				

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	<p>[staff #4] walking [client #2] down the hall toward her bedroom. He stated and showed this writer that they linked their arms under hers and took her to her room backward...." The facility's investigation indicated staff #6 observed the inappropriate escort but did not report the allegation of abuse to the administrator at the time of the incident. The facility's 8/21/15 investigation indicated staff #3 reported the allegation of abuse to the administrator when she heard staff #6 talking about the incident on 8/16/15.</p> <p>Interview with the Area Director (AD) on 1/6/16 at 12:02 PM stated facility staff were to report all allegations of abuse, neglect and/or injuries of unknown source "immediately." The AD indicated the 8/15 incident was not reported when the incident actually occurred prior to 8/16/15.</p> <p>2. Client #1's record was reviewed on 1/5/16 at 11:10am. Client #1's 10/8/15 Indiana mentor daily support record indicated "[Client #1] was up chaning (sic) clothes when staff arrived. Noticed he had a very large bruise on his right butt cheek. HM (House Manager) was called."</p> <p>A review of the facility's incident reports on 1/4/16 at 12:03pm, from 1/2015 to</p>			

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W 0154 Bldg. 00	<p>1/2016, did not indicate client #1's unknown large bruise was reported to state officials.</p> <p>Interview with the Area Director (AD) on 1/6/16 at 12:02 PM indicated he would double check his reportable incidents to determine if the bruise was reported. The facility was unable to provide any additional information to review.</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.</p> <p>Based on interview and record review for 3 of 8 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct thorough investigations in regard to the allegations of abuse, neglect and/or injuries of unknown source for clients #1, #2 and #3.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 1/4/16 at 12:24 PM. The</p>	W 0154	<p>The facility has policies and procedures in place to ensure complete and thorough investigations take place for any allegation of mistreatment, neglect, or abuse, as well as injuries of unknown origin. The Program Director/QIDP will be retrained on the components of a thorough investigation that include recommendations and/or corrective actions to be taken, as well as all possible clients and/or staff are interviewed even if not present during the time of allegation to determine if similar actions have been experienced and/or observed by others.</p>	02/14/2016			

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	<p>facility's 2/20/15 reportable incident report indicated "On-Call received a call to reported (sic) that overnight staff arrived for her shift and [client #2] was still awake. Staff reported overnight staff began to yell at [client #2] that she needed to go to bed. Staff reported that overnight staff pounded on chair and said 'do not make me pull you from the chair.' Overnight staff asked others to assist with pulling from chair. Staff reported that [client #2] shook her fist at staff and overnight staff said do not threaten me with that. Staff immediately called on call. Overnight staff was suspended pending an investigation...."</p> <p>The facility's 2/27/15 Summary of Internal Investigation Report indicated staff #3 was present when the incident occurred. Staff #3's undated witness statement indicated "[Staff #3] stated that on 2/20/15, [staff #7] the night staff came in and walked in to (sic) the kitchen and put her stuff down and then proceeded to yell at [client #2] that she needed to go to bed. [Staff #3] stated that [staff #7] was slamming [client #2's] walker up and down telling her she needed to get her stuff and go to bed. [Staff #3] stated that she had video of this but it didn't show anything because it was dark. [Staff #3] showed this writer the video that she had and [client #2] could be heard yelling</p>		<p>Furthermore, the Program Director/QIDP will be retrained on the need to complete investigations for injuries of unknown origin to determine possible cause and/or preventive measures that can be taken to prevent recurrence. In the future, the facility will follow the protocol and the state regulation for the supervisor to be notified and a BDDS report sent for injuries of unknown origin, plus completion and documentation of the investigation of said unknown origin injury. Additionally, the facility will completely and thoroughly investigate any allegation of mistreatment, neglect, or abuse including interviews of all possible clients and staff. The Area Director and/or Quality Improvement Specialist will review the next three investigations of mistreatment, neglect, or exploitation to check for thoroughness. Person Responsible: Area Director Date of Completion: February 14, 2016</p>		

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	(which is not out of the normal for [client #2] when she is trying to communicate). Also heard was (sic) what was believed to be [staff #7] telling [staff #3] and the other staff person, [staff #8] to help her pull [client #2] up out of the chair. According to [staff #3], she and [staff #8] could be heard telling [staff #7] that they were not going to help because that would be abusive...." Staff #3's undated witness statement indicated client #2 stood up and went to her bedroom without staff #7 physically assisting client #2 to go to her bedroom. Staff #3's witness statement indicated staff #3 went into the office to call the on-call and inform them what happened. Staff #3's witness statement indicated staff #3 and staff #8 left the house, as their shift had ended. The investigation indicated the on-call returned the phone call when they got outside. Staff #3's witness statement indicated the on-call staff told the staff to go back inside the house which they did. Staff #3's undated witness statement indicated she told the on-call staff she could stay until 11:00 PM if needed. Staff #3's witness statement also indicated "...[Staff #3] stated she was told that since [staff #7] was calm now and [client #2] was in bed they could go ahead and leave.... [Staff #3] stated she was scheduled to work 3-9pm...."			

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	<p>The facility's 2/27/15 investigation indicated when the on-call manager arrived at the group home, staff #7 was the only staff person present at the group home. The facility's investigation indicated the on-call manager asked staff #7 where the other staff were. The facility's investigation indicated staff #7 had told the on-call manager the other staff had left. The investigation indicated "...[On-call staff #1] stated that she asked [staff #7] who told them they could leave and [staff #7] said she didn't know. [On-call staff #1] stated that she informed [staff #7] that she needed to gather her things and to go ahead and leave because she was suspended pending an investigation...."</p> <p>The facility's 2/27/15 investigation indicated "...No other additional clients were interviewed due to consistent reports that no other clients were present during the reported incident. [Client #2's] BSP (Behavior Support Plan) directs staff to remain calm and use a low to moderate tone of voice and when delivering instruction staff should use to 2 to 3 step analysis and allow [client #2] appropriate time to respond...There is no documentation [client #2] should be in bed by 9pm...Conclusion: Evidence supports that it is likely that [staff #7] yelled at [client #2] that she needed to go</p>			

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	<p>to bed when she arrived and found [client #2] still up. Evidence supports that [staff #7] did aggressively move [client #2's] walker in some way but it is unclear exactly how because of staff stories being inconsistent regarding the walker. Evidence supports that [staff #7] did not follow all components of [client #2's] BSP. Evidence supports that the staff working did tell [staff #7] that it was [client #2's] right to stay up." The facility's 2/27/15 investigation did not include any recommendations and/or indicate any corrective actions. The facility's 2/27/15 investigation indicated the staff involved and/or who were present in the group home when the incident occurred, were interviewed. The facility's investigation did not interview the other clients in the group home to see if they had been told and/or made to go to bed when the overnight staff worked. The facility's 2/27/15 investigation did not investigate how and/or why staff #7 was left alone with the clients after an allegation of abuse had been reported.</p> <p>Interview with the Area Director (AD) on 1/6/16 at 12:02 PM indicated the staff was moved from the BlackHawk group home. The AD indicated the staff person was retrained on abuse and neglect. The AD indicated the facility's investigation did not investigate/address and/or</p>			

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	<p>indicate why/how staff #7 was left alone with the clients when staff called and reported the allegation of abuse to the on-call staff.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 1/4/16 at 12:03 PM. The 11/6/15 reportable incident indicated "[Staff #2] reported that another staff member 'yelled at [client #3]' after he began to curse at her. Staff were immediately suspended pending investigation."</p> <p>The facility's 11/11/15 summary of internal investigation report indicated between the investigation dates of 11/6/15 through 11/11/15 staff #2, staff #9, and staff #5 were all interviewed. The internal investigation report did not indicate any other staff who worked at the home were interviewed.</p> <p>An interview with the Area Director (AD) was conducted on 1/6/16 at 12:02 PM. When asked if there were more staff interviewed during this investigation, the AD stated "If it's not in the report then no."</p> <p>3. Client #1's record was reviewed on 1/5/16 at 11:10am. Client #1's 10/8/15 Indiana mentor daily support record</p>			

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W 0159 Bldg. 00	<p>indicated "[Client #1] was up changing (sic) clothes when staff arrived. Noticed he had a very large bruise on his right buttock. HM (House Manager) was called."</p> <p>A review of the facility's incident reports on 1/4/16 at 12:03pm did not indicate client #1's large bruise on his right buttock was investigated by the facility.</p> <p>Interview with the Area Director (AD) on 1/6/16 at 12:02 PM indicated he would double check his reportable incidents to determine if these incidents were reported and/or investigated. The facility was unable to provide any additional information to review.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (#2), the Qualified Intellectual Disabilities Professional (QIDP), failed to monitor and/or coordinate a client's program in regard to addressing a Physical Therapy (PT) recommendation,</p>	W 0159	The facility has active treatment and individualized support plans (ISPs) for each client that are developed, assessed, and approved by the client's Interdisciplinary Team (IDT). The facility's Program Director/QIDP and Facility Nurse are responsible for ensuring assessments and evaluations are	02/14/2016

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	<p>and in regard to reviewing/obtaining a current speech assessment for a client who had difficulty being understood by others.</p> <p>Findings include:</p> <p>1. During the 1/4/16 observation period between 4:17 PM and 6:15 PM and the 1/5/16 observation period between 6:00 AM and 8:20 AM, at the group home, client #2 was non-verbal in communication in that the client's speech was not able to be understood by staff. Client #2 would point and utilize basic signs to get staff to understand what she wanted.</p> <p>During the 1/6/15 observation period between 10:35 AM and 11:05 AM, at the day program, client #2 requested workshop staff be present when interviewed to help her answer questions. Client #2 was able to answer yes/no questions by nodding/shaking her head, but the workshop staff had to interpret any question that required more response, and/or guess what the client was trying to say. During the above mentioned 1/4, 1/5 and 1/6/16 observation periods, client #2 did not use and/or was not encouraged to use any assistive communication devices.</p> <p>Client #2's record was reviewed on</p>				<p>completed in accordance with team and doctor recommendations.</p> <p>The Program Director/QIDP and Facility Nurse will be retrained on ensuring individuals with limited communication skills are assessed annually and/or obtain current speech/communication assessments. Furthermore, the Program Director/QIDP and Facility Nurse will ensure follow through with IDT recommendations following the assessments, such as Client #2's aquatic class recommendation.</p> <p>Additionally, Client #2 will be reassessed for communication needs by a speech therapist.</p> <p>Client #2 will participate in recommended aquatics classes. The Area Director will review the next three Individualized Support Plans to confirm any needed assessments are completed for recommended therapies.</p> <p>Person Responsible: Area Director Date of Completion: February 14, 2016</p>		

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	<p>1/5/16 at 11:12 AM. Client #2's 1/21/15 Risk Management Plan indicated "... [Client #2] is non-verbal. She does little signing to communicate wants and needs...."</p> <p>Client #2's 8/29/05 Speech And Language Evaluation indicated "...Her (client #2's) expressive communication consists of pointing, some signs, and use of the stereotypic phrase: 'back-back.' Her sign language vocabulary includes Help, Please, Mom (which means eat), sorry and toilet...." The 8/29/05 assessment indicated client #2 had "...Severe expressive communication deficits...Overall goal will be to increase her ability to express basic wants and needs through the use of speech, gestures/signs, or AAC (Assistive Augmentative Communication) device. Specific short-term goals will include:</p> <ol style="list-style-type: none"> 1. [Client #2] will select a pictured item by label, feature, function, or class from an array of 4-6 items... 2. [Client #2] will identify desired vocabulary items by indicating Yes/No... 3. [Client #2] will indicate a desired item by handing a picture of the items, pointing to a picture, or activating the appropriate square on an AAC device...." <p>Client #2's 1/21/15 Individual Support Plan (ISP) indicated client #2 had an</p>			

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	<p>objective to "...practice her listed signs, 'help,' 'please,' 'sorry,' 'medication' and will use her communication book/bracelet with 3 verbal prompts or less...." Client #2's record and/or 1/21/15 ISP did not indicate the facility's QIDP reviewed client #2's 8/05 speech assessment annually, and/or obtained a more current speech/communication assessment of client #2's communication needs since 8/05.</p> <p>Interview with the QIDP, RN (Registered Nurse) #1 and the Area Director (AD) on 1/6/16 at 12:02 PM indicated client #2 had a "magnetic board" which had cards for the client to utilize to communicate when communicating with others. RN #1 stated "Doctor did not feel it (speech assessment) was warranted. She did years of speech therapy of no use." The QIDP and the AD indicated client #2's speech/communication skills had not been re-assessed since 8/05. The AD indicated the QIDP and the client's interdisciplinary team (IDT) were to review the client's speech assessment annually to see if it was still current.</p> <p>2. During the 1/4/16 observation period between 4:17 PM and 6:15 PM and the 1/5/16 observation period between 6:00 AM and 8:20 AM, at the group home, client #2 utilized a reverse walker when</p>				

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	<p>ambulating as the client had Cerebral Palsy.</p> <p>Client #2's record was reviewed on 1/5/16 at 11:12 AM. Client #2's 6/15/15 Physical Examination (PE) form indicated "Use walker at all times to prevent falls." Client #2's 6/15/15 PE indicated "Mild grad (gradual) gait instability. Eval (evaluation) PT."</p> <p>Client #2's 8/14/15 Medical Appointment Form indicated client #2 was evaluated by PT on 8/14/15. The form indicated "Recommend PT Evaluation on yearly basis. Continue with Home Ex (exercise) Program as instructed per handout. Recommend trial of aquatic ex. (example) classes with caregiver assist."</p> <p>Client #2's 1/21/15 ISP and/or record indicated the QIDP did not address the 8/14/15 recommendation in regard to the aquatic classes.</p> <p>Interview with the QIDP and the AD on 1/6/16 at 12:02 PM indicated client #2's IDT had discussed the recommendation but the aquatic classes had not been started.</p> <p>9-3-3(a)</p>			
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W 0203 Bldg. 00	<p>483.440(b)(5)(i) ADMISSIONS, TRANSFERS, DISCHARGE At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status.</p> <p>Based on interview and record review for 1 of 2 discharge summaries reviewed (#8), the facility failed to develop a summary which addressed the client's behavioral, social, developmental, nutritional and health needs.</p> <p>Findings include:</p> <p>The facility's discharge summaries were reviewed on 1/4/16 at 12:05 PM. The facility's 2/10/15 Notice of Admission/Transfer/Discharge form indicated client #8 was discharged from the group home to a nursing home on 2/9/15. The 2/9/15 discharge form indicated "[Client #8] was admitted to a Nursing Facility for short term rehab (rehabilitation)." The 2/9/15 discharge form only indicated the date and place the client was discharged from and the place the client was discharged to. The 2/9/15 form did not contain any information in regard to the client's behavioral, social, developmental, nutritional and health needs.</p> <p>Interview with the Area Director (AD) on</p>	W 0203	<p>The facility has policies in place to develop a discharge summary when an individual discharges from services. The final summary includes the client's developmental, behavioral, social, health, and nutritional needs. The Program Director/QIDP will be retrained on the requirement of completing a discharge summary as well as the components of the summary that will be presented to the new setting to which the individual is discharged. The Area Director will review the next three client discharges to confirm a completed discharge summary is developed and includes all necessary components. Person Responsible: Area Director Date of Completion: February 14, 2016</p>	02/14/2016			

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W 0289 Bldg. 00	<p>1/4/16 at 12:00 PM stated the facility did not do a discharge summary for client #8 as he was "going to a nursing home and he was expected to come back, but did not."</p> <p>9-3-4(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on record review and interview for 1 of 3 sampled clients (#1), the facility failed to insure that all behavior interventions were included in the behavior support plan (BSP) for client #1.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 1/5/16 at 11:10am. Client #1's daily support record indicated the following (not all inclusive):</p> <p>-10/15/15: "[Client #1] was up to change into his pajamas and refused, stating 'I'll do it tomorrow'. Staff said that was fine. [Client #1] continued watching TV and then began to cry stating, 'I lost my pop</p>	W 0289	<p>The facility uses systematic interventions to manage inappropriate client behavior and incorporates that into a Behavior Support Plan (BSP) that is developed, reviewed, and approved by the Interdisciplinary Team (IDT).</p> <p>The Program Director/QIDP will be retrained on requirement to include any and all behavior interventions, such as soda reinforcers, into a BSP.</p> <p>The Area Director will review the next three BSP's with the Program Director and Behavior Support Specialist to ensure inclusion of any and all behavior interventions.</p> <p>Person Responsible: Area Director Date of Completion: February 14, 2016</p>	02/14/2016

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W 0312 Bldg. 00	<p>tomorrow."</p> <p>11/11/15: "...He had a behavior and yelled he lost his pop."</p> <p>11/16/15: "[Client #1] had a crying episode where he thought he lost his pop."</p> <p>11/18/15: "[Client #1] was upset that he lost his pop and had a behavior."</p> <p>11/25/15: "...talked to staff about earning his pop."</p> <p>Client #1's 2/18/15 BSP did not indicate how client #1 could lose and/or earn a pop throughout the day.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director) on 1/6/16 at 12:02 PM indicated client #1's BSP did not include how client #1 could lose a pop. QIDP stated "he doesn't lose pops, he earns them, but it should be in his plan and it's not."</p> <p>9-3-5(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan</p>						

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	<p>that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on interview and record review for 3 of 3 sampled clients (#1, #2 and #3), on behavior controlling medications, the facility failed to ensure the clients' medications were a part of the clients' Behavioral Support Plans (BSPs) and/or included an active treatment program for the behaviors for which the medications were prescribed.</p> <p>Findings include:</p> <p>1. Client #2's record was reviewed on 1/5/16 at 11:12 AM. Client #2's 9/1/15 to 9/30/15 physician's orders indicated client #2 received Duloxetine HCL (Hydrochloride) DR (Delayed Release) 30 milligrams daily at 8 AM for Depression.</p> <p>Client #2's 9/10/15 BSP indicated client #2 demonstrated resistance to instructions, aggressive outbursts and taking others' property without permission. Client #2's 9/10/15 BSP did not clearly define the client's Depression and/or include an active treatment program for the client's Depression.</p> <p>Interview with the Qualified Intellectual</p>	W 0312	<p>The facility has Behavior Support Plans (BSPs) in place to assist individuals with managing inappropriate behaviors. The facility's policies require that any client who receives behavior controlling medications will have these medications listed in the BSP and/or active treatment plan. The Program Director/QIDP will be retrained on the need to include all behavior controlling medications into the client's BSP. Additionally, the Program Director/QIDP will be retrained to ensure Depression is clearly defined in the BSP for any individual with that diagnosis. Client #2's BSP and/or active treatment plan will be updated to include a clear definition of Depression. Client #1 and Client #3's BSPs will be updated to include the current behavior controlling medications prescribed to them. The Area Director will review the next three BSP's to ensure all behavior controlling medications are listed in the BSP, as well as clearly defined Depression as applicable. Person Responsible: Area Director Date of Completion: February 14, 2016</p>	02/14/2016			

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	<p>Disabilities Professional (QIDP) and the Area Director (AD) on 1/5/16 at 12:02 PM indicated client #2's BSP did not define the client's Depression and did not include an active treatment program which addressed the client's Depression.</p> <p>2. Client #3's record was reviewed on 1/6/16 at 1:45 PM. Client #3's 12/1/15 to 12/31/15 physician's orders indicated client #3 received Saphris 5 milligrams at bedtime for behavior.</p> <p>Client #3's 9/11/15 BSP indicated client #3 received Seroquel instead of Saphris. Saphris was not part of client #3's BSP.</p> <p>Interview with the AD and the QIDP on 1/5/16 at 12:02 PM indicated client #3's Seroquel had not been removed from client #3's BSP. The AD and the QIDP indicated client #3 had been placed on the Saphris as the client was being suspended from school due to his behaviors. The QIDP indicated the Saphris had not been added to client #3's BSP.</p> <p>3. Client #1's record was reviewed on 1/5/16 at 11:10am. Client #1's 9/13/15 physician's orders indicated client #1 received Guanfacine HCL 1 1/2 milligrams 2 times daily for mood.</p>			

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W 0331 Bldg. 00	<p>Client #1's 2/18/15 BSP indicated client #1 received Clonazepam, Divalproex, Thioridazine, and Clomipramine. Guanfacine HCL was not part of client #1's BSP.</p> <p>Interview with the AD and the QIDP on 1/5/16 at 12:02 PM indicated the Guanfacine HCL was not part of Client #1's BSP.</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review for 1 of 3 sampled clients (#1), the facility's nursing services failed to meet the nursing needs of clients in regard to developing a risk plan for client #1's osteoporosis.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 1/5/16 at 11:10am. Client #1's 9/13/15 physician order indicated client #1 had a diagnosis of osteoporosis and took Oyster Calcium 500mg three times daily.</p> <p>Client #1's nursing progress notes indicated the following (not all</p>	W 0331	<p>The facility has policies and procedures in place to ensure all clients receive nursing services in accordance with their needs, such as development of protocols and/or risk plans for any diagnosis or need that puts a client at risk.</p> <p>The Facility Nurse will be retrained on the need to develop and implement protocols and/or risk plans for any client that has a diagnosis or need that puts them at risk. Client #1 now has an osteoporosis risk plan in place to guide staff in strategies to reduce risk to Client #1.</p> <p>The Area Director will review next three annual plans to ensure all nursing needs are being met for each client in regards to their specific diagnosis.</p>	02/14/2016

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	<p>inclusive).</p> <p>- 4/13/15: Nurse received a report that client #1 fell at the workshop. Nursing progress note indicated "small abrasion present right hand."</p> <p>-7/24/15: Nurse spoke with staff who reported fall. Nurses progress note indicated Client #1 "banged up right elbow and right knee otherwise fine." Nurses progress note indicated nurse assessed him and observed "right elbow with redness, minor abrasion to right knee. Covered with bandaid (sic)."</p> <p>-8/20/15: Nurses progress note indicated "Call from [Home Manager], [client #1] fell last noc (night) only superficial abrasions to palm and knee."</p> <p>-8/26/15: The nurses progress note indicated "Call from [Home Manager], [client #1] fell last night, abrasion to forehead, but no other injury."</p> <p>Client #1's 2/18/15 Individualized Support Plan (ISP) indicated client #1 was at risk for falls due to an unsteady gait. Client #1's ISP did not indicate client #1 had an osteoporosis protocol.</p> <p>An interview with the Registered Nurse (RN), was conducted on 1/5/16 at 12:02</p>		<p>Person Responsible: Area Director Date of Completion: February 14, 2016</p>	

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W 0426 Bldg. 00	<p>PM. When asked if client #1 had a osteoporosis protocol, the RN stated "He is on medication, but no official protocol."</p> <p>9-3-6(a)</p> <p>483.470(d)(3) CLIENT BATHROOMS</p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>Based on observation, interview and record review for 2 of 3 sampled clients (#1 and #2) and for 3 additional clients (#4, #5 and #6), the facility failed to maintain their hot water at 110 degrees Fahrenheit as clients were not independent in regulating water temperatures.</p> <p>Findings include:</p> <p>During the 1/5/16 observation period between 6:00 AM and 8:20 AM, at the group home the water temperature was 124.7 degrees Fahrenheit, at the kitchen sink, at 6:21 AM. The kitchen's sink hot water had steam coming off the water. At 6:24 AM in the large bathroom shower, the water temperature was 120.6</p>	W 0426	<p>The facility has policies in place to ensure the temperature of the hot water in the facility does not exceed 110 degrees Fahrenheit when clients are unable to regular their own how water. This is a safeguard in place to protect clients for possible injury or harm based on their inability to safely regular water temperature. The facility has corrected the hot water temperature regulator and calibrated it to ensure the temperature does not exceed 110 degrees Fahrenheit. The staff at the facility will also be trained on completing daily tracking to confirm the water temperature does not exceed this amount, and notify an on-call supervisor should the water temperature exceed 110 degrees Fahrenheit. Weekly Program Coordinator will check the hot water temperature documentation as well as</p>	02/14/2016

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	<p>degrees Fahrenheit and the water temperature at the bathroom sink was 123.4 degrees Fahrenheit. During the 1/5/16 observation period, staff #2 physically assisted client #5 to take her shower/bath.</p> <p>On 1/5/16 at 8:35 AM, the water temperature, at the kitchen sink, was taken along with the facility's maintenance man. The facility's maintenance staff #1 thermometer got a reading of 121.5 degrees Fahrenheit.</p> <p>Client #1's record was reviewed on 1/5/16 at 11:10 AM. Client #1's 2/18/15 Individualized Support Plan indicated client #1 was not able to regulate his own water temperature.</p> <p>Client #2's record was reviewed on 1/5/16 at 11:12 AM. Client #2's 1/20/15 Camelot Behavioral Checklist indicated client #2 was not able to regulate her own water temperature.</p> <p>Client #4's record was reviewed on 1/5/16 at 1:35 PM. Client #4's 3/4/15 Camelot behavioral Checklist indicated client #4 was not able to regulate his own water temperature.</p> <p>Client #6's record was reviewed on 1/5/16 at 1:37 PM. Client #6's 6/2/15</p>		<p>completing a test of the hot water temperature at that time. Person Responsible: Area Director Date of Completion: February 14, 2016</p>	

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	<p>Camelot behavioral Checklist indicated client #6 was not able to regulate his own water temperature.</p> <p>Client #5's record was reviewed on 1/5/16 at 1:40 PM. Client #5's 7/21/15 Camelot Behavioral Checklist indicated client #5 was able to regulate water temperatures.</p> <p>Interview with staff #1 on 1/5/16 at 8:15 AM when asked which clients could regulate their own water temperatures, staff #2 stated "Almost all can."</p> <p>Interview with maintenance staff #1 on 1/5/16 at 8:35 AM indicated he checked the water temperature at the group home. Maintenance staff #1 stated "It is normally around 109 degrees Fahrenheit." Maintenance staff #1 indicated the water temperature should not go over 110 degrees Fahrenheit.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 1/5/16 at 8:43 AM indicated client #3 was the only client who could independently regulate/mix water temperatures safely. The QIDP indicated clients #1, #2, #4, #5 and #6 required physical assistance to regulate the water temperature.</p>			

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W 0436 Bldg. 00	<p>9-3-7(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client #1) with adaptive equipment, the facility failed to have client #1's adaptive silverware and chair booster available.</p> <p>Findings include:</p> <p>1. During the 1/4/16 observation period between 4:17 PM and 6:15 PM and the 1/5/16 observation period between 6:00 AM and 8:20 AM, at the group home, client #1 ate his meals with regular silverware. Staff did not encourage client #1 to use adaptive silverware at anytime during his meals.</p> <p>Client #1's record was reviewed on 1/5/16 at 11:10am. Client #1's 6/5/15 medical appointment form indicated he had an occupational therapy (OT) visit. An order was written for swivel fork and spoon. The medical appointment form indicated "the 'adjustable swivel utensil'</p>	W 0436	<p>The facility furnishes, maintains in good repair, and teaches clients to use and to make informed choices about the use of adaptive equipment/devices as identified by the Interdisciplinary Team (IDT) as needed for the client. The facility will discuss with Client #1's IDT the recommendation of swivel silverware to determine the need and/or follow up recommendations from his OT evaluation. Additionally, Client #1's IDT will discuss the need and/or follow up recommendations from his PT evaluation for the use of a chair/booster seat to assist with his standing upright from a sitting position.</p> <p>The Program Director/QIDP and Facility Nurse will be retrained on to discuss with each client's IDT the need and implementation of any recommended adaptive equipment as determine by a healthcare professional. The Program Director/QIDP will be retrained on ensuring completed follow up based on the IDT</p>	02/14/2016	

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	<p>may make it easier to use utensils w/o (without) spilling food." Client #1's June 2015 monthly health review indicated "Appointment with [name of occupational therapist] for OT evaluation. His only suggestion was to try to use swivel spoon and fork. Provided HM (House Manager) with ordering information."</p> <p>An interview with the Area Director (AD), Registered Nurse (RN), and Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/5/16 at 12:02 PM. When asked if client #1's silverware was available QIDP stated "We ordered the silverware and it was very flimsy. I never followed up with ordering more."</p> <p>2. During the 1/4/16 observation period between 4:17 PM and 6:15 PM and the 1/5/16 observation period between 6:00 AM and 8:20 AM, at the group home, client #1 was not able to stand himself up off the couch. On 1/4/16 at 4:17pm client #1 was sitting on the couch on the living room. He attempted to stand up and fell back down into the couch. Client #1 attempted this 5 times before he asked staff to assist him. The HM (House Manager) helped client #1 to stand encouraging him to put both his hands on his walker. On 1/5/16 at 6:00am client #1</p>		<p>recommendations. Person Responsible: Area Director Date of Completion: February 14, 2016</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G264	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 124 BLACKHAWK LN WEST LAFAYETTE, IN 47906
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W 9999 Bldg. 00	<p>was sitting on the couch in the living room. Client #1 again made several attempts to get himself up off the couch, each time falling back down onto the couch. He had to wait for staff to come assist him up off the couch.</p> <p>Client #1's record was reviewed on 1/5/16 at 11:10am. Client #1's 11/3/15 medical appointment form indicated client #1 had a physical therapy (PT) appointment. The medical appointment form indicated "PT educated staff on possible use of booster seat or seat riser to assist [client #1] with sit to stand transfers to decrease patients difficulty with transfers."</p> <p>An interview with the Area Director (AD), Registered Nurse (RN), and Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/5/16 at 12:02 PM. When asked if client #1's seat cushion was available, the RN stated "We tried it, it didn't work. He would sit on it and it would just smash down."</p> <p>9-3-7(a)</p>	W 9999	The facility has policies and	02/14/2016
	State Findings			

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	<p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division:</p> <p>"Incidents to be reported to BQIS (Bureau of Quality Improvement Services) include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual including but not limited to:</p> <p>15. A fall resulting in injury, regardless of the severity of the injury."</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview for 1 of 3 sampled clients (#1), the facility failed to report falls which resulted in injury to the Bureau of Developmental Disabilities Services (BDDS).</p> <p>Findings include:</p>		<p>procedures in place requiring the staff to notify the Bureau of Developmental Disabilities Services (BDDS) on any incident characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual. The facility will retrain staff and Program Director/QIDP on the requirement to report any BDDS reportable incidents, including falls with injury, immediately to the on-call supervisor so that written summaries can be completed and sent to BDDS within 24 hours of occurrence. The Program Director will ensure any reported instances are reported to the local BDDS office and any other applicable members of the Interdisciplinary Team so that preventive measures can be implemented to reduce recurrence. Person Responsible: Area Director Date of Completion: February 14, 2016</p>				

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	<p>Client #1's record was reviewed on 1/5/16 at 11:10am.</p> <p>- 4/13/15: Nurses progress note indicated the nurse received a report that client #1 fell at the workshop. Nursing progress note indicated "small abrasion present right hand."</p> <p>-7/24/15: Nurses progress note indicated the nurse spoke with staff who reported fall. Nurses progress note indicated Client #1 "banged up right elbow and right knee otherwise fine." Nurses progress note indicated nurse assessed him and observed "right elbow with redness, minor abrasion to right knee. Covered with bandaid (sic)."</p> <p>-8/20/15: Nurses progress note indicated "Call from [HM] (House Manager), [client #1] fell last noc (night) only superficial abrasions to palm and knee."</p> <p>-8/26/15: The nurses progress note indicated "Call from [HM], [client #1] fell last night, abrasion to forehead, but no other injury."</p> <p>A review of the facility's incident reports on 1/4/16 at 12:03pm, from 1/2015 to 1/2016, did not indicate client #1's falls with injuries were reported to state</p>			

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	<p>officials.</p> <p>Interview with the Area Director (AD) on 1/6/16 at 12:02 PM indicated he would double check his reportable incidents to determine if these incidents were reported. The facility was unable to provide any additional information to review.</p> <p>9-3-1(b)</p>				