

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
W 0000  Bldg. 00	<p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Dates of Survey: 4/12/16, 4/13/16, 4/21/16 and 4/22/16.</p> <p>Facility Number: 004445 Provider Number: 15G722 AIMS Number: 200518250</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/28/16.</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.</p> <p>Based on observation, record review and interview for 2 of 2 sampled clients (#1 and #2), plus 2 additional clients (#3 and #4), the facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections, to implement its policy and procedures to ensure an allegation of staff neglect</p>	W 0104	<p>Area Director will retrain Program Director and Program Coordinator on ensure that all reportable incidents are filed timely. Area Director will meet weekly with Program Director to review that all reportable incidents have been reported timely according to State policy. Area Director will retrain nurse on using accurate documentation regarding healing/non-healing of</p>	05/22/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>regarding clients #2 and #3 was reported to BDDS (Bureau of Developmental Disabilities Services), to prevent neglect of client #4 regarding recurring pressure ulcers, to report occurrences of pressure ulcers to BDDS regarding client #4 and to develop and implement effective corrective measures to prevent additional occurrences of pressure ulcers regarding client #4.</p> <p>The facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure client #4 was taught to manage her own financial affairs, to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, monitored and coordinated clients #1, #2 and #4's active treatment programs, to ensure client #4's ISP (Individual Support Plan) included formal training objectives to increase client #4's independence regarding her identified needs, to ensure client #4 had a medication administration goal and to ensure client #4 had a wheelchair that prevented her from sliding forward.</p> <p>Findings include:</p> <p>1. The facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of</p>		<p>pressure ulcers. During the exit interview it was our interpretation that the surveyor felt that the ulcer had healed based on the nurses documentation. The Nurse used the word "scab" which is part of the healing process, however the scab would fall off and the ulcer would continue to be open so it never completely healed. This was the QIDP's interpretation from her ongoing conversations with the Nurse as well as her own observations however the QIDP was retrained on incident reporting per state policy. Nurse will review skin integrity protocol and develop positioning schedule for client #4. Nurse will retrain all staff on protocol and schedule. Area Director will review monthly nursing notes to ensure that proper documentation regarding healing/non-healing of pressure ulcers is being implemented. Program Director will retrain all staff on abuse/neglect prevention.</p> <p>Goals for client #4 to manage her own financial affairs, medication administration as well other formal training objectives to increase her independence regarding her identified needs were in place at the time of survey review. Program Director will retrain all staff on implementing goals. Area Director will review Program Directors monthly reviews to ensure that goals are being implemented correctly for all</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>Participation: Client Protections for clients #2, #3 and #4. Please see W122.</p> <p>2. The facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure client #4 was taught to manage her own financial affairs. Please see W126.</p> <p>3. The facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure to ensure allegations of staff neglect regarding clients #2 and #3 was reported to BDDS (Bureau of Developmental Disabilities Services). The facility failed to prevent neglect of client #4 regarding recurring pressure ulcers, to report occurrences of pressure ulcers to BDDS regarding client #4 and to develop and implement effective corrective measures to prevent additional occurrences of pressure ulcers regarding client #4. Please see W149.</p> <p>4. The facility's governing body failed to exercise general policy, budget and operating direction over the facility to report an allegation of staff neglect regarding clients #2 and #3 and occurrences of pressure ulcers to BDDS regarding client #4. Please see W153.</p> <p>5. The facility's governing body failed to</p>		<p>clients. Area Director will retrain Program Director on developing and implementing active treatment programs for all clients. Client #4 wheelchair has been approved. Nurse will have weekly follow up with National Seating to ensure the process and delivery of wheelchair is completed. The developed position schedule will be in place to ensure that client does not slide forward in wheelchair until new chair arrives. Program Director and or Program Coordinator will complete at least 4 weekly visits for 1 month, 1 weekly visit for 3 months and then ongoing visits at least monthly to ensure that all goals, protocols, activetreatment and positioning schedules are being implemented correctly as well as ensuring the ulcers are being dealt with accordingly.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>exercise general policy, budget and operating direction over the facility to develop and implement effective corrective measures to prevent additional occurrences of pressure ulcers regarding client #4. Please see W157.</p> <p>6. The facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure the QIDP integrated, monitored and coordinated clients #1, #2 and #4's active treatment programs. Please see W159.</p> <p>7. The facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure client #4's ISP included formal training objectives to increase client #4's independence regarding her identified needs. Please see W227.</p> <p>8. The facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure client #4 had a medication administration goal. Please see W371.</p> <p>9. The facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure client #4 had a wheelchair that prevented her from sliding forward.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
W 0122 Bldg. 00	<p>Please see W436.</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 record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 1 of 2 sampled clients (#2), plus 2 additional clients (#3 and #4). The facility failed to implement its policy and procedures to ensure an allegation of staff neglect regarding clients #2 and #3 was reported to BDDS (Bureau of Developmental Disabilities Services). The facility failed to prevent neglect of client #4 regarding recurring pressure ulcers, to report occurrences of pressure ulcers to BDDS regarding client #4 and to develop and implement effective corrective measures to prevent additional occurrences of pressure ulcers regarding client #4.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to ensure allegations of staff neglect regarding clients #2 and #3 was reported to BDDS (Bureau of Developmental Disabilities</p>	W 0122	<p>Area Director willretrain Program Director (QIDP) and Program Coordinator on ensure that all reportable incidents are filed timely. Area Director will meet weekly with Program Director (QIDP) to review that all reportable incidents have been reported timely according to State policy. Area Director will retrain nurse on using accuratedocumentation regarding healing/non-healing of pressure ulcers. Area Director will review Nurses notes monthly to ensure proper documentation regarding healing/non-healing of pressure ulcers is being implemented. .</p> <p>During the exit interview it was our interpretation that the surveyor felt that the ulcer had healed based on the nurses documentation. The Nurse used the word "scab" which is part of the healing process, however the scab would fall off and the ulcer would continue to be open so it never completely healed. This was the QIDP's interpretation from her ongoing conversations with the Nurse as well as her own observations however the</p>	05/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
W 0126 Bldg. 00	<p>Services). The facility failed to prevent neglect of client #4 regarding recurring pressure ulcers, to report occurrences of pressure ulcers to BDDS regarding client #4 and to develop and implement effective corrective measures to prevent additional occurrences of pressure ulcers regarding client #4. Please see W149.</p> <p>2. The facility failed to report an allegation of staff neglect regarding clients #2 and #3 and occurrences of pressure ulcers to BDDS regarding client #4. Please see W153.</p> <p>3. The facility failed to develop and implement effective corrective measures to prevent additional occurrences of pressure ulcers regarding client #4. Please see W157.</p> <p>9-3-2(a)</p> <p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p>		<p>QIDP was retrained on incident reporting per statepolicy. Nursewill review skin integrity protocol and develop positioning schedule for client#4. Nurse will retrain all staff on protocol and schedule. Area Directorwill review monthly nursing notes to ensure that proper documentation regardinghealing/non-healing of pressure ulcers is being implemented. Nursewill review skin integrity protocol and develop positioning schedule for client#4. Nurse will retrain all staff on protocol and schedule. Area Directorwill review monthly nursing notes to ensure that proper documentation regardinghealing/non-healing of pressure ulcers is being implemented. ProgramDirector (QIDP) will retrain all staff on abuse/neglect prevention. Program Director (QIDP) and orProgram Coordinator will complete at least 4 weekly visits for 1 month, 1weekly visit for 3 months and then ongoing visits at least monthly to ensurethat positioning schedules are being implementedcorrectly as well as ensuring theulcers are being dealt with accordingly.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>Based on record review and interview for 1 additional client (#4), the facility failed to ensure client #4 was taught to manage her own financial affairs.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 4/13/16 at 11:20 AM. Client #4's ISP (Individual Support Plan) dated 1/17/16 indicated, "[Client #4] is dependent on staff to meet all her personal needs. She currently participates in ADL (Activities of Daily Living) skill development training, which includes the areas of ... money management...." Client #4's ISP dated 1/17/16 did not indicate documentation of a formal training objective regarding client #4's money management training.</p> <p>Client #4's day services QIDP (Qualified Intellectual Disabilities Professional) Monthly Summary form dated December 2015 indicated client #4 was admitted to the group home on 12/17/15. Client #4's day services QIDP Monthly Summary form dated December 2015 indicated, "Goals will be developed."</p> <p>Client #4's record did not indicate documentation of formal training objectives regarding money management skills.</p>	W 0126	<p>Goals for client #4 to manage her own financial affairs, medication administration as well as other formal training objectives to increase her independence regarding her identified needs were in place at the time of survey review. Program Director will retrain all staff on implementing goals. Area Director will review Program Directors monthly reviews to ensure that goals are being implemented correctly for all clients.</p> <p>Program Director and or Program Coordinator will complete at least 4 weekly visits for 1 month, 1 weekly visit for 3 months and then ongoing visits at least monthly to ensure that goals are being implemented correctly.</p>	05/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
W 0149 Bldg. 00	<p>QIDP #1 was interviewed on 4/21/16 at 9:18 AM. When asked if she could provide documentation of formal training objectives for client #4, QIDP #1 indicated in the affirmative and she would email a copy of client #4's formal training objectives.</p> <p>QIDP #1 sent an email on 4/21/16 at 10:19 AM. QIDP #1 attached a copy of client #4's group home QIDP Monthly Summary form dated December 2015. Client #4's group home QIDP Monthly Summary form dated December 2015 indicated, "Goals will be developed."</p> <p>QIDP #1 did not provide documentation of the development of a formal money management goal for client #4.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 2 sampled clients (#2), plus 2 additional clients (#3 and #4), the facility failed to implement its policy and procedures to ensure an allegation of staff neglect regarding clients #2 and #3 was</p>	W 0149	Area Director willretrain Program Director (QIDP) and Program Coordinator on ensure that all <b>reportable incidents are filed timely. Area Director will meet weekly with Program Director (QIDP) to review thatall</b>	05/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>reported to BDDS (Bureau of Developmental Disabilities Services). The facility failed to prevent neglect of client #4 regarding recurring pressure ulcers, to report occurrences of pressure ulcers to BDDS regarding client #4 and to develop and implement effective corrective measures to prevent additional occurrences of pressure ulcers regarding client #4.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 4/12/16 at 2:34 PM. The review indicated the following:</p> <p>1. Investigation Summary dated 9/27/15 indicated the facility was conducting an investigation regarding an allegation of facility staff being asleep while on duty in the home while supervising clients #2 and #3.</p> <p>The review did not indicate documentation of the 9/27/15 allegation of neglect regarding clients #2 and #3 being reported to BDDS.</p> <p>2. BDDS report dated 1/4/16 indicated, "[RN (Registered Nurse) #1] notified of (an) open area. [RN #1] stated [client #4]</p>		<p>reportable incidents have been reported timely according to State policy. Area Director will retrain nurse on using accurate documentation regarding healing/non-healing of pressure ulcers. Area Director will review Nurses notes monthly to ensure proper documentation regarding healing/non-healing of pressure ulcers is being implemented During the exit interview it was our interpretation that the surveyor felt that the ulcer had healed based on the nurses documentation. The Nurse used the word "scab" which is part of the healing process, however the scab would fall off and the ulcer would continue to be open so it never completely healed. This was the QIDP's interpretation from her ongoing conversations with the Nurse as well as her own observations however the QIDP was retrained on incident reporting per state policy. Nurse will review skin integrity protocol and develop positioning schedule for client #4. Nurse will retrain all staff on protocol and schedule. Area Director will review monthly nursing notes to ensure that proper documentation regarding healing/non-healing of pressure ulcers is being implemented. Nurse will review skin integrity protocol and develop positioning schedule for client #4. Nurse will retrain all staff on protocol and schedule. Area</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>has a 1 inch by 1/3 inch open area on (her) buttock just left of rectum. [RN #1] instructed [PC (Program Coordinator) #1] to contact (her) PCP (Primary Care Physician) on 1/5/16 for appointment or wound care instructions (sic). [RN #1] instructed [client #4] to be out of her wheelchair except for meals and transport. Impaired skin integrity protocol is in place, which includes repositioning every two hours. Area most likely caused by movement/friction in wheelchair. [PC #1] will follow up with PCP for instructions/wound care. Staff will follow RN instructions. [Company] will be contacted now that holidays are over with script for seating evaluation and any possible repairs/adaptation to present chair. Staff will continue to monitor [client #4's] health status and open area for additional concerns."</p> <p>Client #4's record was reviewed on 4/13/16 at 11:30 AM.</p> <p>Client #4's ISP (Individual Support Plan) dated 1/17/16 indicated, "[Client #4] is diagnosed with Atypical Stereotypic Movement Disorder (repetitive, non-functional movement) and Severe Spastic Paraplegia (stiffness and contraction of limbs)." Client #4's ISP dated 1/17/16 indicated, "[Client #4] is non-weight bearing and non-ambulatory.</p>		<p>Director will review monthly nursing notes to ensure that proper documentation regarding healing/non-healing of pressure ulcers is being implemented. Program Director (QIDP) will retrain all staff on abuse/neglect prevention. Client #4 wheelchair has been approved. Nurse will have weekly follow up with National Seating to ensure the process and delivery of wheelchair is completed. The developed position schedule will be in place to ensure that client does not slide forward in wheelchair until new chair arrives. Program Director (QIDP) and or Program Coordinator will complete at least 4 weekly visits for 1 month, 1 weekly visit for 3 months and then ongoing visits at least monthly to ensure that positioning schedules are being implemented correctly as well as ensuring the ulcers are being dealt with accordingly.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>She uses a wheelchair for mobility which is propelled by staff. She is a two persons lift or [brand] Lift to ensure minimal bruising and reduce potential for breaks. Staff complete cleaning of her wheelchair daily. She is scheduled to be seen by the OT (Occupational Therapist/Therapy) at [hospital] and [company] on 2/3/16 for a seating and mobility evaluation for a new wheelchair for improved cushioning and positioning. She tends to slide forward in her current chair regardless of the use of harness and seat belt with the slight movements that she does make. OT/PT (Physical Therapy) evaluation was held in 1/16 and recommendations were consistent with the above information." Client #4's ISP dated 1/17/16 indicated, "[Client #4] relies on staff to propel her wheelchair and to provide re-positioning while in her chair, as she has a tendency to slide forward in her current chair, which can constitute to skin integrity issues from friction and rubbing. A wedge under her bottom can be used currently to help keep her in position when upright."</p> <p>Client #4's Nursing Progress Notes (NPNs) dated from 12/17/15 through 4/11/16 indicated the following:</p> <p>-12/17/15, indicated client #4 was admitted to the group home from another</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>agency operated location.</p> <p>-1/6/16, "Spoke with day program PC (Program Coordinator), she reports that she worked at [client #4's] home last evening and the area on [client #4's] buttocks is getting progressively worse." The 1/6/16 NPN indicated client #4 was sent to a medical clinic and was diagnosed with a stage 2 pressure sore (open skin, ulcers, tenderness/pain). The 1/6/16 NPN indicated RN #1 communicated with the home's PC to make arrangements for client #4 to be seen by a new PCP after moving to the new home. The 1/6/16 NPN indicated, "Discussed with [PC #1] report that the area is worse."</p> <p>-1/7/16, indicated RN #1 and PC #1 communicated regarding the 1/6/16 medical clinic recommendations regarding the use of patches and cushions.</p> <p>-1/9/16, indicated communication between PC #1 and RN #1 regarding the size and application of client #4's patches.</p> <p>-1/11/16, "At home with [client #4], the original area is 10 (mm) millimeters by 11 mm. She also has a new scab between the first area and her rectum which is 10</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>mm by 3 mm." The 1/11/16 NPN indicated PC #1 and RN #1 communicated regarding ongoing issues with client #4's patches fitting and staying in position. The 1/11/16 NPN indicated RN #1 instructed staff on layering or manipulating the size of the patches to better fit client #4's wound.</p> <p>-1/15/16, indicated RN #1 instructed staff on placing dressing and reinforcing dressing if it starts to roll or move and expose the area.</p> <p>-1/19/16, "At home with [client #4] the original wound higher up her buttocks is 4 mm by 9 mm. The secondary area closer to her rectum is 44 mm by 9 mm. Both areas continue to be stage 2." The 1/19/16 NPN indicated RN #1 instructed staff regarding a new dressing and how to wash the wound area.</p> <p>-1/22/16, "At day program with [client #4] the higher up wound is 5 mm by 9 mm. The secondary wound is 40 mm by 9 mm."</p> <p>-1/25/16, "At home with [client #4], her higher wound is 1 mm by 2 mm and the secondary is 39 mm by 4 mm."</p> <p>-1/27/16, "At home with [client #4], the higher wound is 1 mm by 2 mm and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>scabbed. The secondary wound is 30 mm by 4 mm and remains open."</p> <p>-2/1/16, "At day program with [client #4], the scab has fallen off the smaller wound leaving a 1 mm by 2 mm ruffed area. The secondary wound is 23 mm by 4 mm."</p> <p>-2/2/16, indicated communication between PC #1 and RN #1 regarding PCP visits and reorders for client #4's wound dressing.</p> <p>-2/3/16, "At day program with [client #4], there is a light pink area when (sic) smaller wound was located but skin has smoothed over area. The secondary wound is 28 mm by 8 mm." The 2/3/16 NPN indicated RN #1 communicated with the day program PC and PC #1 regarding patches being sent from the home to the day program.</p> <p>-2/8/16, "Wound is 29 mm by 8 mm."</p> <p>-2/11/16, indicated communication between PC #1 and RN #1 regarding a PCP visit on 2/11/16. RN #1 instructed PC #1 to discuss client #4's larger wound with regard to the amount of time for the wound to heal. The 2/11/16 NPN indicated, "At day program with [client #4], wound is 26 mm by 7 mm."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>-2/16/16, "At day program with [client #4], her wound is 20 mm by 5 mm."</p> <p>-2/18/16 and 2/19/16 NPNS indicated communication between RN #1 and PC #1 regarding coordination and monitoring of client #4's wounds.</p> <p>-2/19/16, "Scab has fallen off of the stage 2 area, it measures 22 mm by 4 mm. There continues to be a stage 1 (closed, discolored, tender) area surrounding the stage 2 of healing skin which measures from 4 mm to 6 mm in width."</p> <p>-2/22/16, "At day program with [client #4], the stage 2 is now 11 mm by 2 mm."</p> <p>-2/25/16, "At home with [client #4], scab had fallen off of stage 2 area leaving a stage 1 area which is 19 mm by 7 mm."</p> <p>-3/3/16, "At day program with [client #4], she had a 5 mm by 6 mm stage 1 area remaining that is uncovered."</p> <p>-3/7/16, "At day program with [client #4], she has a 22 mm by 6 mm area of new light pink skin in the area where her pressures sores were."</p> <p>-3/14/16, "At home with [client #4], she has a 12 mm by 7 mm dark purple area at site of previous pressure sore. It is</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>surrounded with light pink skin. Applied patch to area. Notified staff to keep patch on area and keep [client #4] off of area until healed."</p> <p>-3/15/16, "Phone call from [PC #1], she is working today. Purple area has opened up again. Keep patch on area and keep her off of the area. [PC #1] wants to make sure that day program PC is aware. Texted day program PC informing her. She will make sure [client #4] is kept off the area."</p> <p>-3/17/16, "Covering (on call) LPN (Licensed Practical Nurse) reports that there is a silver dollar sized blanchable area (area that does not lose color briefly when pressed and removed) with a 10 mm by 10 mm open area in the middle."</p> <p>-3/21/16, "At home with [client #4], she has a stage 1 pressure sore which is 22 mm by 11 mm at the same location on her left buttocks as the discolored area last week. There is a 15 mm line of scab at the base of the stage 1 area."</p> <p>-3/24/16, "At day program with [client #4], the scab line on her left buttocks is 5 mm. There is an area of new skin which is 20 mm by 20 mm."</p> <p>-3/30/16, "At day program with [client</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>#4], she has a 70 mm by 30 mm light pink area on her left buttocks, there is on 2 mm by 2 mm scab at the base of the pink area."</p> <p>-4/4/16, "At day program with [client #4], scab has fallen off of her left buttocks. The light pink area is 45 mm by 35 mm."</p> <p>-4/11/16, "Pink area on buttocks is 50 mm by 35 mm."</p> <p>Client #4's Monthly Health Review (MHR) form dated December 2015 indicated client #4 was admitted to the group home on 12/17/15. Client #4's MHR form dated December 2015 indicated RN #1 had completed the summary and had signed the form. The December 2015 MHR form indicated QIDP (Qualified Intellectual Disabilities Professional) #1 had signed the document indicating she had reviewed the MHR.</p> <p>Client #4's MHR form dated January 2016 indicated RN #1 made narrative entries regarding the coordination and monitoring of client #4's stage 2 pressure ulcers on 1/4/16, 1/6/16, 1/7/16, 1/9/16, 1/11/16, 1/15/16, 1/19/16, 1/25/16 and 1/27/16. Client #4's MHR form dated January 2016 indicated RN #1 had completed the summary and had signed the form. The January 2016 MHR form</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>did not indicate documentation of QIDP #1's signature indicating she had not reviewed the January 2016 MHR (the QIDP signature line was blank).</p> <p>Client #4's MHR form dated February 2016 indicated RN #1 made narrative entries regarding the coordination and monitoring of client #4's pressure ulcers on 2/1/16, 2/3/16, 2/11/16, 2/16/16, 2/18/16, 2/19/16, 2/22/16 and 2/25/16. Client #4's MHR form dated February 2016 indicated RN #1 had completed the summary and had signed the form. The February 2016 MHR form did not indicate documentation of QIDP #1's signature indicating she had not reviewed the February 2016 MHR (the QIDP signature line was blank).</p> <p>Client #4's MHR form dated March 2016 indicated RN #1 made narrative entries regarding the coordination and monitoring of client #4's pressure ulcers on 3/3/16, 3/7/16, 3/14/16, 3/15/16, 3/17/16, 3/21/16, 3/24/16 and 3/30/16. Client #4's MHR form dated March 2016 indicated RN #1 had completed the summary and had signed the form. The March 2016 MHR form did not indicate documentation of QIDP #1's signature indicating she had not reviewed the March 2016 MHR (the QIDP signature line was blank).</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>Client #4's Impaired Skin Integrity Protocol (ISIP) dated 12/3/15 indicated the following:</p> <p>-"[Client #4] has a history of stage 1 and 2 pressures (sic) sores on her buttocks and coccyx (tailbone)."</p> <p>-"Signs and symptoms: Discoloration-red, pink, purple, black or white. Open wound with or without drainage."</p> <p>-"[Client #4's] buttocks will often become red. She may develop areas that are open or peeling."</p> <p>-"Keep off of area until normal color returns."</p> <p>QIDP #1 was interviewed on 4/21/16 at 9:18 AM. QIDP #1 indicated she was not aware of additional issues since January 2016 regarding client #4's pressure ulcers. QIDP #1 indicated there were no IDT (Interdisciplinary Team) meetings specifically regarding client #4's pressure ulcers.</p> <p>RN #1 was interviewed on 4/21/16 at 9:32 AM. RN #1 indicated client #4 had recurring pressure ulcers on her buttocks and coccyx area. RN #1 indicated client #4's pressure ulcers had healed and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>re-opened since she was admitted to the home December 2015. When asked if facility staff had been implementing her nursing measures to reposition client #4 to prevent recurrence of the pressure ulcers, RN #1 stated, "I think they are. The wheelchair has a lot to do with it. She slides in it. We try to keep her out of it as much as possible. They keep her out of it, it heals up, then she's back in the wheelchair and it re-opens. I think they are doing it appropriately, until she gets a new wheelchair she's going to continue to have issues. There's no pommel (upward curved post positioned between the legs to prevent sliding out)." RN #1 indicated client #4 had been evaluated for a new wheelchair and the agency was in the process of obtaining the new chair for client #4. RN #1 indicated she had communicated the coordination and monitoring of client #4's wound care with the home's PC.</p> <p>The review indicated client #4's pressure ulcer noted on 1/4/16 had continued through 2/25/16 with an additional stage 2 ulcer also opening and healing in the same time period. The review did not indicate documentation of the second ulcer being reported to BDDS. The review indicated client #4's skin was noted as being progressively discolored in the areas of her previous pressure</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>ulcers and the area re-opened on 3/15/16. The review did not indicate documentation of the 3/15/16 pressure ulcers being reported to BDDS. The review indicated client #4's buttocks and coccyx area continued to be discolored/stage 1 through the 4/11/16 date of documentation. The review indicated the facility had a wheelchair and OT evaluation on 2/3/16. Through the time of review on 4/21/16 client #4 did not have a new wheelchair to address her skin integrity issues. The review indicated the facility failed to prevent neglect regarding recurring pressure ulcers and to develop and implement measures to prevent additional occurrences of pressure ulcers.</p> <p>QIDP #1 was interviewed on 4/13/16 at 11:05 AM. QIDP #1 indicated the facility's abuse and neglect policy should be implemented, abuse and neglect should be prevented, all allegations of abuse, neglect and mistreatment should be reported to BDDS within 24 hours of the facility's knowledge of the alleged incident and corrective measures should be developed and implemented to prevent recurrence of abuse, neglect or mistreatment.</p> <p>The facility's policy and procedures were reviewed on 4/21/16 at 2:30 PM. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
W 0153  Bldg. 00	<p>facility's Quality and Risk Management policy dated April 2011 indicated the following:</p> <p>- "Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluation and reducing risk to which individuals are exposed."</p> <p>- "Failure to provide appropriate supervision, care or training."</p> <p>- "Failure to provide medical supplies or safety equipment as indicated in the ISP."</p> <p>- "Any occurrence of skin breakdown related to a decubitus ulcer regardless of severity" should be reported to BDDS.</p> <p>9-3-2(a)</p> <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>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>Based on record review and interview for 2 of 4 allegations of abuse, neglect, mistreatment or injuries of unknown origin reviewed, the facility failed to ensure allegations of staff neglect regarding clients #2 and #3 and recurring incidents of skin breakdown regarding client #4 were reported to BDDS (Bureau of Developmental Disabilities Services).</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 4/12/16 at 2:34 PM. The review indicated the following:</p> <p>1. Investigation Summary dated 9/27/15 indicated the facility was conducting an investigation regarding an allegation of facility staff being asleep while on duty in the home while supervising clients #2 and #3.</p> <p>The review did not indicate documentation of the 9/27/15 allegation of neglect regarding clients #2 and #3 being reported to BDDS.</p> <p>2. BDDS report dated 1/4/16 indicated, "[RN (Registered Nurse) #1] notified of (an) open area. [RN #1] stated [client #4] has a 1 inch by 1/3 inch open area on</p>	W 0153	<p>Area Director will retrain Program Director and Program Coordinator on ensure that all <b>reportable incidents are filed timely. Area Director will meet weekly with Program Director</b> to review that all reportable incidents have been reported timely according to State policy. Area Director will retrain nurse on using accurate documentation regarding healing/non-healing of pressure ulcers. Area Director will review Nurses notes monthly to ensure proper documentation regarding healing/non-healing of pressure ulcers is being implemented. Nurse will review skin integrity protocol and develop positioning schedule for client #4. Nurse will retrain all staff on protocol and schedule. Area Director will review monthly nursing notes to ensure that proper documentation regarding healing/non-healing of pressure ulcers is being implemented. Program Director will retrain all staff on abuse/neglect prevention. Client #4 wheelchair has been approved. Nurse will have weekly follow up with National Seating to ensure the process and delivery of wheelchair is completed. The developed position schedule will be in place to ensure that client does not slide forward in wheelchair until new chair arrives. Program Director and or Program Coordinator will complete at least</p>	05/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>(her) buttock just left of rectum. [RN #1] instructed [PC (Program Coordinator) #1] to contact (her) PCP (Primary Care Physician) on 1/5/16 for appointment or wound care instructions (sic). [RN #1] instructed [client #4] to be out of her wheelchair except for meals and transport. Impaired skin integrity protocol is in place, which includes repositioning every two hours. Area most likely caused by movement/friction in wheelchair. [PC #1] will follow up with PCP for instructions/wound care. Staff will follow RN instructions. [Company] will be contacted now that holidays are over with script for seating evaluation and any possible repairs/adaptation to present chair. Staff will continue to monitor [client #4's] health status and open area for additional concerns."</p> <p>Client #4's record was reviewed on 4/13/16 at 11:30 AM.</p> <p>Client #4's Nursing Progress Notes (NPNs) dated from 12/17/15 through 4/11/16 indicated the following:</p> <p>-1/6/16, "Spoke with day program PC (Program Coordinator), she reports that she worked at [client #4's] home last evening and the area on [client #4's] buttocks is getting progressively worse." The 1/6/16 NPN indicated client #4 was</p>		<p>4 weekly visits for 1 month, 1 weekly visit for 3 months and then ongoing visits at least monthly to ensure that positioning schedules are being implemented correctly.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>sent to a medical clinic and was diagnosed with a stage 2 pressure sore (open skin, ulcers, tenderness/pain).</p> <p>-1/11/16, "At home with [client #4], the original area is 10 (mm) millimeters by 11 mm. She also has a new scab between the first area and her rectum which is 10 mm by 3 mm."</p> <p>-1/19/16, "At home with [client #4] the original wound higher up her buttocks is 4 mm by 9 mm. The secondary area closer to her rectum is 44 mm by 9 mm. Both areas continue to be stage 2."</p> <p>-1/27/16, "At home with [client #4], the higher wound is 1 mm by 2 mm and scabbed. The secondary wound is 30 mm by 4 mm and remains open."</p> <p>-2/1/16, "At day program with [client #4], the scab has fallen off the smaller wound leaving a 1 mm by 2 mm ruffed area. The secondary wound is 23 mm by 4 mm."</p> <p>-2/3/16, "At day program with [client #4], there is a light pink area when (sic) smaller wound was located but skin has smoothed over area. The secondary wound is 28 mm by 8 mm."</p> <p>-2/8/16, "Wound is 29 mm by 8 mm."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>-2/19/16, "Scab has fallen off of the stage 2 area, it measures 22 mm by 4 mm. There continues to be a stage 1 (closed, discolored, tender) area surrounding the stage 2 of healing skin which measures from 4 mm to 6 mm in width."</p> <p>-2/25/16, "At home with [client #4], scab had fallen off of stage 2 area leaving a stage 1 area which is 19 mm by 7 mm."</p> <p>-3/3/16, "At day program with [client #4], she had a 5 mm by 6 mm stage 1 area remaining that is uncovered."</p> <p>-3/7/16, "At day program with [client #4], she has a 22 mm by 6 mm area of new light pink skin in the area where her pressures sores were."</p> <p>-3/14/16, "At home with [client #4], she has a 12 mm by 7 mm dark purple area at site of previous pressure sore. It is surrounded with light pink skin. Applied patch to area. Notified staff to keep patch on area and keep [client #4] off of area until healed."</p> <p>-3/15/16, "Phone call from [PC #1], she is working today. Purple area has opened up again. Keep patch on area and keep her off of the area."</p> <p>-3/17/16, "Covering (on call) LPN</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>(Licensed Practical Nurse) reports that there is a silver dollar sized blanchable area (area that does not lose color briefly when pressed and removed) with a 10 mm by 10 mm open area in the middle."</p> <p>-3/21/16, "At home with [client #4], she has a stage 1 pressure sore which is 22 mm by 11 mm at the same location on her left buttocks as the discolored area last week. There is a 15 mm line of scab at the base of the stage 1 area."</p> <p>-3/24/16, "At day program with [client #4], the scab line on her left buttocks is 5 mm. There is an area of new skin which is 20 mm by 20 mm."</p> <p>-4/11/16, "Pink area on buttocks is 50 mm by 35 mm."</p> <p>RN #1 was interviewed on 4/21/16 at 9:32 AM. RN #1 indicated client #4 had recurring pressure ulcers on her buttocks and coccyx area. RN #1 indicated client #4's pressure ulcers had healed and re-opened since she was admitted to the home December 2015.</p> <p>The review indicated client #4's pressure ulcer noted on 1/4/16 had continued through 2/25/16 with an additional stage 2 ulcer also opening and healing in the same time period. The review did not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
W 0157 Bldg. 00	<p>indicate documentation of the second ulcer being reported to BDDS. The review indicated client #4's skin was noted as being progressively discolored in the areas of her previous pressure ulcers and the area re-opened on 3/15/16. The review did not indicate documentation of the 3/15/16 pressure ulcers being reported to BDDS. The review indicated client #4's buttocks and coccyx area continued to be discolored/stage 1 through the 4/11/16 date of documentation.</p> <p>QIDP #1 was interviewed on 4/13/16 at 11:05 AM. QIDP #1 indicated all allegations of abuse, neglect and mistreatment should be reported to BDDS within 24 hours of the facility's knowledge of the alleged incident.</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 for 1 of 4 allegations of abuse, neglect or mistreatment reviewed, the facility failed to develop and implement effective corrective measures to prevent recurrence of pressure ulcers regarding client #4.</p>	W 0157	Area Director will retrain nurse on using accurate documentation regarding healing/non-healing of pressure ulcers. Area Director will review Nurses notes monthly to ensure proper documentation regarding healing/non-healing of	05/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 4/12/16 at 11:24 AM. The review indicated the following:</p> <p>-BDDS report dated 1/4/16 indicated, "[RN (Registered Nurse) #1] notified of (an) open area. [RN #1] stated [client #4] has a 1 inch by 1/3 inch open area on (her) buttock just left of rectum. [RN #1] instructed [PC (Program Coordinator) #1] to contact (her) PCP (Primary Care Physician) on 1/5/16 for appointment or wound care instructions (sic). [RN #1] instructed [client #4] to be out of her wheelchair except for meals and transport. Impaired skin integrity protocol is in place, which includes repositioning every two hours. Area most likely caused by movement/friction in wheelchair. [PC #1] will follow up with PCP for instructions/wound care. Staff will follow RN instructions. [Company] will be contacted now that holidays are over with script for seating evaluation and any possible repairs/adaptation to present chair. Staff will continue to monitor [client #4's] health status and open area for additional concerns."</p>		<p>pressure ulcers is beingimplemented. Nurse will review skinintegrity protocol and develop positioning schedule for client #4. Nursewill retrain all staff on protocol and schedule. Area Director will reviewmonthly nursing notes to ensure that proper documentation regarding healing/non-healingof pressure ulcers is being implemented.ProgramDirector will retrain all staff on abuse/neglect prevention. Client #4 wheelchair hasbeen approved. Nurse will have weekly follow up with National Seating toensure the process and delivery of wheelchair is completed. The developedposition schedule will be in place to ensure that client does not slide forwardin wheelchair until new chair arrives. Program Director and orProgram Coordinator will complete at least 4 weekly visits for 1 month, 1weekly visit for 3 months and then ongoing visits at least monthly to ensurethat positioning schedules are being implementedcorrectly.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>Client #4's record was reviewed on 4/13/16 at 11:30 AM.</p> <p>Client #4's ISP (Individual Support Plan) dated 1/17/16 indicated, "[Client #4] is diagnosed with Atypical Stereotypic Movement Disorder (repetitive, non-functional movement) and Severe Spastic Paraplegia (stiffness and contraction of limbs)." Client #4's ISP dated 1/17/16 indicated, "[Client #4] is non-weight bearing and non-ambulatory. She uses a wheelchair for mobility which is propelled by staff. She is a two persons lift or [brand] Lift to ensure minimal bruising and reduce potential for breaks. Staff complete cleaning of her wheelchair daily. She is scheduled to be seen by the OT (Occupational Therapist/Therapy) at [hospital] and [company] on 2/3/16 for a seating and mobility evaluation for a new wheelchair for improved cushioning and positioning. She tends to slide forward in her current chair regardless of the use of harness and seat belt with the slight movements that she does make. OT/PT (Physical Therapy) evaluation was held in 1/16 and recommendations were consistent with the above information." Client #4's ISP dated 1/17/16 indicated, "[Client #4] relies on staff to propel her wheelchair and to provide re-positioning while in her chair, as she has a tendency to slide forward in her current chair,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>which can constitute to skin integrity issues from friction and rubbing. A wedge under her bottom can be used currently to help keep her in position when upright."</p> <p>Client #4's Nursing Progress Notes (NPNs) dated from 12/17/15 through 4/11/16 indicated the following:</p> <p>-12/17/15, indicated client #4 was admitted to the group home from another agency operated location.</p> <p>-1/6/16, "Spoke with day program PC (Program Coordinator), she reports that she worked at [client #4's] home last evening and the area on [client #4's] buttocks is getting progressively worse." The 1/6/16 NPN indicated client #4 was sent to a medical clinic and was diagnosed with a stage 2 pressure sore (open skin, ulcers, tenderness/pain). The 1/6/16 NPN indicated RN #1 communicated with the home's PC to make arrangements for client #4 to be seen by a new PCP after moving to the new home. The 1/6/16 NPN indicated, "Discussed with [PC #1] report that the area is worse."</p> <p>-1/11/16, "At home with [client #4], the original area is 10 (mm) millimeters by 11 mm. She also has a new scab between</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>the first area and her rectum which is 10 mm by 3 mm." The 1/11/16 NPN indicated PC #1 and RN #1 communicated regarding ongoing issues with client #4's patches fitting and staying in position. The 1/11/16 NPN indicated RN #1 instructed staff on layering or manipulating the size of the patches to better fit client #4's wound.</p> <p>-1/19/16, "At home with [client #4] the original wound higher up her buttocks is 4 mm by 9 mm. The secondary area closer to her rectum is 44 mm by 9 mm. Both areas continue to be stage 2." The 1/19/16 NPN indicated RN #1 instructed staff regarding a new dressing and how to wash the wound area.</p> <p>-1/22/16, "At day program with [client #4] the higher up wound is 5 mm by 9 mm. The secondary wound is 40 mm by 9 mm."</p> <p>-1/25/16, "At home with [client #4], her higher wound is 1 mm by 2 mm and the secondary is 39 mm by 4 mm."</p> <p>-1/27/16, "At home with [client #4], the higher wound is 1 mm by 2 mm and scabbed. The secondary wound is 30 mm by 4 mm and remains open."</p> <p>-2/1/16, "At day program with [client #4],</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>the scab has fallen off the smaller wound leaving a 1 mm by 2 mm ruffed area. The secondary wound is 23 mm by 4 mm."</p> <p>-2/3/16, "At day program with [client #4], there is a light pink area when (sic) smaller wound was located but skin has smoothed over area. The secondary wound is 28 mm by 8 mm." The 2/3/16 NPN indicated RN #1 communicated with the day program PC and PC #1 regarding patches being sent from the home to the day program.</p> <p>-2/8/16, "Wound is 29 mm by 8 mm."</p> <p>-2/11/16, indicated communication between PC #1 and RN #1 regarding a PCP visit on 2/11/16. RN #1 instructed PC #1 to discuss client #4's larger wound with regard to the amount of time for the wound to heal. The 2/11/16 NPN indicated, "At day program with [client #4], wound is 26 mm by 7 mm."</p> <p>-2/16/16, "At day program with [client #4], her wound is 20 mm by 5 mm."</p> <p>-2/19/16, "Scab has fallen off of the stage 2 area, it measures 22 mm by 4 mm. There continues to be a stage 1 (closed, discolored, tender) area surrounding the stage 2 of healing skin which measures from 4 mm to 6 mm in width."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>-2/22/16, "At day program with [client #4], the stage 2 is now 11 mm by 2 mm."</p> <p>-2/25/16, "At home with [client #4], scab had fallen off of stage 2 area leaving a stage 1 area which is 19 mm by 7 mm."</p> <p>-3/3/16, "At day program with [client #4], she had a 5 mm by 6 mm stage 1 area remaining that is uncovered."</p> <p>-3/7/16, "At day program with [client #4], she has a 22 mm by 6 mm area of new light pink skin in the area where her pressures sores were."</p> <p>-3/14/16, "At home with [client #4], she has a 12 mm by 7 mm dark purple area at site of previous pressure sore. It is surrounded with light pink skin. Applied patch to area. Notified staff to keep patch on area and keep [client #4] off of area until healed."</p> <p>-3/15/16, "Phone call from [PC #1], she is working today. Purple area has opened up again. Keep patch on area and keep her off of the area. [PC #1] wants to make sure that day program PC is aware. Texted day program PC informing her. She will make sure [client #4] is kept off the area."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>-3/17/16, "Covering (on call) LPN (Licensed Practical Nurse) reports that there is a silver dollar sized blanchable area (area that does not lose color briefly when pressed and removed) with a 10 mm by 10 mm open area in the middle."</p> <p>-3/21/16, "At home with [client #4], she has a stage 1 pressure sore which is 22 mm by 11 mm at the same location on her left buttocks as the discolored area last week. There is a 15 mm line of scab at the base of the stage 1 area."</p> <p>-3/24/16, "At day program with [client #4], the scab line on her left buttocks is 5 mm. There is an area of new skin which is 20 mm by 20 mm."</p> <p>-3/30/16, "At day program with [client #4], she has a 70 mm by 30 mm light pink area on her left buttocks there is on 2 mm by 2 mm scab at the base of the pink area."</p> <p>-4/4/16, " At day program with [client #4], scab has fallen off of her left buttocks. The light pink area is 45 mm by 35 mm."</p> <p>-4/11/16, "Pink area on buttocks is 50 mm by 35 mm."</p> <p>Client #4's Impaired Skin Integrity</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>Protocol (ISIP) dated 12/3/15 indicated the following:</p> <p>-"[Client #4] has a history of stage 1 and 2 pressures (sic) sores on her buttocks and coccyx (tailbone)."</p> <p>-"Signs and symptoms: Discoloration-red, pink, purple, black or white. Open wound with or without drainage."</p> <p>-"[Client #4's] buttocks will often become red. She may develop areas that are open or peeling."</p> <p>-"Keep off of area until normal color returns."</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 4/21/16 at 9:18 AM. QIDP #1 indicated there were no IDT (Interdisciplinary Team) meetings specifically regarding client #4's pressure ulcers.</p> <p>RN #1 was interviewed on 4/21/16 at 9:32 AM. RN #1 indicated client #4 had recurring pressure ulcers on her buttocks and coccyx area. RN #1 indicated client #4's pressure ulcers had healed and re-opened since she was admitted to the home December 2015. When asked if facility staff had been implementing her nursing measures to reposition client #4</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>to prevent recurrence of the pressure ulcers, RN #1 stated, "I think they are. The wheelchair has a lot to do with it. She slides in it. We try to keep her out of it as much as possible. They keep her out of it, it heals up, then she's back in the wheelchair and it re-opens. I think they are doing it appropriately, until she gets a new wheelchair she's going to continue to have issues. There's no pommel (upward curved post positioned between the legs to prevent sliding out)." RN #1 indicated client #4 had been evaluated for a new wheelchair and the agency was in the process of obtaining the new chair for client #4. RN #1 indicated she had communicated the coordination and monitoring of client #4's wound care with the home's PC.</p> <p>The review indicated client #4's pressure ulcer noted on 1/4/16 had continued through 2/25/16 with an additional stage 2 ulcer also opening and healing in the same time period. The review indicated client #4's skin was noted as being progressively discolored in the areas of her previous pressure ulcers and the area re-opened on 3/15/16. The review indicated client #4's buttocks and coccyx area continued to be discolored/stage 1 through the 4/11/16 date of documentation. The review indicated the facility had a wheelchair and OT</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
W 0159 Bldg. 00	<p>evaluation on 2/3/16. Through the time of review 4/21/16 client #4 did not have a new wheelchair to address her skin integrity issues. The review indicated the facility failed to develop and implement effective corrective measures to prevent additional occurrences of pressure ulcers.</p> <p>QIDP #1 was interviewed on 4/13/16 at 11:05 AM. QIDP #1 indicated corrective measures should be developed and implemented to prevent recurrence of abuse, neglect or mistreatment.</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. Based on observation, record review and interview for 2 of 2 sampled clients (#1 and #2), plus 1 additional client (#4), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, monitor and coordinate client #1's active treatment program by failing to ensure client #1 had opportunities for meaningful activity, social interaction and intellectual stimulation. The QIDP failed to integrate, monitor and coordinate clients #2's active treatment</p>	W 0159	<p>Area Director will retrain Program Director (QIDP) and Program Coordinator on ensure that all <b>reportable incidents are filed timely. Area Director will meet weekly with Program Director</b> to review that all reportable incidents have been reported timely according to State policy. Area Director will retrain nurse on using accurate documentation regarding healing/non-healing of pressure ulcers. Area Director will review Nurses notes monthly to ensure proper documentation</p>	05/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>programs by failing to ensure clients #2's formal training objectives were monitored for progression and regression of skills.</p> <p>The QIDP failed to integrate, coordinate and monitor client #4's active treatment program by failing to ensure client #4 was taught to manage her own financial affairs, to coordinate client #4's IDT (Interdisciplinary Team) and monitor client #4's skin integrity needs to aggressively develop and implement effective corrective measures to prevent recurrence of pressure ulcers, to ensure client #4's ISP (Individual Support Plan) included formal training objectives to increase client #4's independence regarding her identified needs, to ensure client #4 had a medication administration goal and to ensure client #4 had a wheelchair that prevented her from sliding forward.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 4/12/16 from 4:15 PM through 6:00 PM. Clients #1, #2, #3 and #4 were observed in the home throughout the observation period. Client #1 utilized verbal communication to express his wants and needs. Clients #2, #3 and #4 was non-verbal in that their</p>		<p>regarding healing/non-healing of pressure ulcers is being implemented. Nurse will review skin integrity protocol and develop positioning schedule for client #4. Nurse will retrain all staff on protocol and schedule. Area Director will review monthly nursing notes to ensure that proper documentation regarding healing/non-healing of pressure ulcers is being implemented. Program Director (QIDP) will retrain all staff on abuse/neglect prevention. Client #4 wheelchair has been approved. Nurse will have weekly follow up with National Seating to ensure the process and delivery of wheelchair is completed. The developed position schedule will be in place to ensure that client does not slide forward in wheelchair until new chair arrives. Goals and active treatment plans for clients 1, 2 and 4 were in place at the time of survey review. Program Director will retrain all staff on implementing goals. Area Director will review Program Directors (QIDP) monthly reviews to ensure that goals are being implemented correctly for all clients and monitored for progression and regression of skills. Program Director (QIDP) and or Program Coordinator will complete at least 4 weekly visits for 1 month, 1 weekly visit for 3 months and then ongoing visits at least monthly to ensure that goals</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>communication of their wants and needs was made through physical gestures (pointing, touching, reaching) and inarticulate vocalizations (grunts, crying, noises). Client #1 interacted with staff throughout the observation period and expressed his preferences and choices regarding his activities and snack items. At 5:05 PM, client #1 was seated in his manual wheelchair in the home's living room area watching television. Client #1 was watching a political news show on the television. Staff #1 assisted client #2 to transfer from her manual wheelchair to a couch located in the home's living room where client #1 was watching the news program. Client #2 began crying and making inarticulate sounds. Staff #1 changed the home's television channel to cartoons for client #2 to watch. Staff #1 indicated watching/listening to cartoons on the television helped client #2 relax when she was upset. Staff #1 told client #1 he would watch his news shows later in the evening. Client #1 remained in the home's living room while client #2 watched/listened to the cartoons through 5:50 PM, when he was prompted to the home's kitchen area for the evening meal. Staff #1 placed servings of rice, beans and ground beef and cooked carrots on a plate and served the meal to client #1. Client #1 was not encouraged to participate in the home's meal preparation</p>		<p>and active treatment schedules are being implemented correctly. Area Director will review all observations of active treatment schedule to ensure it is being implemented and followed by staff and that QIDP is addressing issues appropriately.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>or serve himself portions of his meal.</p> <p>Observations were conducted at the group home on 4/13/16 from 6:30 AM through 7:45 AM. At 6:30 AM, client #1 was prompted to come to the home's kitchen area. Staff #3 served client #1 a bowl of oatmeal and coffee. Client #1 did not assist in making his oatmeal or coffee. At 7:08 AM, client #1 finished eating his oatmeal, took his bowl to the sink and returned to the living room to watch television. At 7:30 AM, client #1 received his morning medications in the home's medication administration room and then returned to the living room to watch television.</p> <p>Client #1 was interviewed on 4/12/16 at 5:22 PM. Client #1 indicated he had moved to the group home on 4/1/16. Client #1 indicated he liked to watch political news shows and followed the 2016 Presidential Debates. Client #1 indicated he had a favorite presidential candidate and expressed his dislike of other candidates. Client #1 was cognizant of the names of the candidates. Client #1 indicated he was his own guardian, had worked in the community at a restaurant and had been working on obtaining his GED (General Education Diploma) prior to a decline in his health which resulted in his admission to a nursing home prior</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>to his admission to the group home.</p> <p>Staff #1 was interviewed on 4/12/16 at 5:10 PM. Staff #1 indicated client #1 utilized verbal communication to express his wants and needs. Staff #1 indicated clients #2, #3 and #4 did not use verbal communication to express their wants and needs. Staff #1 stated, "I don't think [client #1] has an [intellectual disability]. He's really just here because of his health issues and mobility. He's the only verbal one in the house. [Clients #2, #3 and #4] are lower functioning, in the profound to severe range."</p> <p>Staff #2 was interviewed on 4/13/16 at 7:26 AM. Staff #2 stated, "[Client #1] is higher functioning than the others. He doesn't really interact with the others. Though, he does seem to enjoy being in the home."</p> <p>Client #1's record was reviewed on 4/13/16 at 8:49 AM. Client #1's IDE (Interdisciplinary Diagnostic and Evaluation) form dated 2/12/15 indicated client #1 had lived in a supported living agency with in-home supports. Client #1's IDE dated 2/12/15 indicated client #1 had been hospitalized due to recurrent bowel obstructions and had declined in his mobility and independence with daily living skills. Client #1's IDE dated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>2/12/15 indicated, "[Client #1] should benefit from activities that would allow him meaningful socialization and intellectual stimulation. He should be encouraged to continue to pursue his GED."</p> <p>Client #1's preliminary ISP (Individual Support Plan) dated 4/1/16 indicated the following;</p> <p>-"[Client #1] has the diagnosis of depression, anxiety, intermittent explosive disorder and schizophrenia. There is little information provided that give detailed accounts of how each diagnosis is displayed. [Client #1] uses full conversational speech and is generally easy to understand. He seems to communicate well his wants, needs and desires and starts conversations with others without prompting."</p> <p>-"[Client #1] will be engaged in a variety of activities that are meaningful to him."</p> <p>-"[Client #1] is transferring from [nursing home] on 4/1/16 to the medically fragile group home."</p> <p>-"[Client #1] was once able to transfer himself and once was more ambulatory than his present status. His history includes being able to prepare simple</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>meals and use the microwave."</p> <p>Client #1's record indicated he was admitted to the home on 4/1/16. Client #1's ISP dated 4/1/16 was preliminary and formal goals were being developed. Client #1's record indicated he should be offered meaningful activity, opportunities for social interaction and intellectual stimulation.</p> <p>QIDP #1 was interviewed on 4/13/16 at 11:05 AM. QIDP #1 indicated client #1 had moved into the home on 4/1/16. QIDP #1 indicated client #1's ISP was still being developed and the IDT (Interdisciplinary Team) was meeting on 4/13/16 to discuss client #1's active treatment program. QIDP #1 indicated client #1 should be offered meaningful activity, opportunities for social interaction and intellectual stimulation. QIDP #1 indicated she had not completed routine day service observations regarding client #1's active treatment program.</p> <p>2. Client #2's record was reviewed on 4/13/16 at 9:37 AM.</p> <p>Client #2's Quarterly Program Review form dated 11/10/15 indicated client #2 had goals for bathing, medication administration, meal time participation,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>oral hygiene, money management and community integration during the months of August, September and October 2015.</p> <p>Client #2's group home QIDP Monthly Summary form dated October 2015 indicated QIDP #1 had reviewed client #2's formal training objectives for progression/regression of skills. Client #2's October 2015 QIDP Monthly Summary Form indicated client #2's goals included medication administration training, meal time training, oral hygiene training, money management training, community integration, communication training and bathing training.</p> <p>Client #2's record did not indicate documentation of QIDP review of client #2's group home formal training objectives since October 2015.</p> <p>3. The QIDP failed to integrate, coordinate and monitor client #4's active treatment program by failing to ensure client #4 was taught to manage her own financial affairs. Please see W126.</p> <p>4. The QIDP failed to integrate, coordinate and monitor client #4's active treatment program by failing to coordinate client #4's IDT (Interdisciplinary Team) and monitor client #4's skin integrity needs to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
W 0227 Bldg. 00	<p>aggressively develop and implement effective corrective measures to prevent recurrence of pressure ulcers. Please see W157.</p> <p>5. The QIDP failed to integrate, coordinate and monitor client #4's active treatment program by failing to ensure client #4's ISP (Individual Support Plan) included formal training objectives to increase client #4's independence regarding her identified needs. Please see W227.</p> <p>6. The QIDP failed to integrate, coordinate and monitor client #4's active treatment program by failing to ensure client #4 had a medication administration goal. Please see W371.</p> <p>7. The QIDP failed to integrate, coordinate and monitor client #4's active treatment program by failing to ensure client #4 had a wheelchair that prevented her from sliding forward. Please see W436.</p> <p>9-3-3(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on record review and interview for 1 additional client (#4), the facility failed to ensure client #4's ISP (Individual Support Plan) included formal training objectives to increase client #4's independence regarding her identified needs.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 4/13/16 at 11:20 AM. Client #4's ISP dated 1/17/16 indicated, "[Client #4] is dependent on staff to meet all her personal needs. She currently participates in ADL (Activities of Daily Living) skill development training, which includes the areas of communication, community integration... teeth brushing, bathing, dressing and mealtime skills." Client #4's ISP dated 1/17/16 did not indicate documentation of formal training objectives regarding client #4's ADL skill development, communication, community integration, tooth brushing, bathing, dressing or mealtime skills.</p> <p>Client #4's day services QIDP Monthly Summary form dated December 2015 indicated client #4 was admitted to the group home on 12/17/15. Client #4's day</p>	W 0227	<p>Goalsfor client #4 to manage her own financial affairs, medication administration aswell other formal training objectives to increase her independence regardingher identified needs were in place at the time of survey review.</p> <p>ProgramDirector will retrain all staff on implementing goals. Area Directorwill review Program Directors monthly reviews to ensure that goals are beingimplemented correctly for all cilents.</p> <p>Program Director and orProgram Coordinator will complete at least 4 weekly visits for 1 month, 1weekly visit for 3 months and then ongoing visits at least monthly to ensurethat goals are being implemented correctly.</p>	05/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>services QIDP Monthly Summary form dated December 2015 indicated, "Goals will be developed."</p> <p>Client #4's day services QIDP Monthly Summary form dated January 2016 indicated client #4 had the following formal training objectives:</p> <p>-"[Client #4] will participate in an activity with her peers. [Client #4] will tolerate hand over hand assistance to participate in an activity with her peers."</p> <p>Client #4's group home QIDP Monthly Summary form dated December 2015 indicated, "Goals will be developed."</p> <p>Client #4's record did not indicate documentation of formal training objectives regarding ADL skill development, communication, community integration, tooth brushing, bathing, dressing or mealtime skills.</p> <p>QIDP #1 was interviewed on 4/21/16 at 9:18 AM. QIDP #1 indicated the QIDP monthly summary forms were completed for the day services and the home on separate forms. When asked if she could provide documentation of formal training objectives for client #4, QIDP #1 indicated in the affirmative and she would email a copy of client #4's formal</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
W 0371 Bldg. 00	<p>training objectives.</p> <p>QIDP #1 sent an email on 4/21/16 at 10:19 AM. QIDP #1 had attached client #4's December group home QIDP Monthly Goal summary to the email. Client #4's group home QIDP Monthly Goal Summary dated December 2015 indicated, "Goals to be developed." QIDP #1 did not provide documentation of the development of formal goals for client #4.</p> <p>9-3-4(a)</p> <p>483.460(k)(4) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. Based on record review and interview for 1 additional client (#4), the facility failed to ensure client #4 had a medication administration goal.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 4/13/16 at 11:20 AM. Client #4's ISP (Individual Support Plan) dated 1/17/16 indicated, "[Client #4] is dependent on staff to meet all her personal needs. She</p>	W 0371	Goals for client #4 for medication administration as well other formal training objectives to increase her independence regarding her identified needs were in place at the time of survey review. Program Director will retrain all staff on implementing goals. Area Director will review Program Directors monthly reviews to ensure that goals are being implemented correctly for all clients. Area Director will retrain Program Director on developing	05/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>currently participates in ADL (Activities of Daily Living) skill development training, which includes the areas of ... medication administration..." Client #4's ISP dated 1/17/16 did not indicate documentation of formal training objectives regarding client #4's medication administration training. Client #4's ISP dated 1/17/16 indicated client #4's medication daily doses included but were not limited to Phenobarbital (seizures), Colace (constipation), Miralax (constipation), Zantac (GERD-gastroesophageal reflux disease), Oyster Shell Calcium (osteoporosis), Potassium (hypokalemia) and Remeron (insomnia).</p> <p>Client #4's day services QIDP Monthly Summary form dated December 2015 indicated client #4 was admitted to the group home on 12/17/15. Client #4's day services QIDP Monthly Summary form dated December 2015 indicated, "Goals will be developed."</p> <p>Client #4's record did not indicate documentation of formal training objectives regarding medication administration skills.</p> <p>QIDP #1 was interviewed on 4/21/16 at 9:18 AM. When asked if she could provide documentation of formal training</p>		<p>and implementing activetreatment programs for all clients. Program Director and or Program Coordinator willcomplete at least 4 weekly visits for 1 month, 1 weekly visit for 3 months andthen ongoing visits at least monthly to ensure that goals are being implementedcorrectly.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
W 0436 Bldg. 00	<p>objectives for client #4, QIDP #1 indicated in the affirmative and she would email a copy of client #4's formal training objectives.</p> <p>QIDP #1 sent an email on 4/21/16 at 10:19 AM. QIDP #1 attached a copy of client #4's group home QIDP Monthly Summary form dated December 2015. Client #4's group home QIDP Monthly Summary form dated December 2015 indicated, "Goals will be developed."</p> <p>QIDP #1 did not provide documentation of the development of a formal medication administration goal for client #4.</p> <p>9-3-6(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. Based on record review and interview for 1 of 4 clients who utilized adaptive equipment, the facility failed to ensure</p>	W 0436	Client #4 wheelchair has been approved. Nurse will have weekly follow up with National Seating to ensure the process and	05/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>client #4 had a wheelchair that prevented her from sliding forward.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 4/12/16 at 2:34 PM. The review indicated the following:</p> <p>-BDDS report dated 1/4/16 indicated, "[RN (Registered Nurse) #1] notified of (an) open area. [RN #1] stated [client #4] has a 1 inch by 1/3 inch open area on (her) buttock just left of rectum. [RN #1] instructed [PC (Program Coordinator) #1] to contact (her) PCP (Primary Care Physician) on 1/5/16 for appointment or wound care instructions (sic). [RN #1] instructed [client #4] to be out of her wheelchair except for meals and transport. Impaired skin integrity protocol is in place, which includes repositioning every two hours. Area most likely caused by movement/friction in wheelchair. [PC #1] will follow up with PCP for instructions/wound care. Staff will follow RN instructions. [Company] will be contacted now that holidays are over with script for seating evaluation and any possible repairs/adaptation to present chair. Staff will continue to monitor [client #4's] health status and open area</p>		<p>delivery of wheelchair is completed. The developed position schedule will be in place to ensure that client does not slide forward in wheelchair until new chair arrives. Staff complete checks on all adaptive equipment daily to ensure they are in proper working condition. When something is not working it is reported to the QIDP and they work on replacing item or repairing as needed. For wheelchairs we follow all necessary medicaid/medicare guidelines to get clients properly fitted and a new chair ordered or repairs to old chair made. No other clients were affected by this deficient practice. Nurse will submit weekly email to Area Director regarding status and delivery date for wheelchair.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>for additional concerns."</p> <p>Client #4's record was reviewed on 4/13/16 at 11:30 AM.</p> <p>Client #4's ISP (Individual Support Plan) dated 1/17/16 indicated, "[Client #4] is diagnosed with Atypical Stereotypic Movement Disorder (repetitive, non-functional movement) and Severe Spastic Paraplegia (stiffness and contraction of limbs)." Client #4's ISP dated 1/17/16 indicated, "[Client #4] is non-weight bearing and non-ambulatory. She uses a wheelchair for mobility which is propelled by staff. She is a two persons lift or [brand] Lift to ensure minimal bruising and reduce potential for breaks. Staff complete cleaning of her wheelchair daily. She is scheduled to be seen by the OT (Occupational Therapist/Therapy) at [hospital] and [company] on 2/3/16 for a seating and mobility evaluation for a new wheelchair for improved cushioning and positioning. She tends to slide forward in her current chair regardless of the use of harness and seat belt with the slight movements that she does make. OT/PT (Physical Therapy) evaluation was held in 1/16 and recommendations were consistent with the above information." Client #4's ISP dated 1/17/16 indicated, "[Client #4] relies on staff to propel her wheelchair and to provide re-positioning</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>while in her chair, as she has a tendency to slide forward in her current chair, which can constitute to skin integrity issues from friction and rubbing. A wedge under her bottom can be used currently to help keep her in position when upright."</p> <p>RN #1 was interviewed on 4/21/16 at 9:32 AM. RN #1 indicated client #4 had recurring pressure ulcers on her buttocks and coccyx area. RN #1 indicated client #4's pressure ulcers had healed and re-opened since she was admitted to the home December 2015. When asked if facility staff had been implementing her nursing measures to reposition client #4 to prevent recurrence of the pressure ulcers, RN #1 stated, "I think they are. The wheelchair has a lot to do with it. She slides in it. We try to keep her out of it as much as possible. They keep her out of it, it heals up, then she's back in the wheelchair and it re-opens. I think they are doing it appropriately, until she gets a new wheelchair she's going to continue to have issues. There's no pommel (upward curved post positioned between the legs to prevent sliding out)." RN #1 indicated client #4 had been evaluated for a new wheelchair and the agency was in the process of obtaining the new chair for client #4.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
W 9999 Bldg. 00	<p>The review indicated the facility had a wheelchair and OT evaluation on 2/3/16. Through the time of review 4/21/16 client #4 did not have a new wheelchair to address her skin integrity issues.</p> <p>9-3-7(a)</p> <p>STATE FINDINGS:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>(1) 460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin (TB) test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic</p>	W 9999	<p>Area Director will send out list of staff that are due to TB test or chest x-ray to Program Director every 2 weeks. Program Director will ensure that staff get updated TB test prior to theirs expiring. Any staff with expired TB test will be removed from the schedule until a TB test can be completed. Area Director will review staff compliance list every 2 weeks to ensure that no staff are working who have expired TB test.</p>	05/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
---	--

(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
	<p>treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview for 1 of 3 employee files reviewed, the facility failed to ensure written documentation of an annual PPD, x-ray or symptom checklist was completed for staff #1.</p> <p>Findings include:</p> <p>Staff #1's employee file was reviewed on 4/12/16 at 3:38 PM. Staff #1's TB testing form was dated 2/23/15. The review did not indicate documentation of annual PPD, x-ray or symptom checklist since 2/23/15.</p> <p>Office Coordinator #1 was interviewed on 4/12/16 at 3:40 PM. Office Coordinator #1 indicated there was not additional documentation regarding an annual PPD, x-ray or symptom checklist for staff #1.</p> <p>9-3-3(e)</p>			