

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G466	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1926 W 75TH PL INDIANAPOLIS, IN 46260
-----------------------------------------------------	-----------------------------------------------------------------------------------

(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 a PCR (Post Certification Revisit) to a PCR to the investigation of complaint #IN00176248 completed on 7/1/15 which resulted in an Immediate Jeopardy.</p> <p>This visit was done in conjunction with a PCR to the investigation of complaint #IN00179045 completed on 8/28/15.</p> <p>This visit was done in conjunction with a pre-determined full annual recertification and state licensure survey.</p> <p>This visit was done in conjunction with a PCR to a PCR to the investigation of complaint #IN00171443 completed on 6/4/15.</p> <p>Complaint #IN00176248: Not Corrected.</p> <p>Dates of Survey: 9/22/15, 9/23/15, 9/24/15, 9/29/15 and 10/1/15</p> <p>Facility Number: 000980 Provider Number: 15G466 AIMS Number: 100244620</p> <p>This deficiency also reflects a state finding in accordance with 460 IAC 9. Quality Review of this report completed</p>	W 0000		
------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------	--	--

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: 15G466	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1926 W 75TH PL INDIANAPOLIS, IN 46260
-----------------------------------------------------	-----------------------------------------------------------------------------------

(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 0104 Bldg. 00	<p>by #15068 on 10/6/15.</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 1 of 3 sampled clients (A), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure client A received recommended speech therapy.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 9/23/15 at 9:15 AM. Client A's Appointment List form dated 1/1/15 through 9/21/15 indicated client A was referred to speech therapy by her primary care physician on 4/9/15. The undated Appointment List form indicated client A had a speech therapy evaluation on 4/17/15 with recommendations for 8 weeks of therapy, one time a week for 45 minutes.</p> <p>Client A's Appointment List form dated 1/1/15 through 9/21/15 did not indicate additional documentation of client A receiving speech therapy services after the 4/17/15 recommendation.</p>	W 0104	<p>Program nurse will obtain a referral and schedule an appointment for Client A for speech therapy evaluation as recommended by her Primary Care Physician on 4/9/15.</p> <p>Program Nurse will receive retraining to include ensuring that all recommendations for follow up from any medical appointments are reviewed, scheduled and/or completed as needed as soon as possible after the medical appointment. Training will also include ensuring that if there are issues with a recommended appointment not being able to be scheduled due to Medicaid/Medicare approval then the Program Nurse will consult with the Area Director to determine if there are other means by which the appointment can be paid for so that the recommended appointment can be completed in a timely manner.</p> <p>Ongoing, the Program Nurse will review all consumers' medical appointment forms within 48</p>	10/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G466	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2015
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1926 W 75TH PL INDIANAPOLIS, IN 46260		
(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 A's Medical Appointment form dated 4/17/15 indicated, "Speech and language were evaluated. [Client A] presented with articulation disorder and expressive and receptive language disorder. Recommend speech therapy for an 8 week trial, one time a week for 45 minutes."</p> <p>Client A's Monthly Health Review narrative note dated 6/4/15 indicated, "Speech therapy for 8 weeks per primary care physician referral and subsequent evaluation. [Speech Therapist] performed speech therapy evaluation on 4/17/15, determined diagnosis: articulation, expressive and receptive language disorders. Recommend speech therapy for 8 weeks/time/week (sic). Awaiting Medicaid approval for services at this time."</p> <p>Client A's Quarterly Nursing Assessment form narrative note dated 7/3/15 indicated, "Still awaiting Medicaid approval for speech therapy for 8 weeks."</p> <p>Client A's record did not indicate documentation of speech therapy services after the 4/17/15 recommendation.</p> <p>QIDP (Qualified Intellectual Disability Professional) #1 was interviewed on</p>		<p>hours of the appointment to determine if any follow up treatment is needed. If any follow up is needed the Program nurse will work with the Program Coordinator and/or QIDP to ensure that appointments are scheduled, medications are ordered, etc.</p> <p>Responsible Party: Program Nurse, Program Coordinator, QIDP</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G466	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2015
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1926 W 75TH PL INDIANAPOLIS, IN 46260		
(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>9/23/15 at 12:32 PM. QIDP #1 indicated client A had not received additional speech therapy services since the 4/27/15 recommendations. QIDP #1 indicated the facility was awaiting Medicaid funding/approval to begin services.</p> <p>This deficiency was cited on 7/1/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>				