

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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
--------------------	--	---------------	---	----------------------

W000000	<p>This visit was for the investigation of Complaint #IN00156183.</p> <p>This visit was completed in conjunction with the post certification revisit survey (PCR) to the recertification and state licensure survey completed on 8/21/14.</p> <p>Complaint #IN00156183: Substantiated, Federal/state deficiencies related to the allegations are cited at W104, W159, W248, W249, and W268.</p> <p>Dates of Survey: 9/22, 9/23, 9/29, 10/2, and 10/6/2014.</p> <p>Facility number: 001020 Provider number: 15G506 AIM number: 100244980</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/15/14 by Ruth Shackelford, QIDP.</p>	W000000		
---------	--	---------	--	--

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:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview, and record review, for 3 of 4 sampled clients (D, E, and F) and for 1 additional client (client B), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility addressed the urine odor in client B's bedroom. The governing body failed to provide oversight to ensure access to each client's record by the outside day service, and failed to ensure the QIDP (Qualified Intellectual Disabilities Professional) ensured the implementation and monitoring of Individual Support Plans (ISPs) to ensure dignity and personal appearance. The governing body failed for 2 of 4 sampled clients (clients E and F) to ensure their dignity in regards to their clothing and personal appearance before attending the outside day service.</p> <p>Findings include:</p> <p>1. During the 9/22/14 observation period from 3:25pm until 6:00pm, observation and interviews were conducted at the group home. From 3:25pm until 5:15pm,</p>	W000104	<p>1. The Home Manager and Program Director will work with staff to deep clean Client B room in an attempt to remove the urine smell. The Home Manager will work with staff to ensure that the bed and floor in Client B room are cleaned a minimum of daily to ensure the odor of urine is minimized.</p> <p>Ongoing, the Program Director and/or Home Manager will complete walkthroughs of the home a minimum of twice weekly to evaluate the cleanliness of the home and address issues with staff as needed to ensure the house is maintained in a clean and odor-free order.</p> <p>Staff will receive retraining to ensure that they are assisting Client B in doing her laundry as soon as possible after it becomes wet to ensure the odor of urine is minimized.</p> <p>2. Please refer to W159</p>	11/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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>GHS (Group Home Staff) #1 stated client B's bedroom "had a light smell of urine" upon entering the group home. At 4:45pm, GHS #1 indicated client B's soiled clothing was kept in a hamper for storage inside the bedroom. At 5:15pm, client B entered the group home from the facility van. At 5:15pm, GHS #2 entered the group home pushing client B's wheel chair into the home and stated client B "smelled of urine."</p> <p>Client B's record was reviewed on 9/23/14 at 1:15pm. Client B's 5/5/14 ISP (Individual Support Plan) indicated client B's diagnoses included, but were not limited to, Frequent Bladder Infections, Urinary Incontinence, Overactive Bladder and Spastic Bladder. Client B's 12/7/13 Risk Management Assessment and Plan indicated client B was "Incontinent with refusals to change Attends (adult briefs)." Client B's May 2014 Behavioral Support Plan (BSP) indicated client B demonstrated "Incontinence-Urinating and/or defecating in a location other than the interior of a toilet." Client B's BSP indicated facility staff were to prompt the client to toilet every 2 hours when client B was awake. The BSP indicated "...If [client B] is incontinent, [client B] must be held responsible for cleaning herself and any other area that may have been wet or soiled. Staff are to provide [client</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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>B] with physical prompting and direction as needed to assure she remains on task throughout the period...1. When you discover that [client B] has been incontinent, immediately direct her to go to the restroom and clean herself up...2. Direct [client B] to return to the place where she became incontinent and assure that she cleans any urine or feces from the area...."</p> <p>On 9/22/14 at 4:45pm, an interview with GHS #1 was conducted and GHS #1 indicated client B's bedroom smelled of urine. GHS #1 indicated facility staff used sprays/deodorizers, wiped off client B's mattress each morning, and would change the linens on client B's bed. GHS #1 indicated client B urinated on herself at workshop during the day and was responsible to clean up herself at the workshop.</p> <p>On 9/22/14 at 5:00pm, an interview with QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client B would urinate on herself at the group home and at the workshop. The QIDP indicated the group home was not able to get the smell out of the client's bedroom. The QIDP indicated he thought the urine may be in the floor of the client's room. The QIDP indicated client B had an objective to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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
W000159	<p>clean her wheelchair. The QIDP indicated client B sat in the urine and did not clean herself properly or clean her wheelchair thoroughly at the workshop during the day and smelled of urine when client B returned home daily.</p> <p>2. Please refer to W159. The governing body failed to provide oversight to ensure the QIDP implemented active treatment plans, failed to ensure access to each client record by the outside day service, and failed to ensure implementation and monitoring of Individual Support Plans (ISPs) to ensure dignity and personal appearance.</p> <p>This federal tag relates to complaint #IN00156183.</p> <p>9-3-1(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</p>	W000159	1. All consumers Individual	11/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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>interview, for 3 of 4 sampled clients (clients D, E, and F) and 1 additional client (client B), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate, and monitor clients B, D, E, F's active treatment plans, failed to ensure access to each client record by the outside day service, and failed to ensure implementation and monitoring of Individual Support Plans (ISPs) to ensure dignity and personal appearance.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Please refer to W248. The QIDP failed to ensure the outside day services had access to clients D, E, and F's ISPs (Individual Support Plans).</li> <li>2. Please refer to W249. The QIDP failed to ensure the facility implemented ISP (Individual Support Plan) goals/objectives when opportunities existed during formal and informal opportunities for clients E and F.</li> <li>3. Please refer to W268. The QIDP failed to ensure the facility protected clients' dignity in regards to client B's incontinence issues and clients E and F's dignity in regards to their clothing and personal appearance.</li> </ol> <p>This federal tag relates to complaint</p>		<p>Support plans have been forwarded to all consumers respective Day Service Providers.</p> <p>Home Manager and Program Director will receive retraining to include ensuring all Day Service Providers are provided with a copy of consumers Individual support Plans a minimum of annually at the yearly review and more often as needed if any addendums are made.</p> <p>Ongoing the Program Director and/or Home Manager will ensure that Day services Providers are receiving consumers ISPs a minimum of annually or more often as needed if addendums are completed.</p> <p>2. A replacement seizure helmet has been obtained for Client F.</p> <p>All Direct Care staff, Home manager and Program Director will receive retraining on client dignity including ensuring that all consumers have clothing that fit, are well shaven and groomed and hair and nails are trimmed.</p> <p>Home manager and Program Director will complete observations in the home a minimum of 3 times per week for the first 4 weeks to ensure that all clients dignity is maintained by ensuring they are wearing</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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
	#IN00156183.  9-3-3(a)		<p>clothing that fits, are well shaven and groomed. After the first4 weeks and ongoing Home manager and Program Director will complete observations in the home a minimum of 2 times per week to ensure that all clients dignity is maintained by ensuring they are wearing clothing that fits, are well shaven and groomed, etc. If consumers need to purchase clothing that fits, Home Manager and Program Director will assist clients with doing so.</p> <p>3. A replacement seizure helmet has been obtained for Client F.</p> <p>All Direct Care staff, Home manager and Program Director will receive retraining on client dignity including ensuring that all consumers have clothing that fit, are well shaven and groomed and hair and nails are trimmed.</p> <p>Home manager and Program Director will complete observations in the home a minimum of 3 times per week for the first 4 weeks to ensure that all clients dignity is maintained by ensuring they are wearing clothing that fits, are well shaven and groomed. After the first4 weeks and ongoing Home manager and Program Director will complete observations in the home a minimum of 2 times per week to ensure that all clients dignity is maintained by ensuring</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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
W000248	483.440(c)(7)		<p>they are wearing clothing that fits, are well shaven and groomed, etc. If consumers need to purchase clothing that fits, Home Manager and Program Director will assist clients with doing so.</p> <p>The Home Manager and Program Director will work with staff to deep clean Client #2 room in an attempt to remove the urine smell. The Home Manager will work with staff to ensure that the bed and floor in Client #2 room are cleaned a minimum of daily to ensure the odor of urine is minimized.</p> <p>Ongoing, the Program Director and/or Home Manager will complete walkthroughs of the home a minimum of weekly to evaluate the cleanliness of the home and address issues with staff as needed to ensure the house is maintained in a clean and odor-free order.</p> <p>Staff will receive retraining to ensure that they are assisting Client #2 in doing her laundry as soon as possible after it becomes wet to ensure the odor of urine is minimized.</p> <p>Responsible Party: Home Manager, Program Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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><b>INDIVIDUAL PROGRAM PLAN</b></p> <p>A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on observation, record review, and interview, for 3 of 3 sampled clients (clients D, E, and F) who attended outside day service site #1, the facility failed to ensure the outside day services had access to clients D, E, and F's ISPs (Individual Support Plans).</p> <p>Findings include:</p> <p>On 9/22/14 from 11:55am until 1:55pm, clients D, E, and F were observed at the outside day services. At 12:16pm, Workshop Supervisor (WKS) stated the outside day services "did not have copies of [client D, E, or F's] ISP (Individual Support Plan) and BSP (Behavior Support Plan)" available for staff to review and/or implement during formal and informal opportunities. The WKS indicated the outside day services created their own goals and objectives for clients D, E, and F. The WKS stated the outside day services had requested client D, E, and F's ISPs and BSPs "for months" with no plans provided by the facility.</p> <p>On 9/22/14 at 12:16pm, client D, E, and F's outside day service records were</p>	W000248	<p>All consumers Individual Support plans have been forwarded to all consumers respective Day Service Providers.</p> <p>Home Manager and Program Director will receive retraining to include ensuring all Day Service Providers are provided with a copy of consumers Individual support Plans a minimum of annually at the yearly review and more often as needed if any addendums are made.</p> <p>Ongoing the Program Director and/or Home Manager will ensure that Day services Providers are receiving consumers ISPs a minimum of annually or more often as needed if addendums are completed.</p> <p>Responsible Party: Home Manager, Program Director</p>	11/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2014	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220			
(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			
W000249	<p>reviewed and indicated the following: -For client D: A 3/25/2011 ISP. -For client E: A 7/29/2011 ISP. -For client F: A 3/30/2011 ISP.</p> <p>On 9/23/14 at 1:10pm, an interview was conducted with the Residential Manager (RM) and the Area Director (AD). Both staff indicated they were unaware the outside day services did not have current copies of client D, E, or F's ISPs and BSPs.</p> <p>This federal tag relates to complaint #IN00156183.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients E and F), the facility failed to implement ISP (Individual Support Plan) goals/objectives when opportunities existed during formal and informal</p>	W000249	<p>1, 2 A replacement seizure helmet has been obtained for Client F.</p> <p>All Direct Care staff, Home manager and Program Director</p>	11/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2014
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220		
(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>opportunities.</p> <p>Findings include:</p> <p>1. On 9/22/14 at 5:15pm, client E arrived at the group home. Client E had on a tee shirt which hung off her shoulders to expose her bra straps, elastic waisted blue jeans she continuously pulled up, her pant legs had four inch splits up each leg of the jeans, and the jean legs hung over her shoes. Client E walked on the hems of her blue jeans. Client E had three nicks (shaving cuts) on her face. From 5:15pm until 6:00pm, client E wore the same clothing.</p> <p>Client E's record was reviewed on 9/23/14 at 12:00pm. Client E's 8/30/14 and 7/15/14 physician's orders indicated client E's diagnosis included, but was not limited to, Urinary Incontinence. Client E's 3/25/14 ISP (Individual Support Plan) indicated a goal to gather items for shaving, to select and wear clothing daily with staff assistance, and indicated client E "required" staff assistance with her personal hygiene.</p> <p>Interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 9/22/14 at 5:00pm. Both staff indicated client E should wear</p>		<p>will receive retraining on client dignity including ensuring that all consumers have clothing that fit, are well shaven and groomed and hair and nails are trimmed.</p> <p>Home manager and Program Director will complete observations in the home a minimum of 3 times per week for the first 4 weeks to ensure that all clients dignity is maintained by ensuring they are wearing clothing that fits, are well shaven and groomed. After the first 4 weeks and ongoing Home manager and Program Director will complete observations in the home a minimum of 2 times per week to ensure that all clients dignity is maintained by ensuring they are wearing clothing that fits, are well shaven and groomed, etc. If consumers need to purchase clothing that fits, Home Manager and Program Director will assist clients with doing so.</p> <p>Responsible Party: Home Manager, Program Director</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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>clothing which fit her. The RM indicated client E had a full dark black beard two weeks ago and staff should assist client E with shaving her face. The RM indicated the facility did not protect client E's dignity when her clothing did not fit her and when her hygiene was not completed and supervised by the facility staff.</p> <p>Confidential Interview (CI) #1 was conducted. CI #1 stated client E's personal hygiene was "usually not completed" and client E's clothing was "oversized."</p> <p>2. On 9/22/14 at 5:15pm, client F arrived at the group home. Client F wore a seizure helmet which was torn in multiple places, had pieces of the helmet held together with duct tape, the strap of the helmet did not secure it to his head, the helmet moved when he walked or turned his head, and the helmet was discolored. During both observation periods client F was unshaven, had whiskers all over his face, wore oversized tee shirt and pants. From 5:15pm until 6:00pm, client F had whiskers and wore the same clothing.</p> <p>Client F's record was reviewed on 9/23/14 at 11:00am. Client F's 8/30/14 physician's orders indicated client F's diagnoses included, but were not limited</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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, Seizures and Blindness Left Eye. Client F's 3/30/14 ISP (Individual Support Plan) indicated he was at risk for falls due to unsteady walking and seizures. Client F's ISP indicated he "required" staff assistance for his daily personal hygiene for dressing and shaving. Client F's record indicated on 10/30/13 "a helmet replacement" was requested by the neurologist and no record was available for review of the receipt of a new helmet.</p> <p>Interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 9/22/14 at 5:00pm. Both staff indicated client F should wear clothing which fit him and client F should be shaved daily supervised by the group home staff. The RM indicated client F had whiskers two weeks ago and staff should assist client F with shaving his face. The RM indicated the facility did not protect client F's dignity when his clothing did not fit him and when his hygiene was not completed and supervised by the facility staff. The QIDP and the RM indicated client F needed a replacement seizure helmet.</p> <p>This federal tag relates to complaint #IN00156183.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2014	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220			
(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			
W000268	<p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, interview, and record review, for 2 of 4 sampled clients (clients E and F) and for 1 additional client (client B), the facility failed to ensure the clients' dignity in regards to client B's incontinence issues and clients E and F's dignity in regards to their clothing and personal appearance.</p> <p>Findings include:</p> <p>1. On 9/22/14 from 11:55am until 1:55pm, client E was observed at the outside day service and on 9/22/14 from 5:15pm until 6:00pm, client E was observed and interviewed at the group home. During both observation periods client E wore a tee shirt which hung off her shoulders to expose her bra straps, elastic waisted blue jeans she continuously pulled up, her pant legs had four inch splits up each leg of the jeans, and the jean legs hung over her shoes. Client E walked on the hems of her blue jeans. Client E had three nicks (shaving</p>	W000268	<p>1, 2 A replacement seizure helmet has been obtained for Client F.</p> <p>All Direct Care staff, Home manager and Program Director will receive retraining on client dignity including ensuring that all consumers have clothing that fit, are well shaven and groomed and hair and nails are trimmed.</p> <p>Home manager and Program Director will complete observations in the home a minimum of 3 times per week for the first 4 weeks to ensure that all clients dignity is maintained by ensuring they are wearing clothing that fits, are well shaven and groomed. After the first 4 weeks and ongoing Home manager and Program Director will complete observations in the home a minimum of 2 times per week to ensure that all clients dignity is maintained by ensuring they are wearing clothing that fits, are well shaven and groomed, etc. If consumers need to</p>	11/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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>cuts) on her face. At 12:45pm, Workshop Staff (WKS) #1 stated client E "usually" had a "full beard" of dark black unshaven whiskers on her face. WKS #1 stated client E "often and usually" comes into work with "oversized" clothing. WKS #1 indicated the workshop had notified the group home when client E's hygiene needed attention and stated "in addition, we send an email every month."</p> <p>On 9/22/14 at 5:15pm, client E arrived at the group home. Client E had on a tee shirt which hung off her shoulders to expose her bra straps, elastic waisted blue jeans she continuously pulled up, her pant legs had four inch splits up each leg of the jeans, and the jean legs hung over her shoes. Client E walked on the hems of her blue jeans. Client E had three nicks (shaving cuts) on her face. From 5:15pm until 6:00pm, client E wore the same clothing.</p> <p>Client E's record was reviewed on 9/23/14 at 12:00pm. Client E's 8/30/14 and 7/15/14 physician's orders indicated client E's diagnoses included, but were not limited to, Urinary Incontinence. Client E's 3/25/14 ISP (Individual Support Plan) indicated a goal to gather items for shaving, to select and wear clothing daily with staff assistance, and indicated client E "required" staff</p>		<p>purchase clothing that fits, Home Manager and Program Director will assist clients with doing so.</p> <p>3 The Home Manager and Program Director will work with staff to deep clean Client #2 room in an attempt to remove the urine smell. The Home Manager will work with staff to ensure that the bed and floor in Client #2 room are cleaned a minimum of daily to ensure the odor of urine is minimized.</p> <p>Ongoing, the Program Director and/or Home Manager will complete walkthroughs of the home a minimum of weekly to evaluate the cleanliness of the home and address issues with staff as needed to ensure the house is maintained in a clean and odor-free order.</p> <p>Staff will receive retraining to ensure that they are assisting Client #2 in doing her laundry as soon as possible after it becomes wet to ensure the odor of urine is minimized.</p> <p>Responsible Party: Home Manager, Program Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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>assistance for her personal hygiene.</p> <p>Interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 9/22/14 at 5:00pm, both indicated client E wear clothing which fit her. The RM indicated client E had a full dark black beard two weeks ago and staff should assist client E with shaving her face. The RM indicated the facility did not protect client E's dignity when her clothing did not fit her and when her hygiene was not completed and supervised by the facility staff.</p> <p>Confidential Interview (CI) #1 was conducted. CI #1 stated client E's personal hygiene was "usually not completed" and client E's clothing was "oversized."</p> <p>2. On 9/22/14 from 11:55am until 1:55pm, client F was observed at the outside day service and on 9/22/14 from 5:15pm until 6:00pm, client F was observed and interviewed at the group home. During both observation periods client F wore a seizure helmet which was torn in multiple places, had pieces of the helmet held together with duct tape, the strap of the helmet did not secure it to his head, the helmet moved when he walked or turned his head, and the helmet was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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>discolored. During both observation periods client F was unshaven, had whiskers all over his face, wore oversized tee shirt and pants, and at 12:45pm, WKS #1 stated the pants and shirt "looked stained." Client F's pants were dragging on the floor when he walked and WKS #1 stated client F was a "fall risk." At 12:45pm, WKS #1 stated client E "often and usually" comes into work with "oversized" clothing. WKS #1 indicated the workshop had notified the group home when client F's hygiene needed attention and stated "in addition, we send an email every month."</p> <p>On 9/22/14 at 5:15pm, client F arrived at the group home. Client F wore a seizure helmet which was torn in multiple places, had pieces of the helmet held together with duct tape, the strap of the helmet did not secure it to his head, the helmet moved when he walked or turned his head, and the helmet was discolored. During both observation periods client F was unshaven, had whiskers all over his face, wore oversized tee shirt and pants. From 5:15pm until 6:00pm, client F had whiskers and wore the same clothing.</p> <p>Client F's record was reviewed on 9/23/14 at 11:00am. Client F's 8/30/14 physician's orders indicated client F's diagnoses included, but were not limited</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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, Seizures and Blindness Left Eye. Client F's 3/30/14 ISP (Individual Support Plan) indicated he was at risk for falls due to unsteady walking and seizures. Client F's ISP indicated he "required" staff assistance for his daily personal hygiene for dressing and shaving. Client F's record indicated on 10/30/13 "a helmet replacement" was requested by the neurologist and no record was available for review of the receipt of a new helmet.</p> <p>Interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) on 9/22/14 at 5:00pm. Both indicated client F should wear clothing which fit him and client F should be shaved daily supervised by the group home staff. The RM indicated client F had whiskers two weeks ago and staff should assist client F with shaving his face. The RM indicated the facility did not protect client F's dignity when his clothing did not fit him and when his hygiene was not completed and supervised by the facility staff. The QIDP and the RM indicated client F needed a replacement seizure helmet.</p> <p>3. During the 9/22/14 from 3:25pm until 6:00pm, observation and interviews were conducted at the group home. From</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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>3:25pm until 5:15pm, GHS (Group Home Staff) #1 stated client B's bedroom "had a light smell of urine" upon entering the group home. At 4:45pm, GHS #1 indicated client B's soiled clothing was kept in a hamper for storage inside the bedroom. At 5:15pm, client B entered the group home from the facility van. At 5:15pm, GHS #2 entered the group home pushing client B's wheel chair into the home and stated client B "smelled of urine."</p> <p>Client B's record was reviewed on 9/23/14 at 1:15pm. Client B's 5/5/14 ISP (Individual Support Plan) indicated client B's diagnoses included, but were not limited to, Frequent Bladder Infections, Urinary Incontinence, Overactive Bladder and Spastic Bladder. Client B's 12/7/13 Risk Management Assessment and Plan indicated client B was "Incontinent with refusals to change Attends (adult briefs)." Client B's May 2014 Behavioral Support Plan (BSP) indicated client B demonstrated "Incontinence-Urinating and/or defecating in a location other than the interior of a toilet." Client B's BSP indicated facility staff were to prompt the client to toilet every 2 hours when client B was awake. The BSP indicated "...If [client B] is incontinent, [client B] must be held responsible for cleaning herself and any other area that may have been</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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>wet or soiled. Staff are to provide [client B] with physical prompting and direction as needed to assure she remains on task throughout the period...1. When you discover that [client B] has been incontinent, immediately direct her to go to the restroom and clean herself up...2. Direct [client B] to return to the place where she became incontinent and assure that she cleans any urine or feces from the area...."</p> <p>On 9/22/14 at 4:45pm, an interview with GHS #1 was conducted and GHS #1 indicated client B's bedroom smelled of urine. GHS #1 indicated facility staff used sprays/deodorizers, wiped off client B's mattress each morning, and would change the linens on client B's bed. GHS #1 indicated client B urinated on herself at workshop during the day and was responsible to clean up herself at the workshop.</p> <p>On 9/22/14 at 5:00pm, an interview with QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client B would urinate on herself at the group home and at the workshop. The QIDP indicated the group home was not able to get the smell out of the client's bedroom. The QIDP indicated he thought the urine may be in the floor of the client's room. The QIDP</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2014
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220		
(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>indicated client B had an objective to clean her wheelchair. The QIDP indicated client B sat in the urine and did not clean herself properly or clean her wheelchair thoroughly at the workshop during the day and smelled of urine when client B returned home daily.</p> <p>This federal tag relates to complaint #IN00156183.</p> <p>9-3-5(a)</p>				