

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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 full annual recertification and state licensure survey. This visit included the investigation of complaint #IN00185100.</p> <p>Complaint #IN00185100: Substantiated, a federal and state deficiency related to the allegation(s) is cited at W149.</p> <p>Dates of Survey: 11/16/15, 11/17/15, 11/18/15, 11/24/15 and 11/25/15.</p> <p>Facility Number: 000957 Provider Number: 15G443 AIMS Number: 100244630</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/4/15.</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review and</p>	W 0102	Please also see W104 The Program Coordinator and	12/25/2015

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: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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, the facility failed to meet the Condition of Participation: Governing Body for 3 of 4 sampled clients (A, C and D), plus 2 additional clients (H and G). The governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients C and D's personal finances/resources were not in excess of the predetermined maximum amount allowed by Medicaid.</p> <p>The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent staff neglect of client A and failed to prevent an incident of peer to peer abuse resulting in injury to client A, to ensure client G was assessed for behavioral needs prior to re-admission to the group home and to ensure client A's ISP (Individual Support Plan)/BSP (Behavior Support Plan) addressed client A's smoking cigarettes while wearing his portable oxygen tank. The governing body failed to ensure client H's ISP/BSP addressed how and when staff should monitor client H for pica/eating cigarette butts from the ground, to ensure client G's BSP (Behavior Support Plan) specified when staff should utilize outside emergency services/police to assist with the</p>		<p>Program Director will be retrained on the \$1500.00 Medicaid capon all client bank accounts. Client C will complete a guardian approved spend down to ensure that he does not exceed the \$1500 limit. Client D will complete a guardian approved spend down to ensure that he does not exceed the \$1500 limit. Ongoing, the Client Financial Specialist will review all monthly finances and report to the Area Director who is over the \$1500 limit. All staff, including the Program Coordinator and Program Director will be retrained on Indiana MENTOR's policy on preventing abuse and neglect. Staff #1 from incident on 10/19/2015 refused to participate in the investigation and willingly terminated her employment because of it. All remaining staff will be retrained on each client's supervision needs and Indiana MENTOR's policy regarding the Direct Support Professional's job description regarding preventing abuse and neglect. Client D was transferred to another group home, and Indiana MENTOR will continue to follow up and monitor his court proceedings. The Program Director will complete 3 weekly Active Treatment Observations to ensure that Direct Support Staff are following all behavior support plans and to ensure that all clients are participating in meaningful day activities to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>management of client G's behaviors, to ensure the facility nursing services ensured client H's BM (Bowel Movement) tracking was completed and to ensure the facility did not place client G in a home with housemates who were of significantly different behavioral needs.</p> <p>Findings include:</p> <p>The governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients C and D's personal finances/resources were not in excess of the predetermined maximum amount allowed by Medicaid.</p> <p>The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent staff neglect of client A and failed to prevent an incident of peer to peer abuse resulting in injury to client A, to ensure client G was assessed for behavioral needs prior to re-admission to the group home and to ensure client A's ISP (Individual Support Plan)/BSP (Behavior Support Plan) addressed client A's smoking cigarettes while wearing his portable oxygen tank. The governing body failed to ensure</p>		<p>attempt to reduce the instances of potential client to client abuse. Ongoing all Direct Support Staff will continue to implement Indiana MENTOR's policy and procedure to ensure that neglect and abuse is prevented. IDT on 11/2/2015 discussed Client G's possible application for CIH waiver due to ongoing health and safety needs not being able to be met by this group home. Client G waived in his decision, so the IDT discussed guardianship needs not being met. Program Director/QIDP initiated the process of seeking emergency guardianship from The Center for At Risk Elders. Client G was reassessed on 12/15/15 by his IDT. No immediate changes were made to his Individualized Support Plan, but he was able to get an emergency appointment with the psych doctor scheduled for 12/23/2015, where the QIDP will discuss the need for the doctor's referral of guardianship needs, and a medication change. Area Director received an email of notification from BDDS on 12/18/2015 stating that Client G had been approved for the CIH waiver based on his needs not being met at this particular group home. Client G has been referred over for case management services. Indiana MENTOR will continue to monitor Client G's health and safety, and will continue to work closely with BDDS on the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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 H's ISP/BSP addressed how and when staff should monitor client H for pica/eating cigarette butts from the ground, to ensure client G's BSP (Behavior Support Plan) specified when staff should utilize outside emergency services/police to assist with the management of client G's behaviors, to ensure the facility nursing services ensured client H's BM (Bowel Movement) tracking was completed and to ensure the facility did not place client G in a home with housemates who were of significantly different behavioral needs. Please see W104.</p> <p>9-3-1(a)</p>		<p>impending transfer to the CIH waiver. Client A had an IDT completed on 12/2/2015 to discuss the inappropriate smoking situation. The IDT discussed his ISP and BSP and added in the smoking protocol for Client A. All staff were retrained on this new smoking protocol. The Program Coordinator put visual prompts/clues near the group home front and back exit doors to assist with prompting Client A in removing his oxygen when going outside for an approved cigarette. Client A and the staff were retrained on these plan changes, the smoking protocol, and the visual prompts that have been placed in the group home. The Program Director will complete 3 weekly Active Treatment Observations to ensure that Direct Support Staff are following all behavior support plans and to ensure that all clients are participating in meaningful day activities and following all appropriate client specific protocols. The Program Director will put in place a procedure for staff and client's to appropriately get rid of the cigarette butts. The Program Director along with Client H's IDT will create a procedure for staff to follow when Client H is on the porch potentially seeking inedible items to consume. The Program Coordinator will retrain the direct support staff on assessing the front and back</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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
			yards for dropped cigarette butts on the ground which are at risk of being picked up and consumed by client H. The Program Coordinator and Program Director will put a cleaning schedule in place to ensure that staff are cleaning up the yard, with the assistance of the clients who smoke. The Program Director will complete 3 weekly Active Treatment Observations to ensure that Direct Support Staff are following all behavior support plans and to ensure that all clients are participating in meaningful day activities and following all appropriate client specific protocols. The Program Director will meet with the IDT for Client G to discuss a protocol being in place for emergency situations and when staff should call the police for assistance. Once the updates are in place, the Program Director/QIDP will seek guardian and/or HRC approval for these changes. Once the BSP/protocol is updated and appropriate approvals are in place, all DSPs will be retrained on this update. The Program Director will complete 3 weekly Active Treatment Observations to ensure that Direct Support Staff are following all behavior support plans and to ensure that all clients are participating in meaningful day activities and following all appropriate client	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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
			specific protocols. Ongoing, the Direct Support Staff and Program Coordinator will ensure that all clientspecific protocols are utilized appropriately. The DirectSupport Staff will be retrained on Client H's requirement for the BowelMovement Tracking due to his constipation diagnosis and protocol that are inplace. The Direct Supportstaff will be retrained on Indiana MENTOR's procedure for all requireddocumentation. The ProgramNurse and Program Coordinator will be retrained on checking all requiredmedical documentation and tracking. This retraining will include what to do toaddress the absence of the required documentation. The ProgramNurse will get in touch with the Pharmacy to address the missing recommendationfor bowel movement tracking from the Primary Care Physician on the Physicians'orders. The Program Nurse will complete 3 weekly Medication AdministrationObservations to ensure that Direct Support Staff are following all appropriateclient specific medical protocols. The Program Nurse will complete 3 weekly medical documentation reviewsto ensure that the appropriate staff are completing all required medicaldocumentation. Failure for the staff to complete the required documentation willresult	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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	483.410(a)(1)		in further corrective action following Indiana MENTOR's policy. IDT on 11/2/2015 discussed Client G's possible application for CIH waiver due to ongoing health and safety needs not being able to be met by this group home. Client G waived in his decision, so the IDT discussed guardianship needs not being met. Program Director/QIDP initiated the process of seeking emergency guardianship from The Center for At Risk Elders. Client G was reassessed on 12/15/15 by his IDT. No immediate changes were made to his Individualized Support Plan, but he was able to get an emergency appointment with the psych doctor scheduled for 12/23/2015, where the QIDP will discuss the need for the doctor's referral of guardianship needs, and a medication change. Area Director received an email of notification from BDDS on 12/18/2015 stating that Client G had been approved for the CIH waiver based on his needs not being met at this particular group home. Client G has been referred over for case management services. Indiana MENTOR will continue to monitor Client G's health and safety, and will continue to work closely with BDDS on the impending transfer to the CIH waiver.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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
Bldg. 00	<p>GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 3 of 4 sampled clients (A, C and D), plus 2 additional clients (H and G), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients C and D's personal finances/resources were not in excess of the predetermined maximum amount allowed by Medicaid.</p> <p>The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent staff neglect of client A and failed to prevent an incident of peer to peer abuse resulting in injury to client A, to ensure client G was assessed for behavioral needs prior to re-admission to the group home and to ensure client A's ISP (Individual Support Plan)/BSP (Behavior Support Plan) addressed client A's smoking cigarettes while wearing his portable oxygen tank.</p> <p>The governing body failed to ensure client H's ISP/BSP addressed how and when staff should monitor client H for pica/eating cigarette butts from the ground, to ensure client G's BSP (Behavior Support Plan) specified when</p>	W 0104	<p>The ProgramCoordinator and Program Director will be retrained on the \$1500.00 Medicaid capon all client bank accounts.</p> <ol style="list-style-type: none"> 1. Client C will complete a guardian approved spend down to ensure thathe does not exceed the \$1500 limit. 2. Client D will complete a guardian approved spend down to ensure thathe does not exceed the \$1500 limit. <p>Ongoing,the Client Financial Specialist will review all monthly finances and report tothe Area Director who is over the \$1500 limit.</p> <ol style="list-style-type: none"> 3. Please see W149. <ol style="list-style-type: none"> a. All staff, including the Program Coordinatorand Program Director will be retrained on Indiana MENTOR's policy on preventingabuse and neglect. b. Staff #1 from incident on 10/19/2015 refusedto participate in the investigation and willingly terminated her employmentbecause of it. c. All remaining staff will be retrained on eachclient's 	12/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>staff should utilize outside emergency services/police to assist with the management of client G's behaviors, to ensure the facility nursing services ensured client H's BM (Bowel Movement) tracking was completed and to ensure the facility did not place client G in a home with housemates who were of significantly different behavioral needs.</p> <p>Findings include:</p> <p>1. Client C's financial record was reviewed on 11/18/15 at 2:20 PM. Client C's facility based cluster account ledger report dated 8/1/15 through 10/31/15 indicated the following:</p> <p>-8/1/15, Beginning balance was \$8,082.42</p> <p>-9/1/15, Beginning balance was \$7,920.28</p> <p>-10/1/15, Beginning balance was \$8,150.00</p> <p>-10/31/15, Ending balance was \$8,896.00.</p> <p>2. Client D's financial record was reviewed on 11/18/15 at 2:25 PM. Client D's facility based cluster account ledger</p>		<p>supervision needs and Indiana MENTOR's policy regarding the DirectSupport Professional's job description regarding preventing abuse and neglect.</p> <p>d. Client D was transferred to another grouphome, and Indiana MENTOR will continue to follow up and monitor his courtproceedings.</p> <p>e. The Program Director will complete 3 weeklyActive Treatment Observations to ensure that Direct Support Staff are followingall behavior support plans and to ensure that all clients are participating inmeaning day activities to attempt to reduce the instances of potential clientto client abuse.</p> <p>f. Ongoing all Direct Support Staff will continueto implement Indiana MENTOR's policy and procedure to ensure that neglect andabuse is prevented.</p> <p>4. Please see W200</p> <p>a. IDT on 11/2/2015 discussed Client G's possibleapplication for CIH waiver due to ongoing health and safety needs not beingable to be met by this group home. Client G waived in his decision, so theIDT discussed guardianship needs not being met. Program Director/QIDP initiatedthe</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>report dated 8/1/15 through 10/31/15 indicated the following:</p> <p>-8/1/15, Beginning balance was \$9,074.71</p> <p>-9/1/15, Beginning balance was \$8,394.71</p> <p>-10/1/15, Beginning balance was \$8,414.71</p> <p>-10/31/15, Ending balance was \$7,815.19.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 11/18/15 at 3:00 PM. QIDP #1 indicated clients C and D's resources exceeded the \$2,000.00 Medicaid maximum limit.</p> <p>3. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent staff neglect of client A and failed to prevent an incident of peer to peer abuse resulting in injury to client A. Please see W149.</p> <p>4. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure client G was assessed for behavioral needs prior</p>		<p>process of seeking emergency guardianship from The Center for At RiskElders.</p> <p>b. Client G was reassessed on 12/15/15 by his IDT.No immediate changes were made to his Individualized Support Plan, but he wasable to get an emergency appointment with the psych doctor scheduled for12/23/2015, where the QIDP will discuss the need for the doctor's referral ofguardianship needs, and a medication change.</p> <p>c. Area Director received an email ofnotification from BDDS on 12/18/2015 stating that Client G had been approvedfor the CIH waiver based on his needs not being met at this particular grouphome. Client G has been referred over for case management services.</p> <p>d. Indiana MENTOR will continue to monitor ClientG's health and safety, and will continue to work closely with BDDS on theimpending transfer to the CIH waiver.</p> <p>5. Please see W227</p> <p>a. Client A had an IDT completed on 12/2/2015 todiscuss the inappropriate smoking situation. The IDT discussed his ISP and BSPand</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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 re-admission to the group home. Please see W200.</p> <p>5. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure client A's ISP/BSP addressed client A's smoking cigarettes while wearing his portable oxygen tank. The governing body failed to ensure client H's ISP/BSP addressed how and when staff should monitor client H for pica/eating cigarette butts from the ground. Please see W227.</p> <p>6. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure client G's BSP specified when staff should utilize outside emergency services/police to assist with the management of client G's behaviors. Please see W289.</p> <p>7. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility nursing services ensured client H's BM tracking was completed. Please see W331.</p> <p>8. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility did not place client G in a home with housemates who were of</p>		<p>added in the smoking protocol for Client A.</p> <p>b. All staff were retrained on this new smoking protocol.</p> <p>c. The Program Coordinator put visual prompts/clues near the group home front and back exit doors to assist with prompting Client A in removing his oxygen when going outside for an approved cigarette.</p> <p>d. Client A and the staff were retrained on these plan changes, the smoking protocol, and the visual prompts that have been placed in the group home.</p> <p>e. The Program Director will complete 3 weekly Active Treatment Observations to ensure that Direct Support Staff are following all behavior support plans and to ensure that all clients are participating in meaningful day activities and following all appropriate client specific protocols.</p> <p>f. The Program Director will put in place a procedure for staff and client's to appropriately get rid of the cigarette butts.</p> <p>g. The Program Director along with Client H's IDT will create a procedure for staff to follow when Client H is on the porch potentially seeking inedible</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>significantly different behavioral needs. Please see W407.</p> <p>9-3-1(a)</p>		<p>items to consume.</p> <p>h. The Program Coordinator will retrain the direct support staff on assessing the front and back yards for dropped cigarette butts on the ground which are at risk of being picked up and consumed by client H. The Program Coordinator and Program Director will put a cleaning schedule in place to ensure that staff are cleaning up the yard, with the assistance of the clients who smoke.</p> <p>i. The Program Director will complete 3 weekly Active Treatment Observations to ensure that Direct Support Staff are following all behavior support plans and to ensure that all clients are participating in meaningful day activities and following all appropriate client specific protocols.</p> <p>6. Please see W289</p> <p>a. The Program Director will meet with the IDT for Client G to discuss a protocol being in place for emergency situations and when staff should call the police for assistance.</p> <p>b. Once the updates are in place, the Program Director/QIDP will seek guardian and/or HRC approval for these changes.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>c. Once the BSP/protocol is updated and appropriate approvals are in place, all DSPs will be retrained on this update.</p> <p>d. The Program Director will complete 3 weekly Active Treatment Observations to ensure that Direct Support Staff are following all behavior support plans and to ensure that all clients are participating in meaningful day activities and following all appropriate client specific protocols.</p> <p>7. Please see W331</p> <p>a. The Direct Support Staff will be retrained on Client H's requirement for the Bowel Movement Tracking due to his constipation diagnosis and protocol that are in place.</p> <p>b. The Direct Support staff will be retrained on Indiana MENTOR's procedure for all required documentation.</p> <p>c. The Program Nurse and Program Coordinator will be retrained on checking all required medical documentation and tracking. This retraining will include what to do to address the absence of the required documentation.</p> <p>d. The Program Nurse will get</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>in touch with the Pharmacy to address the missing recommendation for bowel movement tracking from the Primary Care Physician on the Physicians' orders.</p> <p>e. The Program Nurse will complete 3 weekly Medication Administration Observations to ensure that Direct Support Staff are following all appropriate client specific medical protocols.</p> <p>f. The Program Nurse will complete 3 weekly medical documentation reviews to ensure that the appropriate staff are completing all required medical documentation.</p> <p>g. Failure for the staff to complete the required documentation will result in further corrective action following Indiana MENTOR's policy.</p> <p>8. Please see W407</p> <p>a. IDT on 11/2/2015 discussed Client G's possible application for CIH waiver due to ongoing health and safety needs not being able to be met by this group home. Client G waived in his decision, so the IDT discussed guardianship needs not being met. Program Director/QIDP initiated the process of seeking emergency</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/25/2015
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226		
(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	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 4 sampled clients (A), the facility	W 0149	guardianship from The Center for At RiskElders. b. Client G was reassessed on 12/15/15 by his IDT.No immediate changes were made to his Individualized Support Plan, but he wasable to get an emergency appointment with the psych doctor scheduled for12/23/2015, where the QIDP will discuss the need for the doctor's referral ofguardianship needs, and a medication change. c. Area Director received an email ofnotification from BDDS on 12/18/2015 stating that Client G had been approvedfor the CIH waiver based on his needs not being met at this particular grouphome. Client G has been referred over for case management services. d. Indiana MENTOR will continue to monitor ClientG's health and safety, and will continue to work closely with BDDS on theimpending transfer to the CIH waiver. a. All staff, including the Program Coordinatorand	12/25/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>failed to implement its written policy and procedures to prevent staff neglect of client A and failed to prevent an incident of peer to peer abuse resulting in injury to client A.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/17/15 at 10:25 AM. The review indicated the following:</p> <p>1. BDDS report dated 10/19/15 indicated, "On 10/19/15 [client A] told his IDT (Interdisciplinary Team) that he woke up in the middle of the night and seen (sic) overnight staff, [staff #1], sleeping. [Client A] eloped and went to the gas station down the street from the group home to get some soda and cigarettes. [Client A] returned back to the group home without any adverse effects."</p> <p>-Investigation summary dated 10/26/15 indicated the facility substantiated staff #1 was sleeping during the overnight shift while client A eloped from the group home.</p> <p>2. BDDS report dated 6/18/15 indicated, "[Client D] and housemates were on the van run back to the group home after</p>		<p>Program Director will be retrained on Indiana MENTOR's policy on preventing abuse and neglect.</p> <p>b. Staff #1 from incident on 10/19/2015 refused to participate in the investigation and willingly terminated her employment because of it.</p> <p>c. All remaining staff will be retrained on each client's supervision needs and Indiana MENTOR's policy regarding the Direct Support Professional's job description regarding preventing abuse and neglect.</p> <p>d. Client D was transferred to another group home, and Indiana MENTOR will continue to follow up and monitor his court proceedings.</p> <p>e. The Program Director will complete 3 weekly Active Treatment Observations to ensure that Direct Support Staff are following all behavior support plans and to ensure that all clients are participating in meaningful day activities to attempt to reduce the instances of potential client to client abuse.</p> <p>f. Ongoing all Direct Support Staff will continue to implement Indiana MENTOR's policy and procedure to ensure that neglect</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/25/2015
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226		
(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>playing a game of basketball. [Client D] was upset at the results of the game and became verbally aggressive towards housemate, [client A]. [Staff #2] redirected [client D] to calm down but [client D] continued to escalate. [Staff #2] pulled the van over because [client D] would not follow redirection to calm down. Before staff could get between [client D] and [client A], punches were exchanged. Staff separated the two and [client A] sustained some scratches and bruising around his eyes. [Client A] refused to go to the hospital for evaluation and staff notified the program nurse. [Nurse #1] came by to check on [client A] and no further treatment was recommended."</p> <p>-BDDS report dated 6/19/15 indicated, "As a result from a peer to peer aggression on 6/16/15 between housemates, [client D] and [client A], [client A] had bruising around his eyes. On 6/18/15 at around 6:30 PM, [client A] decided to call the police because he had visible bruising and [client D] did not. The police came to the group home, decided to detain [client D] and take him to [hospital] for evaluation. On 6/19/15 at 5:20 PM [QIDP (Qualified Intellectual Disabilities Professional) #1] received a phone call from the [hospital] stating [client D] will be transferred to [county</p>		andabuse is prevented.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>jail] for battery."</p> <p>-Investigation summary form dated 6/23/15 substantiated client D hit client A and caused visible injury to client A. The 6/23/15 Investigation summary indicated client D was charged with battery with injury and was released from jail on 6/22/15 with court scheduled for 6/25/15.</p> <p>AD (Area Director) #1 was interviewed on 11/17/15 at 10:22 AM. AD #1 indicated the facility's abuse and neglect policy should be implemented. AD #1 indicated abuse and neglect should be prevented.</p> <p>The facility's policies and procedures were reviewed on 11/25/15 at 9:16 AM. The 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, evaluating and reducing risk to which individuals are exposed."</p> <p>- "a. Physical Abuse, including but not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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 0200 Bldg. 00	<p>limited to; (i.) Intentionally touching another person in a rude, insolent, or angry manner; (ii.) willful infliction of injury."</p> <p>-"e. Failure to provide appropriate supervision, care or training."</p> <p>This federal tag relates to compliant #IN00185100.</p> <p>9-3-2(a)</p> <p>483.440(b)(3) ADMISSIONS, TRANSFERS, DISCHARGE A preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.</p> <p>Based on record review and interview for 1 additional client (G), the facility failed to ensure client G was assessed for behavioral needs prior to re-admission to the group home.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/17/15 at 10:25 AM. The review</p>	W 0200	<p>a. IDT on 11/2/2015 discussed Client G's possible application for CIH waiver due to ongoing health and safety needs not being able to be met by this group home. Client G waived in his decision, so the IDT discussed guardianship needs not being met. Program Director/QIDP initiated the process of seeking emergency guardianship from The Center for At Risk Elders.</p> <p>b. Client G was reassessed on</p>	12/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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 the following:</p> <p>-BDDS report dated 6/22/15 indicated, "On Sunday, June 21, 2015 the [HM (Home Manager) #1] contacted the on-call program director at 12:21 PM and informed (them) that [client G] had eloped from the group home. The [HM #1] stated he was looking for [client G] at that time. The on-call program director informed the group home staff to call 911 which they did. At 1:07 PM, the [HM #1] informed the on-call program director that he found [client G] at the [gas station] on [intersection]. The on-call program director, whom arrived to the site at 1:10 PM then called 911 at 1:11 PM and reported [client G] had been found; the police stated they would cancel the missing person report at that time. At approximately 1:15 PM, a police officer arrived to the group home site and spoke with the [PD (Program Director) #1] inquiring of (sic) elopement protocol. The police officer was informed that there was not any because this was the [client G's] first elopement but that this new behavior would be added to [client G's] BSP (Behavior Support Plan) and staff trained accordingly. The police officer left and [client G] was asked how he got to the [gas station]. [Client G] said he caught the bus. When [client G] was asked why he left, he stated it was</p>		<p>12/15/15 by his IDT.No immediate changes were made to his Individualized Support Plan, but he was able to get an emergency appointment with the psych doctor scheduled for 12/23/2015, where the QIDP will discuss the need for the doctor's referral of guardianship needs, and a medication change.</p> <p>c. Area Director received an email of notification from BDDS on 12/18/2015 stating that Client G had been approved for the CIH waiver based on his needs not being met at this particular group home. Client G has been referred over for case management services.</p> <p>d. Indiana MENTOR will continue to monitor Client G's health and safety, and will continue to work closely with BDDS on the impending transfer to the CIH waiver.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>because he wanted more cigarettes but the group home staff would not give him anymore. He also stated that management at that gas station let him work picking up trash for a few dollars in the past and that while the staff were looking for him, he earned about \$8.00 doing just that. [Client G] was counseled. [Client G] was immediately placed on line of sight during waking hours and 15 minute checks during sleeping hours. Both protective measures would take place for 24 hours from the time he returned to the house after elopement."</p> <p>-BDDS report dated 7/23/15 indicated, "On 7/22/15 at 7:45 AM, [staff #3] contacted [PD #2] and informed (sic) that [client G] had eloped from the group home. Prior to the elopement [client G] contacted [PD #2] and stated he was upset and wanted to go for a walk to cool off. [PD #2] advised [client G] to let staff know when he wanted to go for his walk to cool off as stated in his BSP. [Client G] walked off without informing staff. Staff notified the police and police came out to the group home. Police stated it was (sic) little they could do because [client G] is an emancipated adult. [Staff #3] and [PD #2] searched for [client G] and [PD #2] found [client G] at his brothers house. [Client G] was calm and returned back to the group home. [PD #2]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>and [client G's] brother counseled [client G] on informing staff when he wants to leave from home. IDT (Interdisciplinary Team) will meet to discuss [client G's] behaviors and make changes to BSP as needed. Staff will be trained accordingly to changes."</p> <p>-BDDS report dated 7/23/15 indicated, "[Client G] became verbally aggressive towards staff and peers for unknown reasons. Staff redirected [client G] and asked [client G] to stop with the verbal threats. [Client G] continued to become agitated and refused to state why he was upset when asked by staff. [Client G] asked [staff #4] for a pack of his cigarettes that were put away earlier per [client G's] request. [Client G] became upset because [staff #4] would not move as fast as he liked. [Client G] continued to be verbally aggressive towards staff and [client G] grabs a knife and threatens staff with it. [Client G] refused to put the knife down and [staff #4] called the police for assistance. [Client G] put the knife down and he did not posture staff (sic) or housemates with the knife. Police came out to the group home and decided to take [client G] to [hospital] for evaluation. [Client G] was transported to [hospital] for further evaluation. [Client G] was counseled by [hospital] staff and he was released with no further treatment</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>recommended. IDT will meet to address [client G's] behaviors, safety and train staff accordingly to any changes."</p> <p>-BDDS report dated 8/23/15 indicated, "[Client G] reported to staff that he was hearing voices and having suicidal thoughts. [PD #2] instructed staff to take [client G] to [hospital] crisis unit for further evaluation. [Client G] was assessed by crisis staff and released with no follow ups. No treatment or medication prescribed. [Client G] placed on 15 minute checks until IDT can meet to discuss [client G's] health and safety."</p> <p>-BDDS report dated 10/15/15 indicated, "On 10/13/15 [staff #5] was assisting housemates with chores after dinner. For no known reason [client G] became upset, took a butter knife from the staff and threatened to hurt himself and staff. [Staff #5] prompted and counseled [client G] to put down the butter knife. When staff could not get [client G] to follow safety directives, staff contacted the police for assistance. Police came out and took [client G] to the [hospital] for evaluation. [Client G] was released from the hospital and he returned back to the group home. [Client G] will be placed on an one to one staffing ratio for safety until IDT meets on 10/29/15."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>-BDDS report dated 10/15/15 indicated, "On 10/14/15, [client G] became upset for unknown reason while in the community. [Client G] got out (of) the van and began to evade supervision from staff. [Client G] was in an unfamiliar neighborhood and would not follow staff's directive. [Client G] refused to get out of the street and follow safety prompts. Staff called the police for assistance. Police came out and counseled [client G] on safety. [Client G] got back into the group home van and he returned home with no further issues. [Client G] is on one on one staffing ratio until IDT meets on 10/19/15 to discuss [client G's] health and safety."</p> <p>-BDDS report dated 10/26/15 indicated, "On 10/21/15, [client G] became upset and began to verbally assault [HM #1]. [Client G] continued to be verbally assaultive (sic) towards staff and housemates. [Client G] started throwing chairs, tipping over tables and began to throw punches towards [HM #1]. [PD #2] attempted to redirect [client G] to different activities but [client G] refused to calm down. [Client G] began threatening housemates but staff was able to stay in between [client G] and his peers. [Client G] refused to take time to calm down or go on a walk with non-targeted staff. [Client G] refused to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>calm down so staff called police for safety assistance. Once police arrived at the group home [client G] continued to be verbally assaultive (sic) and after 45 minutes of throwing things and attempting to hit different staff, police decided to take [client G] to [hospital] crisis (unit) for further treatment. [Client G] was admitted into [hospital] because his medication Dilantin (seizures) levels were high. IDT will be held on 10/27/15 and all staff will be trained accordingly to the behavior (plan) changes. [Client G] was discharged from [hospital] on 10/23/15."</p> <p>-BDDS report dated 11/9/15 indicated, "On 11/8/15 at 8:30 PM, [client G] became upset for unknown reasons and began to swear at staff. [Client G] stated he wanted to get out of the group home and move in with his brother. [Staff #6] offered [client G] a ride to his brothers house and [client G] refused staff assistance. [Client G] walked off from the group home and staff followed [client G] until he ran in between houses. Staff was caught by a red light resulting in losing [client G's] whereabouts. [Staff #6] and [PD #2] continued to search for [client G] but were unsuccessful in locating him. [PD #2] notified police that [client G] eloped from the group home and could not be located. On 11/9/15 at</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>1:45 AM, [client G] returned to the group home. [Client G] stated he went to his friends home but his friend didn't want him to come over or stay the night. IDT will meet to discuss [client G's] health and safety. Staff will continue to monitor [client G's] health and safety."</p> <p>Client G's record was reviewed on 11/18/15 at 2:36 PM.</p> <p>Client G's Nursing Progress Notes dated 3/9/15 indicated client G was admitted to the group home on 3/9/15.</p> <p>Client G's Client Core Discharge Census Form dated 4/3/15 indicated client G was discharged due to being arrested/detained in the county jail on 4/3/15.</p> <p>Client G's record did not indicate documentation of an IDT review or recommendations to assess and determine if the facility could resume providing services for client G upon re-admission from being detained.</p> <p>Client G's Client Core Discharge Census Form dated 10/27/15 indicated client G had initiated his own discharge from the group home services on 10/27/15.</p> <p>Client G's Client Information System Adult Services Data Entry Form dated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>10/30/15 indicated client G was re-admitted to the group home on 10/30/15.</p> <p>Client G's record did not indicate documentation of IDT assessment of client G's behavioral needs prior to re-admission to the facility. Client G's record indicated the IDT convened on 11/2/15 to review client G's BSP and supports. The 11/2/15 IDT did not specifically indicate documentation of assessment of the facility's ability to provide services for client G.</p> <p>Client G's ISP (Individual Support Plan) dated 4/6/15 indicated client G was an emancipated adult. Client G's ISP dated 4/6/15 indicated client G's diagnoses included but were not limited to Paranoid Schizophrenia, Autism Spectrum Disorder, Depression and Seizures.</p> <p>Client G's Level of Care Screening Instrument form dated 11/14/14 indicated the following:</p> <p>- "Assessor Comments: Page 3, 12/6/06 neuropsychological (testing)- [Client G's] testing strongly suggest the presence of focal cerebral dysfunction producing greater compromise of written skills. Also, indication of difficulties in auditory comprehension and verbal expression</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>that go beyond typical mild intellectual disability. Finally, seizure disorder also is consistent with some type of focal brain dysfunction, rather than merely low intellectual level alone."</p> <p>-"Assessor Comments: Page 1, 12/6/06 Neuropsychological (testing)- [Client G] has a history of poor social skills, cognitive impairment, psychosis and delusional thinking."</p> <p>-"Assessor Comments: Page 1, 12/6/06 Neuropsychological (testing)- [Client G] has a history of poor social skills, cognitive impairment, psychosis and delusional thinking. Number 6, 5/21/14 interview [unknown] said [client G] will often call 911 when he is having hallucinations. [Unknown] said not taking his medications is self-injurious. He will threaten people with a knife He will bring out his butcher knife out of his kitchen. [Doctor] said [client G] has gone to the emergency room and threatened suicide. The team has worked really hard to keep him in the community. [Therapist] said we have added more members onto his schedule in order to keep him safe. [Doctor] said [client G's] impulsivity and lack of patience is so bad he cannot sustain his coping skills. Even when he goes into the hospital he will leave against medical advice. [Therapist]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>said he has more than a tendency to impose himself on his friend and stay days on end and will threaten his friend and go off his medications and wind up in the hospital. [Unknown] and everyone said 'no' [client G] does not understand the consequences of his behaviors."</p> <p>Client G's Health Care Coordination/Monthly Health Review dated May 2015 indicated, "[Client G] has a large number of behaviors. Often very non-compliant. Verbally aggressive at times."</p> <p>Client G's Quarterly Nursing Assessment dated 3/2015 indicated, "Extremely attention seeking. Constantly calls 911 frequently. Wants to go to the hospital for attention."</p> <p>Client G's Monthly QIDP Summary form dated June 2015 indicated, "Behavioral crisis: Yes, 6/19/15 threw dinner away, cursing, yelling; 6/29/15, tried to elope; 6/17/15 inappropriate language and tried to hit a resident."</p> <p>Client G's Monthly QIDP Summary form dated July 2015 indicated, "Behavioral crisis: 7/10/15 eloped-staff followed, 7/11/15 eloped- HM found him, 7/15/15, 7/17/15 and 7/31/15 (unspecified)."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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 G's Monthly QIDP Summary form dated August 2015 indicated, "Behavioral crisis: 8/3/15, 8/5/15, 8/22/15 and 8/26/15 (unspecified)."</p> <p>Client G's Monthly QIDP Summary form dated September 2015 indicated, "Behavioral crisis: 9/30/15 inappropriate smoking-heard voices, 9/29/15 started toward [gas station]-staff called (him) back and 9/29/15 cursing and fussing with other clients."</p> <p>Client G's Monthly QIDP Summary form dated October 2015 indicated, "Behavioral crisis: 10/15/15 elopement, 10/15/15 refused medications, 10/2/15 temper outburst and cursing, 10/5/15 verbal aggression, 10/4/15 verbal aggression, 10/10/15, 10/17/15, 10/18/15 and 10/20/15 all verbal aggression."</p> <p>QIDP #1 was interviewed on 11/18/15 at 3:22 PM. QIDP #1 indicated client G had been admitted to the group home on 3/9/15. QIDP #1 stated, "[Client G] is 50 years old and has lived on the streets most of his life. He's very street smart. He has a street mentality. The other guys don't have that. I don't think anyone in the house is afraid of [client G] but he does make them uncomfortable. He's disruptive and always getting stuff stirred up. They don't like being around him and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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 noise when he's yelling or tearing up the house." QIDP #1 indicated client G was verbally disruptive on a daily basis in the home. QIDP #1 indicated client G signed himself out of services on 10/27/15 and was then re-admitted on 10/30/15. QIDP #1 stated, "I don't think he should have been re-admitted." When asked if client G was an appropriate placement at the group home, QIDP #1 stated, "No, I don't think so."</p> <p>Confidential Interview A stated, "I don't know why they re-admitted [client G] to the house. He's disruptive. Always yelling, cursing and throwing things in the house. The guys have to go to their rooms to get away from the chaos. They complain because they don't get to do as much because the staff are always having to deal with [client G]." Confidential Interview A stated, "The other guys are more quiet and laid back. [Client G] is never happy unless there is drama or something going on. He doesn't like it quiet or peaceful. The staff can't manage his behaviors. Even when he has everything he wants like cigarettes or whatever it is at the moment, he still wants to yell and curse and run out into the yard and street. He was out there yelling and cursing the other day while the neighbor's young kids were outside playing in their yard." Confidential</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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 A stated, "I don't think any of the guys are afraid of [client G]. They haven't said they are but they do complain about him. I think [client G] just makes them uneasy and uncomfortable. When [client G] is yelling and throwing things the other guys really can't be out in the living room or out of their rooms. They're just not comfortable in their home.</p> <p>Confidential Interview B stated, "I don't think [client G's] appropriate for this house. He really doesn't want to be here. [Client G] is from the streets, I try to talk to him about how good he has it here but he doesn't really understand. He will say he understands and act like he's listening but then he's running away. [Client G] will just go off for no reason. He's tore the sink in the kitchen up, just got mad one day and slammed his hand on the faucet and broke it. He throws furniture at staff, curses at the staff and clients. He had a knife in his pocket one day and was threatening people for no reason that he was going to cut them with his knife. He's unpredictable."</p> <p>HM #1 was interviewed on 11/18/15 at 5:50 PM. HM #1 stated, "No, I don't think so. I don't think he's a good fit for this house because of the behaviors."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 1 of 4 sampled clients (A), plus 1 additional client (H), the facility failed to ensure client A's ISP (Individual Support Plan)/BSP (Behavior Support Plan) addressed client A's smoking cigarettes while wearing his portable oxygen tank. The facility failed to ensure client H's ISP/BSP addressed how and when staff should monitor client H for pica/eating cigarette butts from the ground.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 11/17/15 from 5:45 AM through 7:45 AM. At 7:20 AM, client A went out to the front porch area of the group home and lit and smoked a cigarette while wearing his portable oxygen tank.</p> <p>Client A's record was reviewed on 11/18/15 at 10:21 AM. Client A's ISP</p>	W 0227	<p>a. Client A had an IDT completed on 12/2/2015 to discuss the inappropriate smoking situation. The IDT discussed his ISP and BSP and added in the smoking protocol for Client A.</p> <p>b. All staff were retrained on this new smoking protocol.</p> <p>c. The Program Coordinator put visual prompts/clues near the group home front and back exit doors to assist with prompting Client A in removing his oxygen when going outside for an approved cigarette.</p> <p>d. Client A and the staff were retrained on these plan changes, the smoking protocol, and the visual prompts that have been placed in the group home.</p> <p>e. The Program Director will complete 3 weekly Active Treatment Observations to ensure that Direct Support Staff are following all behavior support plans and to ensure that all</p>	12/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>dated 6/25/15 indicated, "[Client A] is refusing to quit smoking and was placed back on oxygen."</p> <p>Client A's Health Care Coordination/Monthly Health Review dated October, 2015 indicated, "[Client A] must smoke outside without his oxygen present! [Client A] has been educated and is very compliant with that component."</p> <p>Client A's ISP dated 6/25/15 or BSP dated 12/1/14 did not indicate documentation of specific training or supports to address client A's smoking cigarettes while wearing his portable oxygen tank.</p> <p>2. Observations were conducted at the group home on 11/17/15 from 5:45 AM through 7:45 AM. At 7:45 AM, client H was in the group home's front yard area next to the front porch. Client H picked up two cigarette butts from the ground and consumed them.</p> <p>Client H's record was reviewed on 11/18/15 at 1:22 PM. Client H's Pica (eating of non-food substances) Protocol dated 8/4/15 indicated, "There is no known method to prevent pica. however, taking measures to reduce the ingestion of non-food substance is to remove them</p>		<p>clients are participating inmeaning day activities and following all appropriate client specific protocols.</p> <p>f. TheProgram Director will put in place a procedure for staff and client's toappropriately get rid of the cigarette butts.</p> <p>g. TheProgram Director along with Client H's IDT will create a procedure for staff tofollow when Client H is on the porch potentially seeking inedible items toconsume.</p> <p>h. The Program Coordinator will retrain thedirect support staff on assessing the front and back yards for droppedcigarette butts on the ground which are at risk of being picked up and consumedby client H. The Program Coordinator and Program Director will put a cleaningschedule in place to ensure that staff are cleaning up the yard, with theassistance of the clients who smoke.</p> <p>i. The ProgramDirector will complete 3 weekly Active Treatment Observations to ensure thatDirect Support Staff are following all behavior support plans and to ensurethat all clients are participating in meaning day activities and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/25/2015	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226			
(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>from ready access or areas they can be accessed in, close observation of the person to help limit inappropriate eating behaviors." Client H's BSP dated 2/25/15 indicated, "Pica-Mouthing, licking or consuming non-food objects. Includes holding objects in mouth. For [client H] this includes eating cigarette butts." Client H's BSP dated 2/25/15 indicated, "When possible, provide free range access to edible snacks (gum, hard candy, healthy snacks) that may help deter [client H] from seeking out opportunities to eat inedible objects. If you see [client H] putting non-edible items (including cigarette butts) in his mouth that he may swallow, firmly and briefly tell him to stop. Ask him to give you the item and prompt him to engage in an appropriate activity. If [client H] swallows the item, document what he swallowed. Follow agency approved procedures for notifying the PD (Program Director) and/or medical personnel as needed depending on the item." Client H's BSP dated 2/25/15 did not indicate documentation specifically describing how staff should monitor client H while standing/walking outside near the front porch where clients A and G smoke and discard their cigarette butts.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on</p>		following all appropriate client specific protocols.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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 0289 Bldg. 00	<p>11/18/15 at 3:00 PM. QIDP #1 indicated client A should not smoke cigarettes while wearing his portable oxygen tank. QIDP #1 indicated staff should monitor client A and provide coaching/education to ensure his safety while smoking cigarettes. QIDP #1 indicated client H's behaviors included picking up cigarette butts from the ground and eating them. QIDP #1 indicated staff should be checking the area next to the front porch of the home to ensure there are no cigarette butts on the ground near the entry to home or porch area.</p> <p>9-3-4(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on record review and interview for 1 additional client (G), the facility failed to ensure client G's BSP (Behavior Support Plan) specified when staff should utilize outside emergency services/police to assist with the management of client</p>	W 0289	a. The Program Director will meet with the IDT for Client G to discuss a protocol being in place for emergency situations and when staff should call the police for assistance.	12/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>G's behaviors.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/17/15 at 10:25 AM. The review indicated the following:</p> <p>-BDDS report dated 6/22/15 indicated, "On Sunday, June 21, 2015 the [HM (Home Manager) #1] contacted the on-call program director at 12:21 PM and informed (them) that [client G] had eloped from the group home. The [HM #1] stated he was looking for [client G] at that time. The on-call program director informed the group home staff to call 911 which they did. At 1:07 PM, the [HM #1] informed the on-call program director that he found [client G] at the [gas station] on [intersection]. The on-call program director, whom arrived to the site at 1:10 PM then called 911 at 1:11 PM and reported [client G] had been found; the police stated they would cancel the missing person report at that time. At approximately 1:15 PM, a police officer arrived to the group home site and spoke with the [PD (Program Director) #1] inquiring of (sic) elopement protocol. The police officer was informed that there was not any because this was the</p>		<p>b. Once the updates are in place, the Program Director/QIDP will seek guardian and/or HRC approval for these changes.</p> <p>c. Once the BSP/protocol is updated and appropriate approvals are in place, all DSPs will be retrained on this update.</p> <p>d. The Program Director will complete 3 weekly Active Treatment Observations to ensure that Direct Support Staff are following all behavior support plans and to ensure that all clients are participating in meaningful day activities and following all appropriate client specific protocols.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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 G's] first elopement but that this new behavior would be added to [client G's] BSP (Behavior Support Plan) and staff trained accordingly."</p> <p>-BDDS report dated 7/23/15 indicated, "On 7/22/15 at 7:45 AM, [staff #3] contacted [PD #2] and informed (sic) that [client G] had eloped from the group home. Prior to the elopement [client G] contacted [PD #2] and stated he was upset and wanted to go for a walk to cool off. [PD #2] advised [client G] to let staff know when he wanted to go for his walk to cool off as stated in his BSP. [Client G] walked off without informing staff. Staff notified the police and police came out to the group home. Police stated it was (sic) little they could do because [client G] is an emancipated adult."</p> <p>-BDDS report dated 7/23/15 indicated, "[Client G] became verbally aggressive towards staff and peers for unknown reasons. Staff redirected [client G] and asked [client G] to stop with the verbal threats. [Client G] continued to become agitated and refused to state why he was upset when asked by staff. [Client G] asked [staff #4] for a pack of his cigarettes that were put away earlier per [client G's] request. [Client G] became upset because [staff #4] would not move as fast as he liked. [Client G] continued</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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 be verbally aggressive towards staff and [client G] grabs a knife and threatens staff with it. [Client G] refused to put the knife down and [staff #4] called the police for assistance. [Client G] put the knife down and he did not posture staff (sic) or housemates with the knife. Police came out to the group home and decided to take [client G] to [hospital] for evaluation."</p> <p>-BDDS report dated 10/15/15 indicated, "On 10/13/15 [staff #5] was assisting housemates with chores after dinner. For no known reason [client G] became upset, took a butter knife from the staff and threatened to hurt himself and staff. [Staff #5] prompted and counseled [client G] to put down the butter knife. When staff could not get [client G] to follow safety directives, staff contacted the police for assistance. Police came out and took [client G] to the [hospital] for evaluation."</p> <p>-BDDS report dated 10/15/15 indicated, "On 10/14/15, [client G] became upset for unknown reason while in the community. [Client G] got out (of) the van and began to evade supervision from staff. [Client G] was in an unfamiliar neighborhood and would not follow staff's directive. [Client G] refused to get out of the street and follow safety</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>prompts. Staff called the police for assistance. Police came out and counseled [client G] on safety."</p> <p>-BDDS report dated 10/26/15 indicated, "On 10/21/15, [client G] became upset and began to verbally assault [HM #1]. [Client G] continued to be verbally assaultive (sic) towards staff and housemates. [Client G] started throwing chairs, tipping over tables and began to throw punches towards [HM #1]. [PD #2] attempted to redirect [client G] to different activities but [client G] refused to calm down. [Client G] began threatening housemates but staff was able to stay in between [client G] and his peers. [Client G] refused to take time to calm down or go on a walk with non-targeted staff. [Client G] refused to calm down so staff called police for safety assistance. Once police arrived at the group home [client G] continued to be verbally assaultive (sic) and after 45 minutes of throwing things and attempting to hit different staff, police decided to take [client G] to [hospital] crisis (unit) for further treatment."</p> <p>-BDDS report dated 11/9/15 indicated, "On 11/8/15 at 8:30 PM, [client G] became upset for unknown reasons and began to swear at staff. [Client G] stated he wanted to get out of the group home</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>and move in with his brother. [Staff #6] offered [client G] a ride to his brothers house and [client G] refused staff assistance. [Client G] walked off from the group home and staff followed [client G] until he ran in between houses. Staff was caught by a red light resulting in losing [client G's] whereabouts. [Staff #6] and [PD #2] continued to search for [client G] but were unsuccessful in locating him. [PD #2] notified police that [client G] eloped from the group home and could not be located."</p> <p>Client G's record was reviewed on 11/18/15 at 2:36 PM. Client G's BSP revised November 2015 did not indicate documentation instructing staff to contact 911 or police to assist managing client G's elopement behaviors or verbal/physical aggressive behaviors.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 11/18/15 at 3:22 PM. QIDP #1 indicated client G's BSP was revised November 2015. QIDP #1 indicated client G's BSP did not indicate when staff should utilize 911 or police services to assist managing client G's elopement or verbal/physical aggressive behaviors.</p> <p>9-3-5(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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 0331 Bldg. 00	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 additional client (H), the facility nursing services failed to ensure client H's BM (Bowel Movement) tracking was completed.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/17/15 at 10:25 AM. The review indicated the following:</p> <p>-BDDS report dated 6/20/15 indicated, "[Client H] indicated to [HM (Home Manager) #1] that he had pain in his stomach/chest area. [Client H] lack full (sic) communication skills but he communicated that his stomach/chest area was in pain. [Nurse #1] instructed staff to take [client H] to ER (Emergency Room) for evaluation. [Client H] was transported to hospital (sic) for further care. [Client H] was diagnosed with constipation and received medication to release the pain. [Client H] was discharged and will follow up with his PCP (Primary Care Physician)."</p>	W 0331	<p>a. The Direct Support Staff will be retrained on Client H's requirement for the Bowel Movement Tracking due to his constipation diagnosis and protocol that are in place. b. The Direct Support staff will be retrained on Indiana MENTOR's procedure for all required documentation. c. The Program Nurse and Program Coordinator will be retrained on checking all required medical documentation and tracking. This retraining will include what to do to address the absence of the required documentation. d. The Program Nurse will get in touch with the Pharmacy to address the missing recommendation for bowel movement tracking from the Primary Care Physician on the Physicians' orders. e. The Program Nurse will complete 3 weekly Medication Administration Observations to ensure that Direct Support Staff are following all appropriate client specific medical protocols. f. The Program Nurse will complete 3 weekly medical documentation reviews to ensure that the appropriate staff are completing all required medical documentation. g. Failure for the staff to complete</p>	12/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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 H's record was reviewed on 11/18/15 at 1:22 PM. Client H's HCCMCR (Health Care Coordination/Monthly Health Review) form dated July 2015 indicated, "6/29/15, [doctor's] office (PCP) but seen by [doctor]. Follow up from ER (6/19/15). Miralax (constipation) 3 times a day. Record frequency of BM's. Already tracked and recorded on MAR (Medication Administration Record) every shift. Follow up PRN (As Needed)."</p> <p>Client H's HCCMCR form dated August 2015 indicated, "Protocol remains in place and staff continue to track and record BM's each shift in MAR."</p> <p>Client H's MAR for the months of 8/2015, 9/2015, 10/2015 through the date of review (11/18/15) did not indicate documentation of BM tracking for client H. Client H's record did not indicate documentation of staff's tracking of client H's frequency of BMs. Client H's Physician's Orders form dated 10/23/15 did not indicate documentation of client H's 6/29/15 PCP recommendations for BM tracking for frequency on each shift of personnel.</p> <p>Nurse #1 was interviewed on 11/19/15 at</p>		<p>the required documentation will result in further corrective action following Indiana MENTOR's policy.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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 0407 Bldg. 00	<p>9:45 AM. Nurse #1 indicated client H's BM's should be tracked for frequency each shift. Nurse #1 indicated client H's physician's orders should include BM tracking for each shift.</p> <p>9-3-6(a)</p> <p>483.470(a)(1) CLIENT LIVING ENVIRONMENT The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.</p> <p>Based on record review and interview for 1 additional client (G), the facility housed client G in a home with housemates that were of significantly different behavioral needs.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/17/15 at 10:25 AM. The review indicated the following:</p> <p>-BDDS report dated 6/22/15 indicated, "On Sunday, June 21, 2015 the [HM (Home Manager) #1] contacted the on-call program director at 12:21 PM and informed (them) that [client G] had</p>	W 0407	<p>a. IDT on 11/2/2015 discussed Client G's possible application for CIH waiver due to ongoing health and safety needs not being able to be met by this group home. Client G waived in his decision, so the IDT discussed guardianship needs not being met. Program Director/QIDP initiated the process of seeking emergency guardianship from The Center for At Risk Elders. b. Client G was reassessed on 12/15/15 by his IDT. No immediate changes were made to his Individualized Support Plan, but he was able to get an emergency appointment with the psych doctor scheduled for 12/23/2015, where the QIDP will discuss the need for the doctor's referral of guardianship needs, and a medication change. c. Area Director received an email</p>	12/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>eloped from the group home. The [HM #1] stated he was looking for [client G] at that time. The on-call program director informed the group home staff to call 911 which they did. At 1:07 PM, the [HM #1] informed the on-call program director that he found [client G] at the [gas station] on [intersection]. The on-call program director, whom arrived to the site at 1:10 PM then called 911 at 1:11 PM and reported [client G] had been found; the police stated they would cancel the missing person report at that time. At approximately 1:15 PM, a police officer arrived to the group home site and spoke with the [PD (Program Director) #1] inquiring of (sic) elopement protocol. The police officer was informed that there was not any because this was the [client G's] first elopement but that this new behavior would be added to [client G's] BSP (Behavior Support Plan) and staff trained accordingly. The police officer left and [client G] was asked how he got to the [gas station]. [Client G] said he caught the bus. When [client G] was asked why he left, he stated it was because he wanted more cigarettes but the group home staff would not give him anymore. He also stated that management at that gas station let him work picking up trash for a few dollars in the past and that while the staff were looking for him, he earned about \$8.00 doing just that.</p>		<p>ofnotification from BDDS on 12/18/2015 stating that Client G had been approved for the CIH waiver based on his needs not being met at this particular grouphome. Client G has been referred over for case management services. d. Indiana MENTOR will continue to monitor ClientG's health and safety, and will continue to work closely with BDDS on theimpending transfer to the CIH waiver.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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 G] was counseled. [Client G] was immediately placed on line of sight during waking hours and 15 minute checks during sleeping hours. Both protective measures would take place for 24 hours from the time he returned to the house after elopement."</p> <p>-BDDS report dated 7/23/15 indicated, "On 7/22/15 at 7:45 AM, [staff #3] contacted [PD #2] and informed (sic) that [client G] had eloped from the group home. Prior to the elopement [client G] contacted [PD #2] and stated he was upset and wanted to go for a walk to cool off. [PD #2] advised [client G] to let staff know when he wanted to go for his walk to cool off as stated in his BSP. [Client G] walked off without informing staff. Staff notified the police and police came out to the group home. Police stated it was (sic) little they could do because [client G] is an emancipated adult. [Staff #3] and [PD #2] searched for [client G] and [PD #2] found [client G] at his brothers house. [Client G] was calm and returned back to the group home. [PD #2] and [client G's] brother counseled [client G] on informing staff when he wants to leave from home. IDT (Interdisciplinary Team) will meet to discuss [client G's] behaviors and make changes to BSP as needed. Staff will be trained accordingly to changes."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>-BDDS report dated 7/23/15 indicated, "[Client G] became verbally aggressive towards staff and peers for unknown reasons. Staff redirected [client G] and asked [client G] to stop with the verbal threats. [Client G] continued to become agitated and refused to state why he was upset when asked by staff. [Client G] asked [staff #4] for a pack of his cigarettes that were put away earlier per [client G's] request. [Client G] became upset because [staff #4] would not move as fast as he liked. [Client G] continued to be verbally aggressive towards staff and [client G] grabs a knife and threatens staff with it. [Client G] refused to put the knife down and [staff #4] called the police for assistance. [Client G] put the knife down and he did not posture staff (sic) or housemates with the knife. Police came out to the group home and decided to take [client G] to [hospital] for evaluation. [Client G] was transported to [hospital] for further evaluation. [Client G] was counseled by [hospital] staff and he was released with no further treatment recommended. IDT will meet to address [client G's] behaviors, safety and train staff accordingly to any changes."</p> <p>-BDDS report dated 8/23/15 indicated, "[Client G] reported to staff that he was hearing voices and having suicidal</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>thoughts. [PD #2] instructed staff to take [client G] to [hospital] crisis unit for further evaluation. [Client G] was assessed by crisis staff and released with no follow ups. No treatment or medication prescribed. [Client G] placed on 15 minute checks until IDT can meet to discuss [client G's] health and safety."</p> <p>-BDDS report dated 10/15/15 indicated, "On 10/13/15 [staff #5] was assisting housemates with chores after dinner. For no known reason [client G] became upset, took a butter knife from the staff and threatened to hurt himself and staff. [Staff #5] prompted and counseled [client G] to put down the butter knife. When staff could not get [client G] to follow safety directives, staff contacted the police for assistance. Police came out and took [client G] to the [hospital] for evaluation. [Client G] was released from the hospital and he returned back to the group home. [Client G] will be placed on an one to one staffing ratio for safety until IDT meets on 10/29/15."</p> <p>-BDDS report dated 10/15/15 indicated, "On 10/14/15, [client G] became upset for unknown reason while in the community. [Client G] got out (of) the van and began to evade supervision from staff. [Client G] was in an unfamiliar neighborhood and would not follow</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>staff's directive. [Client G] refused to get out of the street and follow safety prompts. Staff called the police for assistance. Police came out and counseled [client G] on safety. [Client G] got back into the group home van and he returned home with no further issues. [Client G] is on one on one staffing ratio until IDT meets on 10/19/15 to discuss [client G's] health and safety."</p> <p>-BDDS report dated 10/26/15 indicated, "On 10/21/15, [client G] became upset and began to verbally assault [HM #1]. [Client G] continued to be verbally assaultive (sic) towards staff and housemates. [Client G] started throwing chairs, tipping over tables and began to throw punches towards [HM #1]. [PD #2] attempted to redirect [client G] to different activities but [client G] refused to calm down. [Client G] began threatening housemates but staff was able to stay in between [client G] and his peers. [Client G] refused to take time to calm down or go on a walk with non-targeted staff. [Client G] refused to calm down so staff called police for safety assistance. Once police arrived at the group home [client G] continued to be verbally assaultive (sic) and after 45 minutes of throwing things and attempting to hit different staff, police decided to take [client G] to [hospital]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>crisis (unit) for further treatment. [Client G] was admitted into [hospital] because his medication Dilantin (seizures) levels were high. IDT will be held on 10/27/15 and all staff will be trained accordingly to the behavior (plan) changes. [Client G] was discharged from [hospital] on 10/23/15."</p> <p>-BDDS report dated 11/9/15 indicated, "On 11/8/15 at 8:30 PM, [client G] became upset for unknown reasons and began to swear at staff. [Client G] stated he wanted to get out of the group home and move in with his brother. [Staff #6] offered [client G] a ride to his brothers house and [client G] refused staff assistance. [Client G] walked off from the group home and staff followed [client G] until he ran in between houses. Staff was caught by a red light resulting in losing [client G's] whereabouts. [Staff #6] and [PD #2] continued to search for [client G] but were unsuccessful in locating him. [PD #2] notified police that [client G] eloped from the group home and could not be located. On 11/9/15 at 1:45 AM, [client G] returned to the group home. [Client G] stated he went to his friends home but his friend didn't want him to come over or stay the night. IDT will meet to discuss [client G's] health and safety. Staff will continue to monitor [client G's] health and safety."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
---	--	--	--

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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 G's record was reviewed on 11/18/15 at 2:36 PM.</p> <p>Client G's Nursing Progress Notes dated 3/9/15 indicated client G was admitted to the group home on 3/9/15.</p> <p>Client G's Client Core Discharge Census Form dated 4/3/15 indicated client G was discharged due to being arrested/detained in the county jail on 4/3/15.</p> <p>Client G's record did not indicate documentation of an IDT review or recommendations to assess and determine if the facility could resume providing services for client G upon re-admission from being detained.</p> <p>Client G's Client Core Discharge Census Form dated 10/27/15 indicated client G had initiated his own discharge from the group home services on 10/27/15.</p> <p>Client G's Client Information System Adult Services Data Entry Form dated 10/30/15 indicated client G was re-admitted to the group home on 10/30/15.</p> <p>Client G's record did not indicate documentation of IDT assessment of client G's behavioral needs prior to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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-admission to the facility. Client G's record indicated the IDT convened on 11/2/15 to review client G's BSP and supports. The 11/2/15 IDT did not specifically indicate documentation of assessment of the facility's ability to provide services for client G.</p> <p>Client G's ISP (Individual Support Plan) dated 4/6/15 indicated client G was an emancipated adult. Client G's ISP dated 4/6/15 indicated client G's diagnoses included but were not limited to Paranoid Schizophrenia, Autism Spectrum Disorder, Depression and Seizures.</p> <p>Client G's Level of Care Screening Instrument form dated 11/14/14 indicated the following:</p> <p>- "Assessor Comments: Page 3, 12/6/06 neuropsychological (testing)- [Client G's] testing strongly suggest the presence of focal cerebral dysfunction producing greater compromise of written skills. Also, indication of difficulties in auditory comprehension and verbal expression that go beyond typical mild intellectual disability. Finally, seizure disorder also is consistent with some type of focal brain dysfunction, rather than merely low intellectual level alone."</p> <p>- "Assessor Comments: Page 1, 12/6/06</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>Neuropsychological (testing)- [Client G] has a history of poor social skills, cognitive impairment, psychosis and delusional thinking."</p> <p>-"Assessor Comments: Page 1, 12/6/06 Neuropsychological (testing)- [Client G] has a history of poor social skills, cognitive impairment, psychosis and delusional thinking. Number 6, 5/21/14 interview [unknown] said [client G] will often call 911 when he is having hallucinations. [Unknown] said not taking his medications is self-injurious. He will threaten people with a knife He will bring out his butcher knife out of his kitchen. [Doctor] said [client G] has gone to the emergency room and threatened suicide. The team has worked really hard to keep him in the community. [Therapist] said we have added more members onto his schedule in order to keep him safe. [Doctor] said [client G's] impulsivity and lack of patience is so bad he cannot sustain his coping skills. Even when he goes into the hospital he will leave against medical advice. [Therapist] said he has more than a tendency to impose himself on his friend and stay days on end and will threaten his friend and go off his medications and wind up in the hospital. [Unknown] and everyone said 'no' [client G] does not understand the consequences of his behaviors."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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 G's Health Care Coordination/Monthly Health Review dated May 2015 indicated, "[Client G] has a large number of behaviors. Often very non-compliant. Verbally aggressive at times."</p> <p>Client G's Quarterly Nursing Assessment dated 3/2015 indicated, "Extremely attention seeking. Constantly calls 911 frequently. Wants to go to the hospital for attention."</p> <p>Client G's Monthly QIDP Summary form dated June 2015 indicated, "Behavioral crisis: Yes, 6/19/15 threw dinner away, cursing, yelling; 6/29/15, tried to elope; 6/17/15 inappropriate language and tried to hit a resident."</p> <p>Client G's Monthly QIDP Summary form dated July 2015 indicated, "Behavioral crisis: 7/10/15 eloped-staff followed, 7/11/15 eloped- HM found him, 7/15/15, 7/17/15 and 7/31/15 (unspecified)."</p> <p>Client G's Monthly QIDP Summary form dated August 2015 indicated, "Behavioral crisis: 8/3/15, 8/5/15, 8/22/15 and 8/26/15 (unspecified)."</p> <p>Client G's Monthly QIDP Summary form dated September 2015 indicated,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>"Behavioral crisis: 9/30/15 inappropriate smoking-heard voices, 9/29/15 started toward [gas station]-staff called (him) back and 9/29/15 cursing and fussing with other clients."</p> <p>Client G's Monthly QIDP Summary form dated October 2015 indicated, "Behavioral crisis: 10/15/15 elopement, 10/15/15 refused medications, 10/2/15 temper outburst and cursing, 10/5/15 verbal aggression, 10/4/15 verbal aggression, 10/10/15, 10/17/15, 10/18/15 and 10/20/15 all verbal aggression."</p> <p>QIDP #1 was interviewed on 11/18/15 at 3:22 PM. QIDP #1 indicated client G had been admitted to the group home on 3/9/15. QIDP #1 stated, "[Client G] is 50 years old and has lived on the streets most of his life. He's very street smart. He has a street mentality. The other guys don't have that. I don't think anyone in the house is afraid of [client G] but he does make them uncomfortable. He's disruptive and always getting stuff stirred up. They don't like being around him and the noise when he's yelling or tearing up the house." QIDP #1 indicated client G was verbally disruptive on a daily basis in the home. QIDP #1 indicated client G signed himself out of services on 10/27/15 and was then re-admitted on 10/30/15. QIDP #1 stated, "I don't think</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>he should have been re-admitted." When asked if client G was an appropriate placement at the group home, QIDP #1 stated, "No, I don't think so."</p> <p>Confidential Interview A stated, "I don't know why they re-admitted [client G] to the house. He's disruptive. Always yelling, cursing and throwing things in the house. The guys have to go to their rooms to get away from the chaos. They complain because they don't get to do as much because the staff are always having to deal with [client G]." Confidential Interview A stated, "The other guys are more quiet and laid back. [Client G] is never happy unless there is drama or something going on. He doesn't like it quiet or peaceful. The staff can't manage his behaviors. Even when he has everything he wants like cigarettes or whatever it is at the moment, he still wants to yell and curse and run out into the yard and street. He was out there yelling and cursing the other day while the neighbor's young kids were outside playing in their yard." Confidential Interview A stated, "I don't think any of the guys are afraid of [client G]. They haven't said they are but they do complain about him. I think [client G] just makes them uneasy and uncomfortable. When [client G] is yelling and throwing things the other guys really</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>can't be out in the living room or out of their rooms. They're just not comfortable in their home.</p> <p>Confidential Interview B stated, "I don't think [client G's] appropriate for this house. He really doesn't want to be here. [Client G] is from the streets, I try to talk to him about how good he has it here but he doesn't really understand. He will say he understands and act like he's listening but then he's running away. [Client G] will just go off for no reason. He's tore the sink in the kitchen up, just got mad one day and slammed his hand on the faucet and broke it. He throws furniture at staff, curses at the staff and clients. He had a knife in his pocket one day and was threatening people for no reason that he was going to cut them with his knife. He's unpredictable."</p> <p>Client A was interviewed on 11/18/15 at 5:20 PM. When asked how things were going in the group home, client A stated, "I don't like [client G]. He yells and cusses at me. We can't do anything because of him." Client A stated, "I go to my room to get away from him." Client A indicated he was not fearful or intimidated by client G.</p> <p>Client B was interviewed on 11/18/15 at 5:30 PM. Client B stated, "I don't like</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7310 E 55TH ST INDIANAPOLIS, IN 46226
---	---

(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>being around [client G]. He yells, cusses and threatens everyone. He throws things around and slam things down. [Client G] went on an outing tonight with staff. I didn't go because I didn't want to be with him."</p> <p>Client E was interviewed on 11/18/15 at 5:40 PM. Client E stated, " "[Client G] yells at staff. He's loud and yells a lot. I'm not scared. I just go to my room."</p> <p>HM #1 was interviewed on 11/18/15 at 5:50 PM. HM #1 indicated no clients living in the home had indicated they were fearful or intimidated by client G. HM #1 indicated clients A, B, D and E avoid being in the same room or area as client G. HM #1 indicated clients C and H were deaf and not always aware of client G's verbal outbursts. HM #1 stated, "No, I don't think so. I don't think he's a good fit for this house because of the behaviors."</p> <p>9-3-7(a)</p>			