

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: June 17, 18, 19 and 21, 2013.</p> <p>Facility Number: 001082 Provider Number: 15G568 AIMS Number: 100245520</p> <p>Surveyor: Claudia Ramirez, RN</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/27/13 by Ruth Shackelford, QIDP.</p>	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

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

W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p> <p>Based on record review and interview, for 2 of 4 sample clients (clients #1 and #3), the facility failed to maintain an accurate accounting system for each client's personal fund account.</p> <p>Findings include:</p> <p>On 06/18/13 at 11:30 AM a petty cash (spending money of the clients kept at the group home) review of client funds was conducted for clients #1 and #3 along with a review of their monthly cash ledgers and receipts for petty cash funds from March 2013 to June 17, 2013. The review of ledgers indicated the following:</p> <p>Client #1: The March 2013 ledger indicated client #1 had received a total of \$25.00 for spending money. The April 2013 ledger indicated client #1 had received a total of \$35.00 for spending money. The May 2013 ledger indicated client #1 had received \$15.00 for spending money. The June 2013 ledger indicated client #1 had received \$5.00 for spending money. There were no receipts to indicate how the spending money was</p>	W000140	<p>The Program Director and Home Manager will receive retraining on client finances to ensure that they are completing a full and complete accounting of clients financial transactions including collecting and documenting receipts to show how consumers money is spent and ensuring that client check register records and cash on hand ledgers are balanced and reconciled weekly by the HM and monthly by the Program Director and copies of records are provided monthly to the Client Finance Specialist.</p> <p>Ongoing, the Home Manger will record and balance all client transactions a minimum of weekly and note this in the clients finance records. Ongoing the Program Director will review and reconcile client finances a minimum of monthly and note this in the client finance records. The Program Director will provide copies of the clients' financial transactions to the Client Finance Specialist a minimum of monthly. Monthly, the Client Finance Specialist will provide the Area Director a list of what client finances have not been turned in by the scheduled deadlines and any corrections that need to be made so the Area</p>	07/21/2013
---------	--	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250		
(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>spent.</p> <p>Client #3: The March 2013 ledger indicated client #3 had received a total of \$55.00 for spending money. The April 2013 ledger indicated client #3 had received a total of \$30.00 for spending money. The May 2013 ledger indicated client #3 had received \$165.00 for spending money. The June 2013 ledger indicated client #3 had received \$20.00 for spending money. There were no receipts to indicate how the spending money was spent.</p> <p>Client #1's records were reviewed on 06/18/13 at 11:45 AM. Client #1's ISP (Individual Support Plan) dated 01/09/13 indicated client #1 was not able to independently handle his money and required assistance.</p> <p>Client #3's records were reviewed on 06/18/13 at 1:43 PM. Client #3's ISP dated 05/10/13 indicated client #3 was not able to independently handle his money and required assistance.</p> <p>On 06/19/13 at 12:50 PM an interview with the House Manager (HM) was conducted. The HM indicated clients #1 and #3 carried money on them and did not bring back receipts. She indicated their ISPs indicated they were not independent</p>		<p>Director can follow up with HM and/or PD to ensure these requirements are being met.</p> <p>Responsible Party: Home Manager, Program Director, Client Finance Specialist, Area Director.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(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
	in handling their money and required assistance from the agency/staff.  9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250		
(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	
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 9 of 17 BDDS (Bureau of Developmental Disabilities Services) reports, the facility neglected to implement the facility's policy and procedure, neglected to ensure client safety (clients #1, #2, #3, #4, #5, #6, #7 and #8) and neglected to protect clients from client to client aggression.</p> <p>Findings include:</p> <p>On 06/17/13 at 11:26 AM a record review of the BDDS reports was completed and included the following:</p> <p>11/09/12: A BDDS report indicated, "[Client #5] and [client #1] became upset with each other. They started to fight, scratching each other. Staff intervened immediately and separated them. Staff noticed that both [client #5] and [client #1] had red faces and a few scratches on their faces. Both [client #5] and [client #1] calmed down and there were no further incidents...Staff monitored both guys for their health and safety. Staff will continue to follow the behavior plans for [client #5] and [client #1]."</p>	W000149	<p>As soon as the QDIP became aware of the possibility of a staff falling asleep while on the clock, immediate protective measures were implemented to protect the clients from potential further neglect by suspending the staff. Once the evidence to support the allegation of the staff sleeping was identified staff was terminated from Indiana Mentor's employment. Indiana Mentor management and administration will continue to implement immediate protective measures, investigations, and corrective action as designated when allegations of abuse, neglect, or exploitation are made. All direct care staff will be retrained on incident reporting including reporting to the supervisor immediately when incidents of potential abuse or neglect occur, reporting timelines, and DSP and Home Manager role in reporting incidents. All direct care staff will also retrained on the Indiana Mentor Code of Conduct which includes not sleeping while on the clock. The Program Director will be retrained on involving a client's IDT when an incident of aggression occurs to develop a plan of action to prevent further incidents of aggression. The Program Director will convene the</p>	07/21/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250			
(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>11/15/12: A BDDS report indicated, "While on the morning van run, [client #9 at another group home] became agitated and he hit [client #10 at another group home] on the shoulder...One of the other clients was telling [client #9] not to hit others and [client #9] got upset and hit [client #1]. [Client #1] hit [client #9] back in the mouth causing his lip to be a little bloody. [Client #9] and [client #1] kept arguing with each other and they hit each other once again before staff were able to pull over. The two boys were separated and there was no further incident for the rest of transport. [Client #9's] lip looked a little swollen...Will continue to monitor all consumers for further injury. Behavior consultant will be notified."</p> <p>01/16/13: A BDDS report indicated, "[Client #9] and [client #1] were being transported to work when they began to argue then fight. During the altercation, [client #9] scratched [client #1] in the nose. Staff were able to calm the two residents and there were no further issues. [Client #1] had a slight scratch on his nose. They continued to work as scheduled. Staff checked [client #1's] nose and applied general first aid. There was slight bleeding which was cleaned up immediately. Staff will monitor both residents for their health and safety. BSPs</p>		<p>IDT for clients #1, #2, #3, #4, #5 and #7 to discuss the incidents of aggression and make recommendations as appropriate including changes to plans, as needed. The Area Director will maintain a database of incidents in order to monitor the need for IDTs to address incidents of aggression. The Area Director will review the database a minimum of monthly to determine if any patterns of aggression are occurring. If a pattern of aggression is determined, the Area Director will work with the Program Director and consumer's IDT to determine if any changes to the consumers BSP need to be put into place or if any additional protective measures need to be implemented to prevent further incidents of aggression. The database will include the outcome/results in resolving the issue as part of the database. Responsible Staff: Program Director, Area Director</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(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>(Behavior Support Plans) will be followed to minimize behaviors in the future."</p> <p>03/17/13: A BDDS report indicated, "[Client #1] and [client #5] became aggressive towards each other and began hitting each other. The staff intervened and they were separated. Shortly after they became aggressive again. It was reported that [client #1] started to chase [client #5] with a steak knife. The staff was immediately able to get the steak knife away from [client #1]. [Client #1] got mad and walked outside and down the street to another group home nearby. The staff followed. When [client #1] got to the other house, he called his mother on the phone and told her that the staff had held him down while [client #5] punched him. [Client #5] and the staff said that was not true. It was reported that during the fight between [client #1] and [client #5], that [client #5] sat on [client #1] trying to hold him down and that the staff was trying to intervene and stop the fighting. [Client #1's] face appeared a little swollen...Staff will monitor [client #1] and [client #5] for their health and safety...."</p> <p>05/02/13: A BDDS report indicated, "[Client #3] became upset with [client #1] and (sic) throwing telephone at [client</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250			
(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]. [Client #1] was not hurt from being hit with the telephone in the head. As a result of [client #3's] aggression towards peer [client #1], [client #1] tackled [client #3] and hit [client #3] in the face. [Client #3] appeared to have a small bruise close to his eye. Staff separated the two and no other concerns noted. Staff will continue to follow behavior plans and keep clients in sights at all times when together."</p> <p>06/02/13: A BDDS report indicated, "Client [client #3] was having a conversation with staff [staff #3]. [Client #3] became upset and grabbed roommate [client #4] around the neck. [Client #4] hit [client #3] a few times in the head. Staff [staff #3] stepped in between the roommates and redirected them to different rooms. Staff notified HM (House Manager) and PD (Program Director). [Client #3] came and hit [client #4] in the head with a wooden like stick. [Client #4] hit [client #3] back in (sic) tried to take the stick away from [client #3]. Staff [staff #3] stepped in and redirected the roommates to different areas. PD came by and was able to deescalate the situation. Roommates apologizes (sic) to each other and their parts in the incident. Both roommates sustained minor bruises and cuts. Staff applied first-aid and no further concerns noted. Staff will be retrained on ISP</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250		
(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>(Individual Support Plan) and BSP (Behavior Support Plan)."</p> <p>06/10/13: A BDDS report indicated, "[Client #2] was dropped off at work and he decided to leave out (sic); go (sic) to the liquor store without informing the [day service name] staff. [Client #2] bought beer and may have consumed 18 oz's (ounces) of it. [Client #2] was found shortly by [day service] staff walking back towards the [day service]. [Client #2] was sent home and was picked up by [agency] staff. IDT (Interdisciplinary Team) will meet to come up plan to resolve."</p> <p>06/10/13: A BDDS report indicated, "Staff (unidentified) went to [client #2's] bedroom to prompt him to finish evening chores. Staff noticed [client #2] was not in the house, searched outside and [client #2] not (sic) found. Staff notified HM and PD. PD instructed staff to call Police for assistance. Police found [client #2] and (sic) the gas station close to the Group Home. Police took [staff #2] to [hospital name] Behavioral Center for evaluation. [Hospital name] staff felt [client #2] was safe to (sic) and released him back to staff. [Client #2] was placed on 15 minutes (sic) checks until IDT team is able to meet to discuss [client #2's] elopement."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250			
(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>06/17/13: A BDDS report indicated, "Consumer [client #7] woke up in the middle of the night and came out of his room and noticed staff [staff #5] asleep in the living room. [Client #7] took a picture of [staff #5] sleeping. In the morning, he sent the picture to the Home Manager. The Home Manager followed up with [client #5] and he said he noticed the staff sleeping. There were 6 other consumers home at the time. Consumers did not suffer any adverse effects. Staff [staff #5] is suspended and an internal investigation has been started."</p> <p>Client #2's records were reviewed on 06/18/13 at 12:21 PM. Client #2's ISP (Individual Support Plan) dated 11/16/12 indicated client #2 required 24 hour supervision and alcohol consumption was contraindicated. His BSP dated 12/13/12 indicated he was at risk for elopement behavior.</p> <p>On 06/17/13 at 11:21 AM, a review of the facility's 04/2011 Policy of Quality and Risk Management indicated, "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</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(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>through a process of identifying, evaluation and reducing risk to which individuals are exposed. Indiana MENTOR follows the BDDS Incident Reporting policy as outlined in the Provider Standards. An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS: 1. Alleged, suspected, or actual abuse, neglect, or exploitation of an individual...iii. Cause the individual to experience emotional distress...e. Failure to provide appropriate supervision, care or training...Indiana MENTOR is committed to ensuring the individuals we serve are provided with a safe and quality living environment...."</p> <p>On 06/19/13 at 12:50 PM an interview was conducted with the Area Director (AD). The AD indicated staff failed to follow the policy/procedure as they failed to provide appropriate supervision of the clients and the clients were unsupervised for an unknown period of time. The AD indicated clients #1, #2, #3, #4, #5, #6, #7 and #8 required 24 hour supervision and staff should not have been sleeping on duty. She indicated the clients should not have been unsupervised as their needs required staff supervision at all times and staff should always know the whereabouts of the clients. The AD also indicated client to client aggression and injury</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(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>should not be occurring and the agency had the duty to keep the clients safe.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250			
(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			
W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 9 of 17 allegations of abuse, neglect and/or injuries of unknown source reviewed (clients #1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to conduct an investigation and/or conduct thorough investigations in regard to client to client aggression (clients #1, #3, #4 and #5), elopement behavior (client #2) and lack of client supervision (clients #1, #2, #3, #4, #5, #6, #7 and #8).</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, incident reports and investigations were reviewed on 06/17/13 at 11:26 AM. The reports indicated the following:</p> <p>11/09/12: A BDDS report indicated, "[Client #5] and [client #1] became upset with each other. They started to fight, scratching each other. Staff intervened immediately and separated them. Staff noticed that both [client #5] and [client #1] had red faces and a few scratches on their faces. Both [client #5] and [client</p>	W000154	<p>The Program Director will receive retraining on investigations including ensuring that all reports of injuries of unknown origin for consumes are investigated, investigations are completed thoroughly and accurately and all investigations are reported to the administrator or designee the results within 5 work days.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Quality Assurance Specialist. If the investigations are not thorough enough the Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Program Director, Quality Assurance Specialist, Area Director.</p>	07/21/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250		
(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] calmed down and there were no further incidents...Staff monitored both guys for their health and safety. Staff will continue to follow the behavior plans for [client #5] and [client #1]." There was no investigation available for review of this incident.</p> <p>11/15/12: A BDDS report indicated, "While on the morning van run, [client #9 at another group home] became agitated and he hit [client #10 at another group home] on the shoulder...One of the other clients was telling [client #9] not to hit others and [client #9] got upset and hit [client #1]. [Client #1] hit [client #9] back in the mouth causing his lip to be a little bloody. [Client #9] and [client #1] kept arguing with each other and they hit each other once again before staff were able to pull over. The two boys were separated and there was no further incident for the rest of transport. [Client #9's] lip looked a little swollen...Will continue to monitor all consumers for further injury. Behavior consultant will be notified." There was no investigation available for review of this incident.</p> <p>01/16/13: A BDDS report indicated, "[Client #9] and [client #1] were being transported to work when they began to argue then fight. During the altercation, [client #9] scratched [client #1] in the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250		
(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>nose. Staff were able to calm the two residents and there were no further issue. [Client #1] had a slight scratch on his nose. They continued to work as scheduled. Staff checked [client #1's] nose and applied general first aid. There was slight bleeding which was cleaned up immediately. Staff will monitor both residents for their health and safety. BSPs (Behavior Support Plans) will be followed to minimize behaviors in the future." There was no investigation available for review of this incident.</p> <p>03/17/13: A BDDS report indicated, "[Client #1] and [client #5] became aggressive towards each other and began hitting each other. The staff intervened and they were separated. Shortly after they became aggressive again. It was reported that [client #1] started to chase [client #5] with a steak knife. The staff was immediately able to get the steak knife away from [client #1]. [Client #1] got mad and walked outside and down the street to another group home nearby. The staff followed. When [client #1] got to the other house, he called his mother on the phone and told her that the staff had held him down while [client #5] punched him. [Client #5] and the staff said that was not true. It was reported that during the fight between [client #1] and [client #5], that [client #5] sat on [client #1]</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(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>trying to hold him down and that the staff was trying to intervene and stop the fighting. [Client #1's] face appeared a little swollen...Staff will monitor [client #1] and [client #5] for their health and safety...." There was no investigation available for review of this incident.</p> <p>05/02/13: A BDDS report indicated, "[Client #3] became upset with [client #1] and (sic) throwing telephone at [client #1]. [Client #1] was not hurt from being hit with the telephone in the head. As a result of [client #3's] aggression towards peer [client #1], [client #1] tackled [client #3] and hit [client #3] in the face. [Client #3] appeared to have a small bruise close to his eye. Staff separated the two and no other concerns noted. Staff will continue to follow behavior plans and keep clients in sights at all times when together." There was no investigation available for review of this incident.</p> <p>06/02/13: A BDDS report indicated, "Client [client #3] was having a conversation with staff [staff #3]. [Client #3] became upset and grabbed roommate [client #4] around the neck. [Client #4] hit [client #3] a few times in the head. Staff [staff #3] stepped in between the roommates and redirected them to different rooms. Staff notified HM (House Manager) and PD (Program</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250			
(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>Director). [Client #3] came and hit [client #4] in the head with a wooden like stick. [Client #4] hit [client #3] back in (sic) tried to take the stick away from [client #3]. Staff [staff #3] stepped in and redirected the roommates to different areas. PD came by and was able to deescalate the situation. Roommates apologizes (sic) to each other and their parts in the incident. Both roommates sustained minor bruises and cuts. Staff applied first-aid and no further concerns noted. Staff will be retrained on ISP (Individual Support Plan) and BSP (Behavior Support Plan)." There was no investigation available for review of this incident.</p> <p>06/10/13: A BDDS report indicated, "[Client #2] was dropped off at work and he decided to leave out (sic); go (sic) to the liquor store without informing the [day service name] staff. [Client #2] bought beer and may have consumed 18 oz's (ounces) of it. [Client #2] was found shortly by [day service] staff walking back towards the [day service]. [Client #2] was sent home and was picked up by [agency] staff. IDT (Interdisciplinary Team) will meet to come up plan to resolve." There was no investigation available for review of this incident.</p> <p>06/10/13: A BDDS report indicated,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250			
(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 (unidentified) went to [client #2's] bedroom to prompt him to finish evening chores. Staff noticed [client #2] was not in the house, searched outside and [client #2] not (sic) found. Staff notified HM and PD. PD instructed staff to call Police for assistance. Police found [client #2] and (sic) the gas station close to the Group Home. Police took [staff #2] to [hospital name] Behavioral Center for evaluation. [Hospital name] staff felt [client #2] was safe to (sic) and released him back to staff. [Client #2] was placed on 15 minutes (sic) checks until IDT team is able to meet to discuss [client #2's] elopement." There was no investigation available for review of this incident.</p> <p>06/17/13: A BDDS report indicated, "Consumer [client #7] woke up in the middle of the night and came out of his room and noticed staff [staff #5] asleep in the living room. [Client #7] took a picture of [staff #5] sleeping. In the morning, he sent the picture to the Home Manager. The Home Manager followed up with [client #5] and he said he noticed the staff sleeping. There were 6 other consumers home at the time. Consumers did not suffer any adverse effects. Staff [staff #5] is suspended and an internal investigation has been started." There was no investigation available for review of this incident.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(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>On 06/19/13 at 12:50 PM an interview was conducted with the Area Director (AD). The AD indicated there had been staff changes at that home and some of the investigations did not take place as they should have.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250			
(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			
W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 8 of 17 BDDS (Bureau of Developmental Disabilities Services) reports regarding allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility neglected to initiate and document effective corrective action to prevent client to client aggression (clients #1, #3, #4 and #5) and failed to prevent repeated elopement behavior (client #2) by failing to adequately supervise the client.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, incident reports and investigations were reviewed on 06/17/13 at 11:26 AM. The reports indicated the following:</p> <p>11/09/12: A BDDS report indicated, "[Client #5] and [client #1] became upset with each other. They started to fight, scratching each other. Staff intervened immediately and separated them. Staff noticed that both [client #5] and [client #1] had red faces and a few scratches on their faces. Both [client #5] and [client #1] calmed down and there were no</p>	W000157	<p>The Program Director will be retrained on involving a client's IDT when an incident of aggression occurs to develop a plan of action to prevent further incidents of aggression. The Program Director will convene the IDT for clients #1, #2, #3, #4, #5 and #7 to discuss the incidents of aggression and make recommendations as appropriate including changes to plans, as needed. The Area Director will maintain a database of incidents in order to monitor the need for IDTs to address incidents of aggression. The Area Director will review the database a minimum of monthly to determine if any patterns of aggression are occurring. If a pattern of aggression is determined, the Area Director will work with the Program Director and consumer's IDT to determine if any changes to the consumers BSP need to be put into place or if any additional protective measures need to be implemented to prevent further incidents of aggression. The database will include the outcome/results in resolving the issue as part of the database. Responsible Staff: Program Director, Area Director</p>	07/21/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250		
(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>further incidents...Staff monitored both guys for their health and safety. Staff will continue to follow the behavior plans for [client #5] and [client #1]." No record of documented effective corrective action was available for review in regard to staff monitoring or supervision to prevent clients #1 and #5 from repeating the behavior.</p> <p>11/15/12: A BDDS report indicated, "While on the morning van run, [client #9 at another group home] became agitated and he hit [client #10 at another group home] on the shoulder...One of the other clients was telling [client #9] not to hit others and [client #9] got upset and hit [client #1]. [Client #1] hit [client #9] back in the mouth causing his lip to be a little bloody. [Client #9] and [client #1] kept arguing with each other and they hit each other once again before staff were able to pull over. The two boys were separated and there was no further incident for the rest of transport. [Client #9's] lip looked a little swollen...Will continue to monitor all consumers for further injury. Behavior consultant will be notified." No record of documented effective corrective action was available for review in regard to staff monitoring or supervision to prevent client #1 from repeating the behavior.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250			
(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>01/16/13: A BDDS report indicated, "[Client #9] and [client #1] were being transported to work when they began to argue then fight. During the altercation, [client #9] scratched [client #1] in the nose. Staff were able to calm the two residents and there were no further issue. [Client #1] had a slight scratch on his nose. They continued to work as scheduled. Staff checked [client #1's] nose and applied general first aid. There was slight bleeding which was cleaned up immediately. Staff will monitor both residents for their health and safety. BSPs (Behavior Support Plans) will be followed to minimize behaviors in the future." No record of documented effective corrective action was available for review in regard to staff monitoring or supervision to prevent client #1 from repeating the behavior.</p> <p>03/17/13: A BDDS report indicated, "[Client #1] and [client #5] became aggressive towards each other and began hitting each other. The staff intervened and they were separated. Shortly after they became aggressive again. It was reported that [client #1] started to chase [client #5] with a steak knife. The staff was immediately able to get the steak knife away from [client #1]. [Client #1] got mad and walked outside and down the street to another group home nearby. The</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(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 followed. When [client #1] got to the other house, he called his mother on the phone and told her that the staff had held him down while [client #5] punched him. [Client #5] and the staff said that was not true. It was reported that during the fight between [client #1] and [client #5], that [client #5] sat on [client #1] trying to hold him down and that the staff was trying to intervene and stop the fighting. [Client #1's] face appeared a little swollen...Staff will monitor [client #1] and [client #5] for their health and safety...." No record of documented effective corrective action was available for review in regard to staff monitoring or supervision to prevent clients #1 and #5 from repeating the behavior.</p> <p>05/02/13: A BDDS report indicated, "[Client #3] became upset with [client #1] and throwing telephone at [client #1]. [Client #1] was not hurt from being hit with the telephone in the head. As a result of [client #3's] aggression towards peer [client #1], [client #1] tackled [client #3] and hit [client #3] in the face. [Client #3] appeared to have a small bruise close to his eye. Staff separated the two and no other concerns noted. Staff will continue to follow behavior plans and keep clients in sights at all times when together." No record of documented effective corrective action was available for review in regard</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(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 staff monitoring or supervision to prevent clients #1 and #3 from repeating the behavior.</p> <p>06/02/13: A BDDS report for an incident at 9:00 AM indicated, "Client [client #3] was having a conversation with staff [staff #3]. [Client #3] became upset and grabbed roommate [client #4] around the neck. [Client #4] hit [client #3] a few times in the head. Staff [staff #3] stepped in between the roommates and redirected them to different rooms. Staff notified HM (House Manager) and PD (Program Director). [Client #3] came and hit [client #4] in the head with a wooden like stick. [Client #4] hit [client #3] back in (sic) tried to take the stick away from [client #3]. Staff [staff #3] stepped in and redirected the roommates to different areas. PD came by and was able to deescalate the situation. Roommates apologizes (sic) to each other and their parts in the incident. Both roommates sustained minor bruises and cuts. Staff applied first-aid and no further concerns noted. Staff will be retrained on ISP (Individual Support Plan) and BSP (Behavior Support Plan)." No record of documented effective corrective action was available for review in regard to staff monitoring or supervision to prevent clients #3 and #4 from repeating the behavior.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(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>06/10/13: A BDDS report for an incident at 9:30 PM indicated, "[Client #2] was dropped off at work and he decided to leave out (sic); go (sic) to the liquor store without informing the [day service name] staff. [Client #2] bought beer and may have consumed 18 oz's (ounces) of it. [Client #2] was found shortly by [day service] staff walking back towards the [day service]. [Client #2] was sent home and was picked up by [agency] staff. IDT (Interdisciplinary Team) will meet to come up plan to resolve." No record of documented effective corrective action was available for review in regard to staff monitoring or supervision to prevent client #2 from repeating the behavior.</p> <p>06/10/13: A BDDS report indicated, "Staff (unidentified) went to [client #2's] bedroom to prompt him to finish evening chores. Staff noticed [client #2] was not in the house, searched outside and [client #2] not (sic) found. Staff notified HM and PD. PD instructed staff to call Police for assistance. Police found [client #2] and (sic) the gas station close to the Group Home. Police took [staff #2] to [hospital name] Behavioral Center for evaluation. [Hospital name] staff felt [client #2] was safe to (sic) and released him back to staff. [Client #2] was placed on 15 minutes (sic) checks until IDT team</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250		
(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>is able to meet to discuss [client #2's] elopement." No record of documented effective corrective action was available for review in regard to staff monitoring or supervision to prevent client #2 from repeating the behavior.</p> <p>On 06/19/13 at 12:50 PM an interview was conducted with the Area Director (AD). The AD indicated there had been staff changes at that home and agency neglected to implement and document effective corrective action for the incidents.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250			
(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			
W000225	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills.</p> <p>Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to ensure the clients' vocational assessments included recommendations for future employment opportunities and/or individual preferences for future employment.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 06/18/13 at 11:45 AM. Client #1's ISP (Individual Support Plan) dated 01/09/13 failed to provide a vocational assessment which addressed future work options, interests, or work opportunities outside the facility.</p> <p>Client #2's record was reviewed on 06/18/13 at 12:21 PM. Client #2's ISP dated 11/16/12 failed to provide a vocational assessment which addressed future work options, interests, or work opportunities outside the facility.</p> <p>Client #3's record was reviewed on 06/18/13 at 1:43 PM. Client #3's ISP dated 05/10/13 failed to provide a vocational assessment which addressed future work options, interests, or work</p>	W000225	<p>A vocational assessment will be developed to evaluate the consumers' vocational needs and address items such as future work options, interests and possible work opportunities outside of the facility. This assessment will be given to all consumers to assess their vocational interests and abilities and will be utilized in conjunction with consumers IDT to plan for vocational needs. Once developed, all Program Directors will be trained on completing assessment to address consumers vocational needs at admission and a minimum of annually when the ISP is reviewed. Program Directors will also be trained to utilize vocational assessment in conjunction with consumers IDT to plan for consumers vocational needs. Responsible Party: Program Director, Area Director</p>	07/21/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>opportunities outside the facility.</p> <p>Client #4's record was reviewed on 06/18/13 at 2:35 PM. Client #4's ISP dated 11/16/12 failed to provide a vocational assessment which addressed future work options, interests, or work opportunities outside the facility.</p> <p>On 06/19/13 at 12:50 PM an interview was conducted with the Area Director (AD). The AD indicated the vocational assessments did not specifically address the clients' future work options, interests and/or work opportunities outside the facility.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W000248	<p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 3 of 4 sampled clients (clients #2, #3 and #4), the facility failed to ensure the clients' ISPs (Individual Support Plans) and BSPs (Behavior Support Plans) were received timely at the day program they attended.</p> <p>Findings include:</p> <p>A record review was conducted on 06/18/13 at 9:14 AM, of client #2, #3 and #4's records at the day program. The records did not include their current ISPs and BSPs.</p> <p>Client #2's day service record was reviewed on 06/18/13 at 9:14 AM. Client #2's record indicated the day service provider did not have the ISP or BSP. Client #2's record was reviewed on 06/18/13 at 12:21 PM. Client #2's record contained a signed receipt of documentation which indicated the day service provider had received a copy of the 11/16/12 ISP and the 12/13/12 BSP on 05/01/13.</p>	W000248	<p>The Home Manager and Program Director will receive retraining to include the need to ensure that Day Services are invited to all consumers Interdisciplinary Team Meetings to ensure the consumers whole team is involved in discussions and decisions made. In addition, the Home Manager and Program Director will receive retraining to ensure that Day Service Providers receive copies of completed/updated ISP, RMAP and BSPs as soon as possible once they have been approved by the consumers guardian and/or HRC as needed.</p> <p>The Area Director will review the next 3 ISPs completed by this Program Director to ensure that the Day Service programs are participating in the development of the ISP. The Area Director will provide further guidance as needed after the 3 reviews.</p> <p>Responsible Staff: Home Manager, Program Director, Area Director</p>	07/21/2013
---------	--	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250		
(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 #3's day service record was reviewed on 06/18/13 at 9:14 AM. Client #3's record indicated the day service provider did not have the ISP or BSP. The day service provider had not been provided with the current ISP dated 05/10/12 or the current BSP dated 08/24/12.</p> <p>Client #4's day service record was reviewed on 06/18/13 at 9:14 AM. Client #4's record indicated the day service provider did not have the ISP or BSP. Client #4's record was reviewed on 06/18/13 at 2:35 PM. Client #4's record contained a signed receipt of documentation which indicated the day service provider had received a copy of the 11/16/12 ISP and the 10/07/12 BSP on 05/01/13.</p> <p>An interview was conducted on 06/18/13 at 9:20 AM , with staff #1 of the day program. She indicated the day service had not been invited to the ISPs and she did not have the current ISPs and BSPs for clients #2, #3 and #4.</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250		
(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	
W000312	<p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (clients #2 and #4) who were on medications related to behaviors, by not ensuring the clients' Behavior Support Plans (BSP) included the medication in the plan.</p> <p>Findings include:</p> <p>1. Client #2's record was reviewed on 06/18/13 at 12:21 PM. Client #2's June 2013 physician's orders indicated he was taking Lithium Carbonate, Risperdal, Desyrel and Lexapro for his Psychosis and Depression.</p> <p>Client #2's 12/13/12 BSP indicated client #2 had behaviors which included aggression, irritability, elopement and suicidal ideation. The BSP did not mention the Desyrel.</p> <p>2. Client #4's record was reviewed on 06/18/13 at 2:35 PM. Client #4's June 2013 physician's orders indicated he was</p>	W000312	<p>The QIDP will convene the IDT for client #2 and #4. The IDT will assess the behaviors for which client #2 and #4 are prescribed medication and develop appropriate titration plans.</p> <p>The Behavior Consultant will be retrained on the requirement to include an appropriate plan to address medication withdrawal based on behaviors.</p> <p>The Behavior Consultant will revise the Behavior Plans to include the titration plans developed by the IDT.</p> <p>The QIDP will obtain required approvals as soon as the plan is available. The QIDP will also ensure the staff is trained on the implementation of the plans</p> <p>The QIDP will review each client's files to ensure each client that receives medication to manage behavior has an appropriate titration plan.</p> <p>Responsible Staff: Program Director, Area Director, Behavior Consultant</p>	07/21/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250		
(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>taking Risperdal, Wellbutrin and Concerta for his Mood Disorder and Attention Deficit Hyperactivity Disorder.</p> <p>Client #4's 10/07/12 BSP indicated client #4 had behaviors which included verbal and physical aggression, irritability, property destruction and inappropriate smoking. The BSP did not mention the Risperdal or Wellbutrin.</p> <p>On 06/19/13 at 12:50 PM an interview was conducted with the Area Director (AD). The AD indicated clients #2 and #4's BSPs should be accurate and reflect all of the current behavior meds.</p> <p>9-3-5(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/21/2013
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250		
(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	
W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 1 of 29 medication doses administered at the AM medication administration, the facility failed to follow physician orders for administering medication to 1 of 4 sampled clients (client #3).</p> <p>Findings include:</p> <p>The HM (House Manager) was observed administering medications to client #3 during the 06/17/13 observation period from 6:00 AM until 7:30 AM. At 6:38 AM client #3 was observed eating cereal at the dining room table. At 7:00 AM the HM called him into the medication area and administered a 125 microgram (mcg) tablet of Levothyroxine. The medication card was labeled with the instructions: "take 30 minutes before meals." The card also contained a pharmacy sticker which indicated, "Take on empty stomach, 1 hour before or 2-3 hours after meals." Client #3 walked back to the dining room table after his medication and continued to eat his cereal.</p>	W000369	<p>All staff will receive retraining on all consumers medication orders including Client #4 Omeprazole needing to be given 30 minutes prior to a meal.</p> <p>Home Manager and/or Program Director will complete medication administration observations at least twice per week for four weeks to ensure that all staff are following all consumers medication orders as written.</p> <p>Ongoing, the Home Manager and/or Program Director will complete medication administration observations at least once per week to ensure that all staff are following all consumers medication orders as written.</p> <p>Responsible staff: Home Manager, Program Director</p>	07/21/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(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 #3's records were reviewed on 06/18/13 at 1:43 PM. Client #3's June 2013 Physician's Orders and June 2013 Medication Administration Record (MAR) indicated the order for the medication, "Levothyroxine tablet 125 mcg; take 1 tablet by mouth every day (30 mins (minutes) before meal)."</p> <p>On 06/19/13 at 12:50 PM an interview was conducted with the Area Director (AD). The AD indicated the HM should have followed the medication instructions and client #3 should not start eating before receiving his medication.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(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
W000374	<p>483.460(k)(7) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with State law.</p> <p>Based on observation, interview, and record review, the facility failed for 1 of 4 clients (client #1) observed during the AM medication administration, to ensure that medications are packaged and labeled properly by the pharmacy.</p> <p>Findings include:</p> <p>On 06/17/13 at 6:47 AM the HM (House Manager) was observed to tear open a small white envelope which contained client #1's name and with the time written of 7 AM. The HM dumped all the pills from the envelope into a medication cup. The cup contained eleven pills. One by one the HM was observed to pick up a pill from the medication cup with her gloved finger and match it to a medication card which contained pills which looked like the one she was attempting to match. Once a match was made the HM placed the pill in her hand into a second medication cup. She went through this process matching pills from the envelope with a medication card which contained a like looking pill, until all the pills had</p>	W000374	<p>All staff will receive retraining on all consumers medication orders including not dispensing any consumers medications that have not been properly packaged and labeled by the pharmacy. Home Manager and/or Program Director will complete medication administration observations at least twice per week for four weeks to ensure that all staff are following all consumers' medication orders as written and are not dispensing consumer's medications that have not been properly packaged and labeled by the pharmacy. Ongoing, the Home Manager and/or Program Director will complete medication administration observations at least once per week to ensure that all staff are following all consumers medication orders as written and are not dispensing consumer's medications that have not been properly packaged and labeled by the pharmacy. Responsible staff: Home Manager, Program Director</p>	07/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(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>been matched. Client #1 took the pills at 6:53 AM.</p> <p>On 06/17/13 at 6:56 AM an interview was conducted with the HM. The HM indicated the pills in the envelope had been packaged by the staff (unidentified) and sent home with client #1, however he returned earlier than anticipated and she was using the 7 AM dose now. She indicated the staff on duty when a client was going home would place the client's medication in an envelope and identify the envelope with the client's name and the time of the scheduled medication dose. She indicated the envelopes were then given to the family.</p> <p>On 06/17/13 at 5:45 PM, a review of the Living in the Community: Medication Administration Manual, Product of: Education and Training Resources, 2004, was completed. In Core Lesson 3: Principles of Administering Medications, page 32, under the caption, Key Points about Maintaining Medications, the manual indicated, "...do not re-label the medication. A pharmacist must re-label medications."</p> <p>On 06/19/13 at 12:50 PM an interview was conducted with the Area Director (AD). The AD indicated staff were trained in Core A and Core B and all medications should contain pharmacy</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/21/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(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>labels and staff should not be dispensing medications into an envelope and writing the client's name on the front with the dose time.</p> <p>9-3-6(a)</p>			