

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G369	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/19/2014
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NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
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W000000	<p>This visit was for the investigation of complaint #IN00158626.</p> <p>Complaint #IN00158626: Substantiated, Federal and State deficiencies related to the allegations are cited at W104 and W149.</p> <p>Survey Dates: November 12, 13, 14 and 19, 2014.</p> <p>Facility Number: 000883 Provider Number: 15G369 AIMS Number: 100244300</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed November 26, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 1 of 4 sampled clients (B), the governing body failed to exercise general policy and operating direction over the facility to prevent the neglect of client B.</p>	W000104	The Program Director implemented a more effective procedure in the home for the exiting and incoming staff to communicate in a written form which clients are present in the home. This also includes a	12/19/2014

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.

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W000149	<p>Findings include:</p> <p>The governing body failed to implement written policy and procedures to prevent the neglect of client B. Please see W149.</p> <p>This federal tag relates to complaint #IN00158626.</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 4 sampled clients (B), the facility failed to implement written policy and procedures to prevent the neglect of client B.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 11/12/14 at 2:30 PM. The 10/25/14 BDDS (Bureau of Developmental Disabilities Services)</p>	W000149	<p>physical walkthrough required by staff to check each client's bed before vacating the home for transport. Program Director and Home Manager completed and in-servicetraining with the staff on 11/28/2014 implementing the above procedure to communicate the census of the clients in the home each day. Home Manager will complete observations in the home 3 times weekly for 30 days and the Program Director once weekly to ensure that the new procedure is being implemented as trained. Ongoing, the Home Manager will complete observations per established frequency. Responsible Party: Program Director and Home Manager</p> <p>The Program Director implemented a more effective procedure in the home for the exiting and incoming staff to communicate in a written form which clients are present in the home. This also includes a physical walk through required by staff to check each client's bed before vacating the home for transport. Program Director and Home Manager completed and in-service training with the staff on 11/28/2014 implementing the above procedure to communicate</p>	12/19/2014

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	<p>report indicated on 10/24/14 at 4:30 PM "Staff went to pick up clients at the day service program and accidentally left one client at the group home while she (the staff) went to pick up the other clients. When the staff realized she had left [client B] at home she immediately called the home manager who lives down the street from the group home. The home manager went to the home and the client was still in the bed with the cover over her. Program Director requested the client be taken to a physician to determine that the client was ok. A review of the client by a physician revealed no signs of trauma. Program Director installed effective immediately for the staff leaving for the day to record in the communication log the clients that are present at the home so that the incoming staff are aware of all clients in the home so that in the event the incoming staff has to leave and take clients with them they will have an account of all clients in the home (sic). The staff arriving for work that may have to leave to pick up other clients will review the communication log in addition will do a room check to include a thorough search of each room in the home as well a search of the bed to ensure all clients are accounted for prior to leaving the home for any reason. Staff has received a disciplinary corrective</p>		<p>the census of the clients in the home each day. Home Manager will complete observations in the home 3 times weekly for 30 days and the Program Director once weekly to ensure that the new procedure is being implemented as trained. Ongoing, the Home Manager will complete observations per established frequency. Responsible Party: Program Director and Home Manager</p>	

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	<p>action for leaving a client unattended by not making a thorough search of the home prior to leaving to pick up other clients at the day service."</p> <p>The Summary of Internal Investigation Report dated 10/28/14 indicated client B was left alone and unsupervised at the group home for 1.5 hours. The report indicated staff #5 called the HM (Home Manager) on 10/24/14 at 3:46 PM to inform the HM that client B was not at the day services. The HM informed staff #5 that client B had stayed home from the day services on 10/24/14 due to an appointment with the doctor. The HM indicated the day shift staff "should have told" staff #5 that client B was still at the group home. The report indicated the HM went to the group home and found client B in bed asleep. The HM called the PD (Program Director) and was informed to take client B to the hospital to have a physician examine her to ensure no trauma.</p> <p>The facility's abuse and neglect policy entitled, "Quality and Risk Management" dated 4/11 was reviewed on 11/12/14 at 3 PM. The policy indicated neglect to be, not all inclusive, "Failure to provide appropriate supervision, care or training."</p> <p>During interview with staff #1 on</p>						

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	<p>11/13/14 at 7:30 AM, staff #1 indicated she did not work the day client B was left at home alone but had heard about it. Staff #1 indicated staff #6 had told staff #5 prior to leaving his shift there were three clients remaining in the home and would have to go on transport with staff #5 to pick up the remainder of the clients in the group home. Staff #1 stated, "Apparently she didn't hear him (staff #6) or check the rooms before she (staff #5) left the house." Staff #1 stated staff #5 "should have" checked every bed room thoroughly prior to leaving the home.</p> <p>Interview with the PD on 11/14/14 at 3 PM indicated the morning staff were to write in the staff log which clients if any did not go to the day services and the evening shift staff were to check the log before leaving the home to go on transport. The PD indicated the staff were to also do a thorough check of the group home prior to leaving to ensure no clients were left behind. The PD stated "None of the clients" were to be left home alone and unsupervised.</p> <p>This federal tag relates to complaint #IN00158626.</p> <p>9-3-2(a)</p>			