STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G265		09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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	This visit was for a pre-determined full recertification and state licensure survey. Dates of Survey: 9/22, 9/23, 9/24, 9/25, 9/28, 9/29, and 9/30/2015. Provider Number: 15G265 Facility Number: 000785 AIM Number: 100249010 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 10/2/15.	W 0000		
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients #1, #2, and #3) and 2 additional clients (clients #4 and #5), the facility failed to ensure unimpeded access to the locked sharp objects, locked food and snacks, and locked chemicals for clients	W 0125	The facility has policies and procedures in place to ensure the rights of all clients. The facility allows and encourages the individuals to exercise their rights as clients of the facility, and as citizens of the United States including their right to due process.	10/30/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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: 15G265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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
	#1, #2, #3, #4, and #5 who did not have documented assessments for the restricted access to the locked items. Findings include: On 9/22/15 from 3:50pm until 7:20pm, and on 9/23/15 from 5:45am until 7:30am, clients #1, #2, #3, #4, and #5 were observed at the group home and facility staff had the only available keys to locked sharp objects, locked food and snacks, and locked chemicals. During the observation periods clients #1, #2, #3, #4, and #5 were not offered or encouraged by the facility staff to access locked items. During both observation periods the RM (Residential Manager), Group Home Staff (GHS) #1, GHS #2, GHS #3, GHS #4, and GHS #5 used a key to unlock two of two (2 of 2) locked closets which held locked items: chemicals, sharp objects, snacks, and food. During both observation periods clients #1, #2, #3, #4, and #5 were not offered the opportunity by staff to select their items for use from the closets. During both observation periods group home staff selected items of food, a knife to cook, and snack items from the locked closets to serve clients. On 9/22/15 at 4:15pm, GHS #4 showed the "staff closets" and stated inside each closet (two of two closets) were locked "sharp		The facility has ensured all items, including sharp objects, food, snacks, and chemicals are unlocked at all times and individuals have unimpeded access to these items as no current individuals have the need for items to be locked. In the future, should any individual require the need for an object to be locked, the facility will ensure an assessment is completed and that all other less restrictive measures have been explored, as well as appropriate consent being obtained. All staff will be retrained in the need to ensure all items are unlocked and individuals have unimpeded access to these items. Staff will be retrained in the need to notify a supervisor if an individual should require an item to be restricted at which point the QIDP and IDT would meet to discuss this restrictive measures, as well as completing an assessment to determine the need. Should the IDT agree with these restrictive measures, informed consent by all individuals impacted by the restrictive measure and Human Rights Committee must be obtained. A member of management, the facility nurse, or a member of Quality Assurance will complete an observation at least three times weekly for a minimum of 30 days to ensure items are not locked and individuals have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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
	objects, food, snacks, and chemicals." On 9/23/15 at 6:45am, clients #1, #2, #3, #4, and #5 sat down at the dining room table for breakfast. At 6:45am, clients #1, #2, and #5 requested syrup for their waffles. At 6:45am, GHS #5 obtained the key ring from the desk, opened the locked closet, removed a bottle of maple syrup from the secured closet, and set the maple syrup bottle on the dining room table. At 7:00am, after clients #1, #2, #3, and #5 had used the syrup bottle, GHS #5 picked up the bottle and returned it inside the locked closet. At 7:00am, GHS #5 stated she had "no idea" why food, sharp objects, snacks, and chemicals were kept locked inside the group home. GHS #5 indicated the locked restrictions were in place before she was hired six months ago and items have continued to be locked. On 9/25/15 at 8:35am, client #1's record was reviewed. Client #1's 2/25/15 ISP (Individual Support Plan) and 2015 CFA (Comprehensive Functional Assessment) did not indicate an identified need to lock sharp objects, snacks, food items, and chemicals. Client #1's record did not indicate consent for locked items. On 9/24/15 at 3:45pm, and on 9/25/15 at 9:05am, client #2's record was reviewed.		unimpeded access. If continuous and complete compliance has been achieved, observations will continue at least weekly for an additional 30 days. If continuous and complete compliance remains, observations will be completed as needed moving forward. Person Responsible: Area Director Date of Completion: October 30, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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
	Client #2's 10/16/14 ISP and undated CFA did not indicate an identified need to lock sharp objects, snacks, food items, and chemicals. Client #2's record did not indicate consent for locked items. On 9/25/15 at 9:40am, client #3's record was reviewed. Client #3's 12/10/14 ISP and CFA did not indicate an identified need to lock sharp objects, snacks, food items, and chemicals. Client #3's record did not indicate consent for locked items. On 9/25/15 at 12:15pm, an interview was conducted with the AD (Area Director), PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) #1, and PD/QIDP #2. PD/QIDP #1 indicated clients #1, #2, #3, #4, and #5's sharps, food items, snacks, and chemicals were kept locked at the group home. PD/QIDP #1 indicated clients #1, #2, #3, #4, and #5 did not have a key to access the items, did not have goals or a plan to decrease the restrictions of the locked items, and stated "only staff" had keys to the locked items. PD/QIDP #1 indicated she was unsure if clients #1, #2, #3, #4, and #5 had given consent for the locked items. PD/QIDP #1 indicated no assessments were completed for clients #1, #2, #3, #4, and #5. No reason was provided and/or available for review of why sharp objects, food, snacks, and chemicals were kept			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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
	locked inside two of two closets at the group home. The AD indicated client #1, #2, #3, #4, and #5's sharps, food items, snacks, and chemicals were kept locked at the group home. The AD indicated no other information was available for review regarding the locked items. 9-3-2(a)			
W 0225 Bldg. 00	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on observation, record review, and interview, for 1 of 3 sampled clients (client #1), the facility failed to reassess client #1's vocational abilities related to his individual work history, work skills, and work interests after his continued behavioral needs resulted in workshop suspension and a facility owned day services referral. Findings include: On 9/24/15 from 9:50am until 10:57am, the contracted workshop was observed and client #1 was not present. On 9/24/15 from 8:45am until 9:45am, client #1 was observed at the facility owned day services and did not complete paid work. From 8:45am until 9:45am,	W 0225	The facility has policies in place to ensure a comprehensive functional assessment is completed for each individual, including vocational skills, as applicable. Client #1 will have a more thorough vocational assessment completing including details about his work history and work interests. Client #1's records will also be updated to include his suspension from his previously contracted workshop. The QIDP will be retrained on the need to have a current vocational assessment. In the future, the facility will ensure the vocational assessments completed for individuals include work history and work interests. Additionally, the Area Director will review the next two ISP's to ensure vocational assessments are included, as applicable.	10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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
	client #1 sat on a sofa and looked at pictures and a magazine without his prescribed eye glasses. From 9:30am until 9:45am, client #1 looked at pictures, a magazine, and got up to walk to the refrigerator to retrieve a packaged container of fruit. Client #1 opened the fruit and drank both the fluid and fruit pieces without using a spoon (or utensil). At 9:30am, client #1 stated "I can do whatever I want." On 9/24/15 at 9:45am, client #1's facility owned day services record was reviewed. Client #1's record did not include a current vocational assessment. Client #1's record was reviewed on 9/25/15 at 8:35am. Client #1's 2/25/15 ISP (Individual Support Plan) and 2/2015 Risk Assessment did not include his work history and/or work interests. No vocational assessment was available for review. No day services active treatment goal was available for review. On 9/25/15 at 12:15pm, an interview was conducted with the AD (Area Director), PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) #1, and PD/QIDP #2. PD/QIDP #1 and AD both stated client #1 had been suspended "indefinitely" from the contracted workshop because of client #1's continued behavioral outbursts. The AD		Person Responsible: Area Director Date of Completion: October 30, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G265		09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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
	indicated client #1 began attending the facility owned day services within the past year because of his behaviors at the contracted workshop. On 9/25/15 at 5:00pm, the AD provided client #1's 2/26/15 "Behavioral Functional (Assessment)...Vocational (Assessment)" which indicated client #1 was independent with identifying his boss, understands and follows instructions, stays at work for required periods, handles tools safely, can do folding jobs, can do stacking jobs, can do yard work, can do packing jobs...." Client #1's 2/26/15 vocational assessment indicated he was not able to complete the following: getting to work on time, to work without supervision, respond well to criticism, use lunch facilities, respond appropriately to boss, start work without prompting, operate time clock, respond to a job interview, do sorting jobs, do janitorial work, and assemble by screwing parts. Client #1's 2/26/15 vocational assessment did not include his work history and work interests. Client #1's record did not indicate he had been suspended "indefinitely" by the contracted workshop because of his behaviors. The AD provided client #1's IDT (Interdisciplinary Team) meeting minutes from the contracted workshop for 4/29/14 which indicated client #1 had			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G265		09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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
	"extreme behaviors in past 60 days... (resulting in) suspension x (times) 60 days." An 8/28/14 Workshop IDT indicated client #1 "was involved in an incident that caused an individual to fall." A 9/22/14 Workshop IDT indicated "Discussion over [client #1's] recent behaviors and unprofessional antics and attitude at work...faking falls...tape of horseplay at work...potential suspension...Outcome: Suspend [client #1] Indefinitely." 9-3-4(a)			
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview, for 3 of 9 medications administered (for clients #1 and #4) during the evening medication administration, the facility failed to administer medications without error for clients #1 and #4. Findings include: 1. On 9/22/15 at 4:35pm, GHS (Group Home Staff) #4 selected client #4's "Artificial Tears OP (Optic) Sol	W 0369	The facility has policies and procedures in place for the proper administration of medications. For individuals that self-administer medications, these policies are in place to ensure these medications are administered without error. The facility will retrain staff on medication administration procedures, including ensuring medications are administered without error. Staff will actively work with the individuals that self-administer medications to ensure the proper number of eye drops and nasal sprays are	10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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
	(Solution), place 1 drop in the right eye four times daily for moisture," handed the Artificial Tear medication bottle to client #4, and client #4 placed three (3) drops into her right eye. At 4:35pm, GHS #4 selected client #4's "Saline Nasal Spray 0.65% Sol, spray 2 sprays into each nostril four times daily (for moisture)." GHS #4 handed the nasal spray to client #4, and client #4 pumped three (3) sprays from the medication bottle into each nostril. No staff redirection was observed. On 9/24/15 at 12:38pm, client #4's 9/2015 MAR (Medication Administration Record) and 6/2015 "Physician's Order" both indicated "Artificial Tears OP (Optic) Sol (Solution), place 1 drop in the right eye four times daily for moisture" and "Saline Nasal Spray 0.65% Sol, spray 2 sprays into each nostril four times daily (for moisture)" 2. On 9/22/15 at 3:50pm, client #1 was observed at the group home with GHS #4. At 3:55pm, GHS #4 stated client #1 had stayed home from day services because he was diagnosed with "strep throat," was prescribed an antibiotic the day before, and was not feeling well. From 3:50pm until 7:20pm, client #1 was observed to cough, sneeze, and complain he was not feeling well multiple times.		administered and direction is offered. Additionally, staff will be retrained on confirming medications match Physician's Orders before administration and that every individual has their own properly labeled medication card from the pharmacy. A member of management or the facility nurse will complete a medication administration observation at least three times weekly for a minimum of 30 days. If continuous and complete compliance has been achieved, medication administration observations will continue at least weekly for an additional 30 days. If continuous and complete compliance remains, medication administration observations will be completed as needed moving forward. Person Responsible: Area Director Date of Completion: October 30, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G265		09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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
	At 4:50pm, GHS #4 administered client #1's medications and client #1 requested "Tylenol" for his discomfort. GHS #4 selected an unlabeled bottle of "Acetaminophen 500mg (milligrams)" from a shelf inside the medication cabinet, stated it was "house stock" medication, and gave client #1 two (2) tablets to consume. Client #1 took the two tablets of "Acetaminophen 500mg" medication with water and left the medication room. On 9/25/15 at 8:25am, client #1's 9/2015 MAR and 6/2015 "Physician's Order" both indicated "Acetaminophen 325mg PO (by mouth) tab (tablets), take 2 tablets every 4 hours as needed for pain, discomfort, and temperature over 100 (degrees)." Client #1's 9/2015 MAR indicated an entry by GHS #4 on 9/22/15 "4:50pm...Acetaminophen 325mg x (times) 2 (for) headache." On 9/24/15 at 1:00pm, an interview with the agency nurse was conducted. The agency nurse indicated staff should ensure client #4's physician's orders were followed for client #4's nose spray and eye medications. The agency nurse indicated the facility followed the Core A/Core B training for medication administration and the facility's policy and procedure for medication			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15G265		09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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
	administration. The agency nurse indicated each client should have a medication card from pharmacy for Acetaminophen also known as Tylenol. The agency nurse indicated client #1 should have received two (2) tablets of 325mg Tylenol not 500mg. The agency nurse indicated staff did not follow physician's orders. On 9/25/15 at 12:15pm, an interview was conducted with the AD (Area Director), PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) #1, and PD/QIDP #2. PD/QIDP #1 indicated client #1 and #4's medications should be administered according to physician's orders. PD/QIDP #1 and the AD both indicated the facility followed Core A/Core B Medication Administration Training. On 9/24/15 at 1:30pm, a review was conducted of the facility's 4/2011 "Health" policy and procedures and the 4/2011 "Medication Administration Handbook" which both indicated each client's physician orders should be followed. On 9/24/15 at 1:30pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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
	"Core Lesson 3: Principles of Administering Medication" medications should be administered according to physician's orders. 9-3-6(a)			
W 0383 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients #1, #2, and #3) and 2 additional clients (clients #4 and #5), the facility staff failed to ensure the medication keys were kept secured and to ensure clients #1, #2, #3, #4, and #5 did not have access to the medication keys. Findings include: On 9/23/15 from 5:45am until 7:30am, clients #1, #2, #3, #4, and #5 were observed at the group home and the medication keys lay unsecured on top of the staff desk located between the living room and the dining room. During the observation period clients #1, #2, #3, #4, and #5 independently accessed the areas inside the group home. At 6:20am, GHS (Group Home Staff) #2 administered clients #1, #4, and #6's medications. At 6:35am, GHS #2 indicated the	W 0383	The facility has policies and procedures in place regarding medication administration and the proper storage and safeguarding of medications. The facility will retrain staff on the need to keep the keys to the medication cabinet secured at all times. A member of management or the facility nurse will complete an observation at least three times weekly for a minimum of 30 days to ensure the medication cabinet keep is being secured by staff at all times. If continuous and complete compliance has been achieved, observations will continue at least weekly for an additional 30 days. If continuous and complete compliance remains, observations will be completed as needed moving forward. Person Responsible: Area Director Date of Completion: October 30, 2015	10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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
	medication keys were kept on the staff desk located between the living room and dining room when staff was not using the keys. GHS #2 stated the medication keys were "unsecured" when kept on top of the desk. At 6:35am, GHS #2 indicated clients #1, #2, #3, #4, and #5's medications were kept inside the medication cabinet. On 9/25/15 at 12:15pm, an interview was conducted with the AD (Area Director), PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) #1, and PD/QIDP #2. PD/QIDP #1 indicated clients #1, #2, #3, #4, and #5's medications were stored inside the medication cabinet and the medication keys were not secure when the keys were left out on top of the staff's desk. PD/QIDP #1 stated the medication cabinet keys should be kept secured at "all times." PD/QIDP #1 and the AD both indicated the facility followed Core A/Core B Medication Administration Training. On 9/24/15 at 1:30pm, a review was conducted of the facility's 4/2011 "Health" policy and procedures and the 4/2011 "Medication Administration Handbook" both of which indicated the medication cabinet keys should be kept secured by the facility staff.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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
	On 9/24/15 at 1:00pm, an interview with the agency nurse was conducted. The agency nurse indicated medication cabinet keys should be kept secured when medications were not administered. The agency nurse indicated the facility followed "Living in the Community" for medication administration. On 9/24/15 at 1:30pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications keys should be kept secured. 9-3-6(a)			
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 1 of 2 sampled clients (client #1) with adaptive equipment, facility failed to have available and encourage client #1 to wear his prescribed eye glasses when	W 0436	The facility has policies in place to furnish, maintain in good repair, and teach individuals to use and make informed choices about the use of adaptive equipment, such as eyeglass as identified by the Interdisciplinary Team as needed by the	10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/30/2015
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 926 S TENTH ST LAFAYETTE, IN 47905	

(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
	opportunities existed. Findings include: On 9/22/15 from 3:50pm until 7:20pm, and on 9/23/15 from 5:45am until 7:30am, client #1 did not wear his prescribed eye glasses at the group home. Client #1 watched television, wrote in a book, read a book, and looked at his MAR (Medication Administration Record). Client #1 was not prompted and/or encouraged to wear his prescribed eye glasses. On 9/24/15 from 8:45am until 9:45am, client #1 was observed at the facility owned day services and did not wear his prescribed eye glasses. From 8:45am until 9:45am, client #1 sat on a sofa and looked at pictures and a magazine without his prescribed eye glasses. From 9:30am until 9:45am, client #1 looked at pictures, a magazine, and got up to walk to the refrigerator to retrieve a packaged container of fruit. Client #1 opened the fruit and drank both the fluid and fruit pieces without using a spoon (or utensil). At 9:30am, client #1 stated "I can do whatever I want." Client #1's record was reviewed on 9/25/15 at 8:35am. Client #1's 2/25/15 ISP (Individual Support Plan) and 2/2015		individual. The facility will retrain staff to encourage Client #1 to wear his glasses as applicable and whenever an opportunity exists. A member of management will complete observations at least three times weekly for a minimum of 30 days to ensure staff are encouraging Client #1 to wear his glasses. If continuous and complete compliance has been achieved, observations will continue at least weekly for an additional 30 days. If continuous and complete compliance remains, observations will be completed as needed moving forward. Person Responsible: Area Director Date of Completion: October 30, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G265		09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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
	Risk Assessment indicated he wore prescribed eye glasses and indicated an objective/goal to "put on his (eye) glasses in AM (morning) and off in PM (at night)." Client #1's 12/7/13 visual evaluation indicated he wore prescribed eye glasses to see. On 9/25/15 at 12:15pm, an interview was conducted with the AD (Area Director), PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) #1, and PD/QIDP #2. PD/QIDP #1 and AD both stated client #1 wore prescribed "eye glasses" to see. Both staff indicated client #1 should have been prompted and encouraged to wear his prescribed eye glasses when opportunities existed. 9-3-7(a)			
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 3 of 3 sampled clients (#1, #2, and #3) and 2 additional clients (#4 and #5), to ensure an evacuation drill was conducted at least every 90 days for the day shift (7:00 AM - 3:00 PM) of personnel. Findings include:	W 0440	The facility has developed an emergency drill schedule to inform the QIDP as to when drills are to be completed. This schedule allows for a drill to be completed for each shift of work every quarter. The QIDP and all staff will be retrained in the evacuation drill procedures and documentation requirements.	10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G265		09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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
	The facility's evacuation drills were reviewed on 9/24/15 at 11:25am. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, and #5 for the period before 10/7/14 and after 4/18/15 calendar year for the day shift of personnel. An interview with the Area Director (AD), PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) #1, and PD/QIDP #2 was conducted on 9/25/15 at 12:15pm. The AD and PD/QIDP #2 both indicated the day shift of personnel was 7:00am until 3:00pm daily. The AD indicated he was unable to locate any more evacuation drills for clients #1, #2, #3, #4, and #5. 9-3-7(a)		The QIDP is responsible for ensuring that the drill has been completed and turned in for review. The completed and reviewed drills are then submitted to the Area Director for further review and follow up as needed. Person Responsible: Area Director Date of Completion: October 30, 2015	
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients #1, #2, and #3) and 2 additional clients (clients #4 and #5), the facility failed to implement and teach sanitary methods when opportunities existed.	W 0455	The facility has policies and procedures in place for the prevention, control, and investigation of infection and communicable diseases, including implementation and teaching sanitary methods when opportunities exist.	10/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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
	Findings include: 1. On 9/22/15 at 4:35pm, GHS (Group Home Staff) #4 selected client #4's oral medications for administration. Client #4 complained to GHS #4 that she had vomited four (4) times at the workshop today. From 4:35pm until 4:47pm, client #4 coughed, sneezed, then vomited into a trash can three (3) additional times. Client #4 was not prompted and/or encouraged to wash her hands between periods of coughing into her hand then handling the trash can and wiping vomit from her chin. At 4:47pm, GHS #4 indicated client #4's temperature was 98.4 degrees Fahrenheit. Client #4 applied an arthritic pain cream to her knees and elbows without washing her hands. No handwashing was observed. 2. On 9/22/15 at 3:50pm, client #1 was observed at the group home with GHS #4. At 3:55pm, GHS #4 stated client #1 had stayed home from day services because he was diagnosed with "strep throat," was prescribed an antibiotic the day before, and was not feeling well. From 3:50pm until 7:20pm, client #1 was observed to cough, sneeze, and complain he was not feeling well multiple times. Client #1 did not wash his hands after covering his mouth and coughing into his		The facility will retrain staff on proper hand washing procedures to reduce the possibility of infection and communicable diseases. Additionally, staff will be retrained on ensuring medications are administered in a manner that reduces the possibility of contamination and that clients are taught proper sanitary methods whenever opportunities exist. A member of management, the facility nurse, or a member of Quality Assurance will complete an observation at least three times weekly for a minimum of 30 days to ensure clients are being prompted to wash their hands to prevent infection of communicable diseases. If continuous and complete compliance has been achieved, observations will continue at least weekly for an additional 30 days. If continuous and complete compliance remains, observations will be completed as needed moving forward. Person Responsible: Area Director Date of Completion: October 30, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/30/2015
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 926 S TENTH ST LAFAYETTE, IN 47905	

(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
	hands. At 4:50pm, GHS #4 administered client #1's medications, client #1 did not wash his hands, and client #1 requested "Tylenol" for his discomfort. GHS #4 selected an unlabeled bottle of "Acetaminophen 500mg (milligrams)" from a shelf inside the medication cabinet, stated it was "house stock" medication, and gave client #1 two (2) tablets to consume. Client #1 took the two tablets into his unwashed hands of "Acetaminophen 500mg" medication and drank water then left the medication room. On 9/24/15 at 1:00pm, an interview with the agency nurse was conducted. The agency nurse indicated staff should ensure clients #1 and #4 washed their hands before medication administration was completed. The agency nurse indicated the facility followed Universal Precautions to prevent the spread of infection. The agency nurse stated client #1 had diagnosed "Step throat" and client #4 had Flu like symptoms. The agency nurse indicated client #4 was seen on 9/22/15 at Urgent Care for her medical needs. The agency nurse indicated the facility followed the Core A/Core B training for Universal Precautions. On 9/25/15 at 12:15pm, an interview was conducted with the AD (Area Director),			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15G265		09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	926 S TENTH ST LAFAYETTE, IN 47905

(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
	PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) #1, and PD/QIDP #2. PD/QIDP #1 indicated clients #1 and #4 were ill. The AD indicated clients #1, #2, #3, #4, and #5 lived together in the group home and stated "it has run rampant here lately." PD/QIDP #1 and the AD both indicated the facility followed Core A/Core B Medication Administration Training for Universal Precautions. On 9/24/15 at 1:30pm, the undated Core A/Core B Medication Administration training manual page 3 indicated "Universal precautions" included washing hands before medication administration, before eating, and after using the restroom. 9-3-7(a)			