STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G417	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	5625 E 56TH ST INDIANAPOLIS, IN 46226

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W000000	This visit was for a PCR (Post Certification Revisit) to the extended annual recertification and state licensure survey completed on 12/9/13. This visit was done in conjunction with the investigation of complaint #IN00147011. Dates of Survey: 4/8/14, 4/9/14 and 4/10/14. Facility Number: 000931 Provider Number: 15G417 AIMS Number: 100244550 Surveyor: Keith Briner, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/16/14 by Ruth Shackelford, QIDP.	W000000		
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 2 of 4 sampled clients (A and C), the	W000104	The Home Manager and Program Director will complete an audit of all consumers finances, to	05/10/2014

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.

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	governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients A and C's finances were not in excess of predetermined maximum amount allowed by Medicaid. Findings include: 1. Client A's financial record was reviewed on 4/8/14 at 4:17 PM. Client A's facility based 4/8/14 cluster account ledger balance was $3,437.28. 2. Client C's financial record was reviewed on 4/8/14 at 4:18 PM. Client C's facility based 4/8/14 cluster account ledger balance was $5,384.01. AD (Area Director) #1 was interviewed on 4/9/14 at 10:52 AM. AD #1 indicated the predetermined maximum amount allowed by Medicaid for clients receiving services was $2.000.00. AD #1 indicated clients A and C's finances were in excess of the $2.000.00 limit. This deficiency was cited on 12/9/13. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-1(a)		determine if anyone's account balance is in excess of the allowable amount. If any consumers account balances are in excess of the allowable amount the Home Manager and Program Director will work with the Social Worker and Client Finance Specialist to spend the money in an appropriate manner to get the balance below the allowable amount. The Home Manager and Program Director will receive retraining on consumers' finances including ensuring that all consumers' accounts are below the allowable amount. Ongoing the Client Finance Specialist will provide a record monthly to the Area Director of all consumers that have an account balance in excess of the allowable amount. The Area Director will ensure that the Program Director and Home Manager are notified so they can work with the Social Worker and Client Finance Specialist to spend the money in an appropriate manner to get the balance below the allowable amount. *Addendum: Client A most recent cluster account balance is below the allocated $2000 limit. The Program Director and Social Worker have completed the paperwork to get Client C an Arc Trust to put his money set up so*	

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			that his cluster account balance can be below the $2000 Medicaid allocation. *Weekly for the next 3 months, the Area Director will obtain a copy of the consumers cluster account balances to ensure that consumers cluster account balances are below the $2000 allocation.* Responsible Party: Home Manager, Program Director, Area Director, Client Finance Specialist	
W000263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 3 of 3 sampled clients (B, C and D) with restrictive programs, the facility's HRC (Human Rights Committee) failed to obtain the written informed consent of clients B, C and D and/or HCRs (Health Care Representatives) before the use of psychotropic medications for the management of clients B, C and D's behavior. Findings include: 1. Client B's record was reviewed on 4/9/14 at 12:03 PM. Client B's POF (Physician Order Form) dated 3/27/14 indicated client B received Escitalopram	W000263	The Program Director will receive retraining on ensuring that any updates or changes to consumers' Behavior Support Plans or psychotropic medications are reviewed and written consent is obtained by the consumers Guardian or Health Care Representative or the consumer if they are emancipated prior to getting HRC approval. Ongoing the Program Director will ensure any updates or changes to consumers' Behavior Support Plans or psychotropic medications are reviewed and written consent is obtained by the consumers Guardian or Health Care Representative or the consumer if they are emancipated prior to	05/10/2014

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	10 milligrams daily at 7:00 AM (started on 10/5/12). Client B's ISP (Individual Support Plan) dated 6/18/13 indicated client B had a HCR (Health Care Representative). Client B's record did not indicate documentation of client B or client B's HCR's written informed consent before the use of Escitalopram 10 milligrams for depression. 2. Client C's record was reviewed on 4/9/14 at 12:44 PM. Client C's BSP (Behavior Support Plan) dated March 2014 indicated client C received Cymbalta 20 milligrams (depression). Client C's POF dated 3/28/14 indicated client C's received duloxetine 20 milligrams (started on 8/14/12). Client C's ISP dated 12/20/13 indicated client C was emancipated with an advocate. Client C's record did not indicate documentation of client C's written informed consent before the use of Cymbalta 20 milligrams for depression. 3. Client D's record was reviewed on 4/9/14 at 12:34 PM. Client D's POF dated 3/28/14 indicated client D received Quetiapine 25 milligrams (depression) one tablet by mouth at bedtime (started on 2/3/14). Client D's ISP dated 3/7/14 indicated client D was an emancipated adult with an advocate. Client D's record did not indicate documentation of client		getting HRC approval. Program Director will ensure that documentation of guardian or client approval is available for review. Prior to any future Human Rights Committee meetings, the HRC will be reminded that they should not approve any changes to Behavior Support Plans or psychotropic medications without ensuring that guardian or client, if emancipated, approvals have been obtained. *Addendum:* *1.Client B's Health Care Representative has provided written consent for Client B to use Escitalopram 10 mg for Depression.* *2.Client C provided written consent for the use of Cymbalta 20 mg for depression* *3.Cleitn D provided written consent for the use of Quetiapine 25 mg for depression.* *Program Director received additional retraining to include ensuring that any updates or changes to consumers' Behavior Support Plans or psychotropic medications are reviewed and written consent is obtained by the consumers Guardian or Health Care Representative or the consumer if they are emancipated prior to getting HRC approval.* *Area Director has completed an audit of all consumers Behavior Support Plans to ensure that written consent has been obtained by the consumers Guardian or Health Care Representative or the consumer if*	

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	D's written informed consent before the use of Quetiapine 25 milligrams for depression. AD (Area Director) #1 was interviewed on 4/9/14 at 10:52 AM. AD #1 indicated written informed consent was needed for the use of psychotropic medications prior to implementation. This deficiency was cited on 12/9/13. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-4(a)		*they are emancipated prior to getting HRC approval* Responsible Party: Program Director, Human Rights Committee	
W000312	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. Based on record review and interview for 1 of 3 sampled clients receiving medications to control behaviors (client D), the facility failed to implement a plan of reduction the client could achieve to reduce and eventually eliminate the behavior for which the client received psychoactive medication. Findings include:	W000312	The QIDP will convene the IDT for client #1 and #3. The IDT will assess the behaviors for which clients #1 and #3 are prescribed medication and develop appropriate and attainable titration plans. The Behavior Consultant will be retrained on the requirement to include an appropriate plan to address medication withdrawal based on behaviors and ensure	05/10/2014

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	Client D's record was reviewed on 4/9/14 at 12:34 PM. Client D's POF dated 3/28/14 indicated client D received Quetiapine 25 milligrams (depression) one tablet by mouth at bedtime (started on 2/3/14). Client D's record did not indicate documentation of a plan of reduction for the use of Quetiapine 25 milligrams. AD (Area Director) #1 was interviewed on 4/9/14 at 10:52 AM. AD #1 indicated client D should have a plan of reduction regarding her use of Quetiapine 25 milligrams for depression. This deficiency was cited on 12/9/13. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-5(a)		that the titration plan is measurable and attainable. The Behavior Consultant will revise the Behavior Plans to include the titration plan developed by the IDT. The QIDP will obtain required approvals as soon as the plans are available. The QIDP will also ensure the staff is trained on the implementation of the plans. The QIDP will review each client's files to ensure each client that receives medication to manage behavior has an appropriate titration plan. *Addendum: Client D Behavior Support Plan has been updated to include a plan of reduction for the use of Quetiapine 25 mg for depression. The Program Director received additional training to include ensuring that appropriate plans of reduction are included in all consumers Behavior Support Plans for any medications to address behaviors.* *The Area Director has completed and audit of all consumers Behavior Support Plans to ensure that appropriate plans of reduction have been included for all medications that address client behaviors.* Responsible Staff: Program	

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			Director, Area Director, Behavior Consultant	
W000436	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 4 clients (B) with adaptive equipment, the facility failed to ensure client B had recommended hearing aids and eyeglasses. Findings include: Observations were conducted at the group home on 4/8/14 from 4:45 PM through 6:00 PM. Client B was observed in the home throughout the observation period. Client B did not wear hearing aids or eyeglasses. Observations were conducted at the group home on 4/9/14 from 6:30 AM through 7:30 AM. Client B was observed throughout the observation period. Client B did not wear hearing aids or eyeglasses. Client B's record was reviewed on 4/9/14 at 12:03 PM. Client B's Audiology Assessment form dated 9/15/09 indicated the recommendation for client B to	W000436	Program Nurse will receive clarification from Client #1 physician on if he needs to continue to wear his hearing aids as recommended in a previous hearing evaluation. If it is determined that Client #1 still needs hearing aids, they will be ordered and provided to him as soon as possible. If it is determined that he does not need to continue to wear his hearing aids, written clarification from the physician will be obtained. Home Manager and Program Director will receive retraining to ensure that if any adaptive equipment is recommended for any consumers that it is provided to them and is in good working order. Ongoing the Program Director and Home manager will work with Program Nurse to ensure that all consumers recommended adaptive equipment is provided to consumers and is in good working order. If there are questions or concerns if a	05/10/2014

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	utilize hearing aids. Client B's ISP (Individual Support Plan) dated 6/18/13 indicated, "Results of last audio-logical exam: Hearing lost (sic). Date of last hearing assessment: 10/29/12. Results of last hearing assessment: mild to severe hearing lost (sic). Are amplification devices used: hearing aid. Assessment of ability to care for amplification devices: [client B] needs staff assistance in caring for his hearing aid." Client B's ISP dated 6/18/13 indicated client B should utilize eyeglasses. Client B's QNA (Quarterly Nursing Assessment) narrative note dated 12/30/13 indicated, "eyeglasses, doesn't always wear." Client B's QNA narrative note dated 4/4/14 indicated, "Glasses, occasionally refuses." Client B's record did not indicate documentation of supports or training to assist client B utilize his recommended hearing aids or eyeglasses. Interview with DSP (Direct Support Professional) #1 on 4/8/14 at 5:30 PM indicated client B did not wear his hearing aids or eyeglasses. DSP #1 stated, "I'm not sure if he has hearing aids. They may be back in his room but I'm not sure. I haven't seen him wear hearing aids." AD (Area Director) #1 was interviewed on 4/9/14 at 10:52 AM. AD #1 indicated		consumer still needs recommended adaptive equipment, Home Manager, Program Director and Program Nurse will work together with consumers physicians to obtain reassessments or written clarification regarding the adaptive equipment. The Program Nurse will review each consumer's medical records a minimum of monthly to ensure that all recommendations from physicians for clients are being implemented as directed. *Addendum: The Program Nurse spoke with the Client #1 doctor to get clarification on if Client #1 still needed to wear his hearing aids. The doctor agreed to discontinue the recommendation due to the client continuing to refuse to wear the hearing aids.* *A goal has been developed to assist Client #1 and encourage him to wear his eyeglasses.* *Program Director and Program Nurse will receive additional retraining to include the need to follow up with physicians a minimum of weekly to check on the status of requests to clarify need for adaptive equipment. Training will also include ensuring that all recommendations for clients for adaptive equipment are followed up on and implemented in a timely manner.*	

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	client B should have recommended adaptive equipment. This deficiency was cited on 12/9/13. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-7(a)		*Ongoing the Program Nurse and Program Director will review each consumers medical records a minimum of monthly to ensure all recommendations from physicians for clients are being implemented as directed.* Responsible Party: Program Director, Home Manager	