

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  07/22/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 926 S TENTH ST LAFAYETTE, IN 47905			
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: July 15, 16, 17, 18, 19 and 22, 2013.</p> <p>Facility Number: 000785 Provider Number: 15G265 AIMS Number: 100249010</p> <p>Surveyor: Claudia Ramirez, RN</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed July 29, 2013 by Dotty Walton, 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.

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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. Based on record review and interview for 1 of 20 BDDS (Bureau of Developmental Disabilities Services) reports, the facility neglected to implement the facility's policy and procedure prohibiting client neglect by neglecting to provide adequate supervision for 1 additional client (client #7).</p> <p>Findings include:</p> <p>On 07/15/13 at 10:54 AM the facility's BDDS Reports, investigations and internal incident/accident reports were reviewed from 07/01/12 through 07/14/13 and indicated the following:</p> <p>A BDDS report submitted 10/16/12 for an incident dated 10/16/12 at 12:00 AM indicated, "Another client in the home was looking for his cell phone charger. This client asked the staff, [staff #1] to assist him with looking for it. [Staff #1] knocked on the door to [client #7's] bedroom and asked him if he might have the other client's cell charger. [Staff #1] noticed that [client #7] had an actual cell phone in his possession. [Client #7], per his guardian, is not allowed to have or possess a cell phone. The staff asked</p>	W000149	The facility develops and implements written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The Home Manager will retrain staff will on supervision levels of the clients in the home. Staff will ensure that clients receive the appropriate level of supervision as outlined in their Individual Support Plan, Risk Management Assessment Plan as well as the behavior support plan. The facility is equipped with team and HRC approved door alarms to the outside exits. For any client, who has vacating documented in the behavior support plan, as a target behavior, facility staff will be retrained, by the Home Manager to do a visual check on these clients every 15 minutes to ensure that the client is in the facility. The Home Manager will document on the Home Manager weekly checklist that the visual checks are being documented on the visual check form, and submit the Home Manager checklist to the Program Director, weekly for review. The Program Director will document any incidents or issues on the Monthly Review form, and submit to the Area Director on a monthly basis for review. The Program Director will review all	08/21/2013			

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	<p>[client #7] if he could please return the cell phone, that belonged to yet another housemate. [Client #7] became angry and upset stating that it was okay for him to have the cell phone, and his housemate knew he had it. The staff explained that [client #7's] guardian did not want him to have a cell phone, and he would need to return it. [Client #7] became very upset, yelling at the staff and punching his dresser and the walls. The staff followed [client #7] down the stairs. [Client #7] attempted to vacate out the front door which was locked. [Client #7] then moved to the side door, unlocked and left, despite intervention and attempts from the staff to prevent him from leaving. The staff immediately called Mentor on call, and then the police. Mentor supervisors, and the local police actively looked for [client #7] all night long but were not able to locate him. Mentor also notified [client #7's] guardian that he was now missing. [Client #7] returned to his home at approximately 7 am, 10/16/12."</p> <p>The completed investigation dated 10/22/12 indicated staff #1 could not follow client #7 out of the house because she was the only staff on duty on the overnight hours.</p> <p>Client #7's records were reviewed on 07/16/13 at 1:30 PM. Client #7's ISP</p>		<p>individual plans for the clients in the home, at least quarterly, or more frequently if needed to reflect the appropriate needs of the clients in the home. The Program Director will indicate any changes needed in the monthly review, and will update Individual Support Plans and Risk Plans as needed. Completion Date: 8/21/13 Responsible Parties: Home Manager</p>				

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	<p>(Individual Support Plan) in place on the date of the incident was dated 01/04/12. The ISP indicated client #7's diagnoses included, but were not limited to: Mild [Intellectual Disability], ADHD (Attention Deficit Hyperactivity Disorder) and Anxiety. Client #7's ISP indicated he needed supervision in the community. Client #7's BSP in place at the time of the incident was dated 03/14/12 and indicated client #7's behaviors included physical and verbal aggression and elopement.</p> <p>On 07/15/13 at 10:53 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 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...e. Failure to provide appropriate supervision, care</p>			

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	<p>or training...Indiana MENTOR is committed to ensuring the individuals we serve are provided with a safe and quality living environment...."</p> <p>On 07/19/13 at 1:20 PM an interview was conducted with the Program Director (PD). The PD indicated staff failed to follow the policy/procedure as they failed to provide adequate supervision to client #7 as he eloped into the community and was gone for the entire night.</p> <p>9-3-2(a)</p>				

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview, the facility failed for 1 of 1 new client admitted to the home, (client #1), to ensure assessments were completed within 30 days after admission.</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 07/16/13 at 9:52 AM. The record indicated client #1 was admitted on 04/15/13. Client #1's record indicated he was last seen by the dentist on 10/23/12 during his prior group home placement with the same agency. The record indicated he was to return to the dentist on 04/25/13. There were no documents to indicate he returned for this appointment. Client #1 was seen by his new dentist on 06/26/13. Client #1's record did not contain a dietary evaluation.</p> <p>On 07/19/13 at 1:20 PM an interview with the Program Director (PD) and Registered Nurse (RN) was conducted. They indicated client #1's dental exam and dietary assessment had not been completed with 30 days after his</p>	W000210	The interdisciplinary team performs accurate assessments and reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The Home Manager and Program Director, will be retrained on policy and procedure regarding requirements for mandatory assessments for new clients within 30 days of admission. The Program Nurse will submit a calendar of required appointments that are to be scheduled by the Home Manager. The Home Manager will schedule any appointments and needed follow ups, as indicated on the calendar. The appointment calendar will be reviewed, at least monthly, by the Program Director for verification of completion and follow up, by the required dates. Date of completion: 8/21/13 Responsible Parties: Mentor Nurse, Program Director, Home Manager	08/21/2013			

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	admission and they should have been.  9-3-4(a)				

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility failed for 2 of 4 sampled clients (clients #2 and #4) and 2 additional clients (clients #5 and #6) by not ensuring the clients received evaluations and physician follow-ups as recommended or received the proper dose of medication as ordered (client #6).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Client #2's records were reviewed on 07/16/13 at 10:52 AM. Client #2's dental record indicated he had been seen 10/30/12 for tooth pain and was to follow-up on 01/28/13. The record did not contain documentation that the follow-up was completed.</li> <li>Client #4's records were reviewed on 07/16/13 at 12:50 PM. A letter dated 03/22/13 indicated, "Your recent breast imaging examination on 03/22/13 showed a finding that requires further imaging. Specifically, we are recommending a(n) Diagnostic Mammogram-Call back - Left...Please call your health-care provider to schedule an appointment for these tests if you have not already done so...." The record did not contain documentation that the further testing was</li> </ol>	W000331	The facility provides clients with nursing services in accordance with their needs. The Program Nurse will submit a calendar of required appointments that are to be scheduled by the Home Manager. The Home Manager will schedule any appointments and needed follow ups, as indicated on the calendar. The appointment calendar will be reviewed, at least monthly, by the Program Director for verification of completion and follow up, by the required dates. The Home Manager will be retrained on policy and procedure related to medical appointment follow ups as well as medication changes. All medical appointment forms must be reviewed by the Home Manager to ensure that any follow up or medication changes occur. After any medical appointment the medical appointment form will be submitted to the Program Director and Facility Nurse, by the Home Manager. The Home Manager will initial any changes or follow up mandated on the medical appointment form. The Home Manager is required to make any changes in medication on the medication administration record, to ensure that the change is accurate. This includes discontinuation, change in dosage, or implementation of a	08/21/2013			

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	<p>completed. Client #4 record contained a Psychiatric Medication Review form dated 03/05/13 and indicated she saw the psychiatrist on this date. The form indicated client #4 was on the medication Fluoxetine (for depression) 20 mg (milligrams) daily. After seeing the client, the psychiatrist indicated, "Increase to 40 (mg) in AM." The record did not contain any documentation that the medication had been increased as ordered.</p> <p>3. Client #5's records were reviewed on 07/16/13 at 1:30 PM. The record contained a BDDS (Bureau of Developmental Disabilities Services) report which indicated the following: "Staff (unidentified) was helping clients put food on the table for dinner. Hot rice fell out of the bowl onto [client #5's] shoulder and breast, burning the skin. Staff administered first aid. The nurse assessed [client #5] the next day and determined she should go to Urgent Care to ensure that she get treatment...."</p> <p>4. Client #6's records were reviewed on 07/16/13 at 2:00 PM. The record indicated client #6's Strattera (attention-deficit/hyperactivity disorder) was increased on 11/16/12 from 80 mg to 100 mg. The November 2012 MAR did not discontinue the 80 mg Strattera when the 100 mg order was written. Client #6</p>		<p>new medication. The facility nurse will review appointment follow ups, and changes required on the medication administration record, and document such on the monthly nurses notes. The Home Manager will retrain all staff will on policy and procedure regarding reporting requirements for injuries. Completion Date: 8/21/13 Responsible Parties: Home Manager, Program Director, Facility Nurse</p>				

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	<p>received 180 mg of Strattera instead of 100 mg for 10 days at which time the RN caught the mistake and corrected the MAR to reflect the correct 100 mg dose of Strattera.</p> <p>On 07/19/13 at 1:20 PM an interview was conducted with the Program Director (PD) and the Registered Nurse (RN). The PD indicated the home had gone through many significant staff changes in the past year. The RN indicated staff had failed on many occasions to do the follow-ups that had been recommended. She indicated client #2 did not get his dental follow-up, client #4's mammogram follow-up had not completed and client #4 had not gotten the increase of her medication which was an oversight. The RN indicated staff failed to follow her orders regarding client #6's medication increase. She further indicated staff failed to contact her the night client #5 was burned with the rice and they should have called her as she ended up sending client #5 to the urgent care for further medical evaluation and treatment.</p> <p>9-3-6(a)</p>			

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W000440	<p>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 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7 and #8) who resided in the home, by not ensuring an evacuation drill was conducted at least every quarter on the evening and night shifts.</p> <p>Findings include:</p> <p>On 07/15/13 at 5:11 PM, record reviews were completed of the facility's evacuation drills for the period of 05/09/12 through 07/14/13. The review of the evacuation drill records included evacuation drills which were conducted for personnel and clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>There was an evening shift drill conducted on 11/07/12 at 7:00 PM. The next evening drill was conducted on 05/09/13 at 6:00 PM.</p> <p>The first night shift drill recorded for 2012 was conducted on 12/08/12 at 3:27 AM. There were no night drills in 2012 prior to this drill.</p> <p>On 07/19/13 at 1:20 PM an interview with the Program Director (PD) was</p>	W000440	<p>The facility holds evacuation drills, at least quarterly for each shift of personnel. The Home Manager will receive retraining on requirements for evacuation drills. The Home Manager will ensure that an evacuation drill is conducted, at least quarterly, for each shift of personnel. The Home Manager will document the completion of each drill, on the monthly home manager checklist. The evacuation drills will be submitted to the Program Director, for review, in conjunction with the Home Manager monthly checklist, to ensure accuracy and completion. The Program Director will maintain an office file, with completed evacuation drills. The Home Manager will ensure that all original copies of evacuation drills are stored in the safety book, located in the home. Completion Date: 8/21/13 Responsible Parties: Home Manager, Program Director</p>	08/21/2013			

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	<p>conducted. The PD indicated the home has gone through several new staff and new house managers over the last year and there were no additional evacuation drills for review.</p> <p>9-3-7(a)</p>				