

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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 recertification and state licensure survey.</p> <p>Dates of Survey: April 7, 8, 9 and 10, 2014.</p> <p>Facility number: 000883 Provider number: 15G369 AIM number: 100244300</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/17/14 by Ruth Shackelford, QIDP.</p>	W000000		
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 upon record review and interview, the facility to ensure an accurate accounting of personal funds for 2 of 4 sampled clients (clients #3 and #4).</p> <p>Findings include:</p> <p>The facility's financial records for clients were reviewed on 4/9/14 at 3:25 PM. Client #3's cash on hand ledger for March and April, 2014 indicated a balance of \$18.56 on 4/1/14. Client #3's cash on hand counted by the QIDP (Qualified Intellectual Disabilities</p>	W000140	The Direct Support Professionals will be retrained on Indiana MENTOR's policy and procedures for client finances. The Program Director and Home Manager will be retrained on Client Finances. This training will include ensuring that the client's ledger balance at all times, documentation requirements, and the expectations for supervisory reviews. For the first 4 weeks, the Home Manager will review each client's finances twice per week. After the initial four weeks,	05/10/2014

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.

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 04/10/2014
NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214		
(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	
W000148	<p>Professional) during the review indicated client #3 had \$2.98 in her money envelope. The envelope included receipts totaling \$18.81. There was no documentation to indicate why client #3's receipts and cash on hand totaled \$21.79 instead of \$18.56.</p> <p>Client #4's cash on hand ledger for March and April, 2014 indicated a balance of \$26.07. Client #4's cash on hand counted by the QIDP during the review indicated client #4 had \$26.09 in her money envelope. There was no documentation to indicate why client #4's receipts and cash on hand totaled \$26.09 instead of \$26.07.</p> <p>The Residential Manager (RM) and QIDP were interviewed on 4/9/14 at 3:35 PM. The RM indicated she completed an audit of client funds every 2 weeks and the receipts in client #3's envelope were purchases she made since the balance on 4/1/14. She indicated the excess money could be a result of staff purchasing items for clients while in the community and may have submitted receipts to be added to client #3's funds. The QIDP stated, "The cash on hand should balance out (with the ledger)," and indicated staff should not be purchasing items for clients from staff's personal funds.</p> <p>9-3-2(a)</p> <p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant</p>		<p>the Home Manager will review each client's finances no less than once per week, ongoing. Reviewing the client finances includes, but is not limited to, counting all petty cash, ensuring all transactions are recorded and have a receipt for proof of purchase. For the first 4 weeks, the Program Director will review each client's finances once per week. After the initial four weeks, the Program Director will review each client's finances twice per month. After the next four weeks, the Program Director will continue with reviewing each client's finances no less than once per month. Reviewing the client finances includes, but is not limited to, counting all petty cash, ensuring all transactions are recorded and have a receipt for proof of purchase. For the first 3 months, the Area Director will review each client's finances no less than once per month. After the initial 3 months, the Area Director will review each client's finances twice once per quarter, ongoing. Ongoing, all financial transactions are monitored by the Home Manager, reconciled by the Program Director, and then reviewed by the Client Finance Specialist at the completion of each month.</p>		

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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>incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based upon record review and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) to inform guardians of an incident of missing client personal funds and failed to notify client #2's guardians of an incident of missing medication which resulted in medication errors.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 4/8/14 at 9:50 AM.</p> <p>1. BDDS reports for clients #1, #2, #4, #5, #6, #7 and #8 dated 12/3/13 indicated staff discovered that monies were missing from clients' financial books totaling \$289.09 and the incident was reported to the police. The reports indicated "N/A (not applicable)" in the space to indicate the date guardians were notified.</p> <p>An investigation into the incident was reviewed on 4/8/14 at 10:30 AM. The investigation indicated client #1's funds were missing an accounting of \$215.34. Client #2 was missing \$128.21, client #3 was missing \$31.81 and client #4 was missing \$33.68. There was no evidence in the investigation client #1, #2, #3 or #4's guardians were notified of the missing money.</p>	W000148	<p>The Home Manager and Program Director will be retrained on Indiana MENTOR's policy and procedures regarding ongoing guardian and family contact. Indiana MENTOR's procedures state that the Home Manager should have no less than weekly contact with each guardian and/or family member and the Program Director should have no less than monthly contact with each guardian and/or family member. Indiana MENTOR's policy and procedures state that guardians and/or family members will be contacted in the case of any BDDS reportable incident so that they will be made aware of the situation. At each client's annual team meeting, the amount of communication between Indiana MENTOR and the family is discussed and agreed upon. The Home Manager and Program Director will be retrained on documenting any conversations and visits that are completed with the guardians and/or family members. The weekly/monthly contact will be recorded on the monthly communication form. If contact is made regarding an incident, the Program Director will document this on the BDDS report in the allocated fields. The Program Director will send out a letter to all guardians and/or</p>	05/10/2014

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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 #1's record was reviewed on 4/8/14 at 12:55 PM and indicated he had a guardian. There was no indication client #1's guardian was notified of missing money.</p> <p>Client #2's record was reviewed on 4/8/14 at 1:45 PM and indicated she had a guardian. There was no indication client #2's guardian was notified of missing money.</p> <p>Client #3's record was reviewed on 4/8/14 at 11:38 AM and indicated she had a guardian. There was no indication client #3's guardian was notified of missing money.</p> <p>Client #4's record was reviewed on 4/8/14 at 1:35 PM and indicated she had a guardian. There was no indication client #4's guardian was notified of missing money.</p> <p>2. A BDDS report dated 1/1/14 indicated client #2's Clonazepam (anti-anxiety) .5 mg (milligrams) was missing "and no where to be found." Client #2 missed doses at 7:00 AM, 5:00 PM and 9:00 PM. The Program Director (PD) contacted the police department and a police report was filed. The report indicated "N/A" in the space to indicate the date client #2's guardian was notified.</p> <p>The Area Director (AD) and QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) were interviewed on 4/9/14 at 4:00 PM and indicated there was no evidence client #1, #2, #3 and #4's guardians were notified of the incident and should have been notified.</p> <p>Client #2's guardian was interviewed on 4/10/14 at 1:45 PM and indicated she was unaware of the incident involving client #2's missing funds or missing medications and</p>		<p>family members introducing himself and the House Manager, and ensure that everyone has correct contact information. The Area Director will meet with the Home Manager and Program Director once a week for the first four weeks to review all communication between Indiana MENTOR and the guardians/family members. After the initial four weeks, the Area Director, Program Director, and Home Manager will continue to meet twice a month for three months to continue to review and discuss the ongoing communication between the guardians/family members and Indiana MENTOR.</p>	

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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>would have liked to have been notified.</p> <p>9-3-2(a) 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 upon record review and interview, for 4 of 4 sampled clients (clients #1, #2, #3 and #4), the facility failed to implement facility policy and procedures to prevent abuse and neglect and exploitation by failing to report to BDDS (Bureau of Developmental Disabilities Services) in accordance with state law for an incident of missing personal funds, failed for 1 of 16 incidents involving 1 of 4 sampled clients (client #2) to document a thorough investigation into missing medication, failed to report the results of 2 of 4 investigations of alleged abuse and neglect to the Bureau of Developmental Disabilities Services (BDDS) and other officials within five working days in accordance with State law, failed to implement effective corrective action to address medication administration errors involving 3 of 4 sampled clients (clients #1, #2 and #3) and 1 additional client (client #7), and failed to provide evidence of repayment of missing client funds for 4 of 4 sampled clients (clients #1, #2, #3, #4) and 3 additional clients (clients #6, #7, and #8).</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 4/8/14 at 9:50 AM and indicated the following:</p>	W000149	The Program Director will be retrained on Indiana MENTOR's policy and procedure for completing an investigation. This retraining will also include the expectation of the completion of the recommendations that are results of the completed investigation and the 5 day requirement for all investigations to be completed. The Program Director will be retrained on BDDS reports requirements. To ensure that all investigations are completed accurately and thoroughly, Indiana MENTOR's Quality Assurance Specialist will assist this PD with the next three investigations. Ongoing, all investigations will be reviewed by the Area Director and the Quality Assurance Specialist to ensure that all issues are addressed, that the investigation is completed thoroughly, that recommendations are made and that all recommendations are completed and followed up on in a timely manner.	05/10/2014

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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. BDDS reports for clients #1, #2, #4, #5, #6, #7 and #8 dated 12/3/13 indicated staff discovered that monies were missing from clients' financial books totaling \$289.09 and the incident was reported to the police.</p> <p>An investigation into the incident was reviewed on 4/8/14 at 10:30 AM. The investigation indicated client #1's funds were missing an accounting of \$215.34. Client #2 was missing \$128.21, client #3 was missing \$31.81 and client #4 was missing \$33.68. There was no evidence the incident of client #3's missing money was reported to the BDDS.</p> <p>The Area Director (AD) and QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) were interviewed on 4/9/14 at 4:00 PM. The AD indicated a report had not been submitted for client #3 as when money was first discovered missing, it was thought initially client #3 was not missing money, and reporting client #3's missing money to BDDS had been overlooked.</p> <p>2. A BDDS report dated 1/1/14 indicated client #2's Clonazepam (anti-anxiety) .5 mg (milligrams) was missing "and no where to be found." Client #2 missed doses at 7:00 AM, 5:00 PM and 9:00 PM. The Program Director (PD) contacted the police department and a police report was filed. The report indicated the PD was conducting an internal investigation into the incident as to the whereabouts of the medication.</p> <p>The Area Director (AD) was interviewed on 4/9/14 at 4:00 PM. The AD indicated an investigation should have been completed</p>			

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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>regarding the incident. She indicated she thought there had been an investigation, but was unable to find a copy.</p> <p>The AD was interviewed again on 4/10/14 at 3:00 PM and indicated there was no investigation found regarding the incident of client #2's missing medication.</p> <p>3. a) BDDS reports for clients #1, #2, #4, #5, #6, #7 and #8 dated 12/3/13 indicated staff discovered that monies were missing from clients' financial books totaling \$289.09 and the incident was reported to the police.</p> <p>An investigation into the incident was reviewed on 4/8/14 at 10:30 AM. The investigation indicated client #1's funds were missing an accounting of \$215.34. Client #2 was missing \$128.21, client #3 was missing \$31.81 and client #4 was missing \$33.68. The investigation indicated the incident was discovered on 12/3/13 and the investigation was completed on 2/20/14.</p> <p>b) A BDDS report dated 1/29/14 indicated client #1 had not received Levofloxacin (antibiotic) 500 mg (milligrams) as was prescribed by his physician since 1/24/14. The report indicated the medication had been delivered to the group home, but had not been given to client #1.</p> <p>An investigation into the incident indicated the date of the incident was 1/24/14 and the conclusion of the investigation was 2/20/14.</p> <p>The Area Director was interviewed on 4/8/14 at 12:15 PM and indicated the investigations were not completed within 5 days. She indicated the investigation into the missing funds was involved and it had taken until</p>			

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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>2/20/14 to complete.</p> <p>4. a) A BDDS report dated 1/1/14 indicated client #2's clonazepam (anti-anxiety) .5 mg (milligrams) was missing "and no where to be found." Client #2 missed doses of her clonazepam at 7:00 AM, 5:00 PM and 9:00 PM. The Program Director (PD) contacted the police department and a police report was filed. "Annotation was made in the communication log book, but staff did not read the book which resulted in the client not receiving the medications for the day." The report indicated the nurse re-ordered client #2's medication and staff would be trained on reading the communication log.</p> <p>b) A BDDS report dated 1/4/14 indicated client #2 missed her 7:00 AM dose of Klonopin (Clonazepam) on 1/4/14 as the medication was not available in the house "because they ran out the night before." The pharmacy was notified and delivered client #2's medication. Plan to resolve indicated the Program Director (PD) over the group home was notified of the medication error and is aware of the pills the pharmacy sent. A follow up report dated 1/4/14 indicated the pharmacist did not send enough medication which resulted in the missed medication. "A meeting was held with the pharmacist and the issue was addressed. The pharmacist will in the future call the PD and house manager as to the number of pills required so that this will not happen again."</p> <p>c) A BDDS report dated 1/29/14 indicated client #1 had not received Levofloxacin (antibiotic) 500 mg (milligrams) as was prescribed by his physician since 1/24/14 for a diagnosis of bronchitis. The report indicated the medication had been delivered to the</p>			

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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>group home, but had not been given to client #1.</p> <p>An investigation into the incident completed 2/20/14 was reviewed on 4/8/14 at 10:31 AM and indicated staff #5 had received the medication at the group home after it was delivered from the pharmacy, but did not add the medication to the medication administration record (MAR) as part of procedure. There was no evidence of corrective action to prevent future occurrence of medication error.</p> <p>d) A BDDS report dated 3/1/14 indicated client #7 did not take her Glimeperide (diabetes) 2 mg at 7:00 AM as the medication was not available in the home. The pharmacy was notified and the medication was delivered to the home. Corrective action indicated "Communicate between PD and [Pharmacy name] to make sure all meds (medications) are accounted before to eliminate future occurrences." A follow up report dated 3/18/14 indicated client #7's medication order for Glimeperide had been faxed to the pharmacy, but the staff and the group home and the house manager did not follow up to ensure that it was delivered. "All staff and the home manager were in-serviced on the protocol that must take place when faxing in orders. The home manager will ensure that all faxed orders will be followed up by her as well as the staff are to alert her as to all orders that have been faxed in to the pharmacy. The home manager will follow up the same day and receive confirmation that the medicine was delivered."</p> <p>e) A BDDS report dated 3/14/14 indicated "a script (prescription) was written for consumer (client #3) because of a sore under her</p>			

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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>tongue. The order for oral gel was faxed in but never delivered to the group home." The medication was delivered and "in the future the home manager from this point on will follow up to all scripts to ensure it was delivered and administered as prescribed."</p> <p>The Area Director (AD) was interviewed on 4/8/14 at 12:15 PM. When asked what corrective action had taken place to address the medication administration errors at the home, she stated, "We are meeting with the pharmacy periodically to resolve the situation." She indicated a full list of clients' medications is delivered the month prior for the home manager to review to ensure medications are available. She indicated the system in place had not yet prevented all medication errors.</p> <p>5. BDDS reports for clients #1, #2, #4, #5, #6, #7 and #8 dated 12/3/13 (no BDDS report for client #3) indicated staff discovered that monies were missing from clients' financial books totaling \$289.09 and the incident was reported to the police.</p> <p>An investigation into the incident was reviewed on 4/8/14 at 10:30 AM. The investigation indicated client #1's funds were missing an accounting of \$215.34. Client #2 was missing \$128.21, client #3 was missing \$31.81, client #4 was missing \$33.68, client #6 was missing \$74.18, client #7 was missing \$55.59 and client #8 was missing \$74.18. Recommendations indicated "Reimburse clients for transactions missing receipts and unaccounted funds."</p> <p>The Area Director (AD) was interviewed on 4/8/14 at 12:15 PM and indicated the clients' funds were reimbursed and she would</p>			

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 04/10/2014
NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214		
(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>provide documentation.</p> <p>The AD was interviewed again on 4/10/14 at 3:00 PM and indicated she was unable to produce evidence the funds had been repaid to clients #1, #2, #3, #4, #6, #7 and #8 though she remembered seeing the checks which had been deposited into the clients' accounts.</p> <p>The facility's Quality and Risk Management operating practices revised 4/11 was reviewed on 4/9/14 at 4:40 PM and indicated it was agency policy to report to BDDS "alleged, suspected, or actual abuse, neglect or exploitation of an individual....The Program Director, who serves as the QMRP (Qualified Mental Retardation Professional), shall submit a follow-up report concerning the incident on the BDDS's follow-up incident report form at the following times: (a) Within seven (7) days of the date of the initial report; (b) Every seven (7) days thereafter until the incident is resolved; ...Indiana Mentor is committed to ensuring the individuals we serve are provided with a safe and quality living environment. In order to ensure the highest standard of service delivery specific staff will be assigned to the monitoring and review of Quality Assurance. These staff will assist in providing Individual Support Teams with corporate supports, recommendations and resources for incident management and will review the effectiveness of the recommendations...The Area Director will review each incident and Quality Assurance recommendations monthly. This review will be completed with the Program Director and other appropriate staff to assess the effectiveness of each recommendation made per incident...Indiana Mentor is committed to completing a thorough investigation for any</p>				

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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
W000153	<p>event out of the ordinary which jeopardizes the health and safety of any individual served...Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident...."</p> <p>9-3-2(a) 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based upon record review and interview, the facility failed for 1 of 4 sampled clients (client #3) to report an incident of missing personal funds to the Bureau of Developmental Disabilities Services in accordance with state law.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 4/8/14 at 9:50 AM. Reports for clients #1, #2, #4, #5, #6, #7 and #8 dated 12/3/13 indicated staff discovered that monies were missing from clients' financial books totaling \$289.09 and the incident was reported to the police.</p> <p>An investigation into the incident was reviewed on 4/8/14 at 10:30 AM. The investigation indicated client #1's funds were missing an accounting of \$215.34. Client #2 was missing \$128.21, client #3 was missing</p>	W000153	The Program Director will be retrained on Indiana MENTOR's policy and procedure for completing an investigation. This retraining will also include the expectation of the completion of the recommendations that are results of the completed investigation and the 5 day requirement for all investigations to be completed. The Program Director will be retrained on BDDS reports requirements. To ensure that all investigations are completed accurately and thoroughly, Indiana MENTOR's Quality Assurance Specialist will assist this PD with the next three investigations. Ongoing, all investigations will be reviewed by the Area Director and the Quality Assurance Specialist to ensure that all issues are addressed, that the investigation is completed thoroughly, that recommendations are made and	05/10/2014

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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>\$31.81 and client #4 was missing \$33.68. There was no evidence the incident of client #3's missing money was reported to the BDDS.</p> <p>The Area Director (AD) and QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director) were interviewed on 4/9/14 at 4:00 PM. The AD indicated a report had not been submitted for client #3 as when money was first discovered missing, as it was thought initially client #3 was not missing money, and reporting client #3's missing money to BDDS had been overlooked.</p> <p>9-3-2(a) 483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based upon record review and interview, the facility failed for 1 of 16 incidents involving 1 of 4 sampled clients (client #2) to document a thorough investigation into missing medication.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 4/8/14 at 9:50 AM. A BDDS report dated 1/1/14 indicated client #2's clonazepam (anti-anxiety) .5 mg (milligrams) was missing "and no where to be found." Client #2 missed doses of her clonazepam at 7:00 AM, 5:00 PM and 9:00 PM. The Program Director (PD) contacted the police department and a police</p>	W000154	<p>that all recommendations are completed and followed up on in a timely manner.</p> <p>The Program Director will be retrained on Indiana MENTOR's policy and procedure for completing an investigation. This retraining will also include the expectation of the completion of the recommendations that are results of the completed investigation and the 5 day requirement for all investigations to be completed. The Program Director will be retrained on BDDS reports requirements. To ensure that all investigations are completed accurately and thoroughly, Indiana MENTOR's Quality Assurance Specialist will assist this PD with the next three investigations. Ongoing, all investigations will be reviewed by</p>	05/10/2014

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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
W000156	<p>report was filed. The report indicated the PD was conducting an internal investigation into the incident as to the whereabouts of the medication.</p> <p>The Area Director (AD) was interviewed on 4/9/14 at 4:00 PM. The AD indicated an investigation should have been completed regarding the incident. She indicated thought there had been an investigation, but was unable to find a copy.</p> <p>The AD was interviewed again on 4/10/14 at 3:00 PM and indicated there was no investigation found regarding the incident of client #2's missing medication.</p> <p>9-3-2(a) 483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based upon record review and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and for 4 additional clients (clients #5, #6, #7, and #8) to report the results of 2 of 4 investigations of possible abuse and neglect to the Bureau of Developmental Disabilities Services (BDDS) and other officials within five working days in accordance with State law.</p> <p>Findings include:</p> <p>1. The facility's reportable incidents to the Bureau of Developmental Disabilities</p>	W000156	<p>the Area Director and the Quality Assurance Specialist to ensure that all issues are addressed, that the investigation is completed thoroughly, that recommendations are made and that all recommendations are completed and followed up on in a timely manner.</p> <p>The Program Director will be retrained on Indiana MENTOR's policy and procedure for completing an investigation. This retraining will also include the expectation of the completion of the recommendations that are results of the completed investigation and the 5 day requirement for all investigations to be completed. The Program Director will be retrained on BDDS reports requirements. To ensure that all investigations are completed accurately and thoroughly, Indiana MENTOR's Quality Assurance Specialist will</p>	05/10/2014

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 04/10/2014	
NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214			
(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>Services (BDDS) were reviewed on 4/8/14 at 9:50 AM. Reports for clients #1, #2, #4, #5, #6, #7 and #8 dated 12/3/13 indicated staff discovered that monies were missing from clients' financial books totaling \$289.09 and the incident was reported to the police.</p> <p>An investigation into the incident was reviewed on 4/8/14 at 10:30 AM. The investigation indicated client #1's funds were missing an accounting of \$215.34. Client #2 was missing \$128.21, client #3 was missing \$31.81 and client #4 was missing \$33.68. The investigation indicated it was completed on 2/20/14.</p> <p>2. A BDDS report dated 1/29/14 indicated client #1 had not received Levofloxacin (antibiotic) 500 mg (milligrams) as was prescribed by his physician since 1/24/14. The report indicated the medication had been delivered to the group home, but had not been given to client #1.</p> <p>An investigation into the incident indicated the date of the incident was 1/24/14 and the conclusion of the investigation was 2/20/14.</p> <p>The Area Director was interviewed on 4/8/14 at 12:15 PM and indicated the investigations were not completed within 5 days. She indicated the investigation into the missing funds was involved and it had taken until 2/20/14 to complete.</p> <p>9-3-2(a) 483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p>	W000157	assist this PD with the next three investigations. Ongoing, all investigations will be reviewed by the Area Director and the Quality Assurance Specialist to ensure that all issues are addressed, that the investigation is completed thoroughly, that recommendations are made and that all recommendations are completed and followed up on in a timely manner.	05/10/2014		The Program Director will be retrained on Indiana MENTOR's	

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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>Based upon record review and interview, the facility failed to implement effective corrective action to address medication administration errors involving 3 of 4 sampled clients (clients #1, #2 and #3) and 1 additional client (client #7), and failed to provide evidence of repayment of missing client funds for 4 of 4 sampled clients (clients #1, #2, #3, #4) and 3 additional clients (clients #6, #7, and #8).</p> <p>Findings include:</p> <ol style="list-style-type: none"> The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 4/8/14 at 9:50 AM and indicated the following: <p>A BDDS report dated 1/1/14 indicated client #2's Clonazepam (anti-anxiety) .5 mg (milligrams) was missing "and no where to be found." Client #2 missed doses at 7:00 AM, 5:00 PM and 9:00 PM. The Program Director (PD) contacted the police department and a police report was filed. "Annotation was made in the communication log book, but staff did not read the book which resulted in the client not receiving the medications for the day." The report indicated the nurse re-ordered client #2's medication and staff would be trained on reading the communication log.</p> <p>A BDDS report dated 1/4/14 indicated client #2 missed her 7:00 AM dose of Klonopin (Clonazepam) on 1/4/14 as the medication was not available in the house "because they ran out the night before." The pharmacy was notified and delivered client #2's medication. Plan to resolve indicated the Program Director (PD) over the group home was notified of the medication error and is aware of the pills the pharmacy sent. A follow up</p>		<p>policy and procedure for completing an investigation. This retraining will also include the expectation of the completion of the recommendations that are results of the completed investigation and the 5 day requirement for all investigations to be completed. The Program Director will be retrained on BDDS reports requirements. To ensure that all investigations are completed accurately and thoroughly, Indiana MENTOR's Quality Assurance Specialist will assist this PD with the next three investigations. Ongoing, all investigations will be reviewed by the Area Director and the Quality Assurance Specialist to ensure that all issues are addressed, that the investigation is completed thoroughly, that recommendations are made and that all recommendations are completed and followed up on in a timely manner.</p>	

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 04/10/2014	
NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214			
(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>report dated 1/4/14 indicated the pharmacist did not send enough medication which resulted in the missed medication. "A meeting was held with the pharmacist and the issue was addressed. The pharmacist will in the future call the PD and house manager as to the number of pills required so that this will not happen again."</p> <p>A BDDS report dated 1/29/14 indicated client #1 had not received Levofloxacin (antibiotic) 500 mg (milligrams) as was prescribed by his physician since 1/24/14 for a diagnosis of bronchitis. The report indicated the medication had been delivered to the group home, but had not been given to client #1.</p> <p>An investigation into the incident completed 2/20/14 was reviewed on 4/8/14 at 10:31 AM and indicated staff #5 had received the medication at the group home after it was delivered from the pharmacy, but did not add the medication to the medication administration record (MAR) as part of procedure. There was no evidence of corrective action to prevent future occurrence of medication error.</p> <p>A BDDS report dated 3/1/14 indicated client #7 did not take her Glimeperide (diabetes) 2 mg at 7:00 AM as the medication was not available in the home. The pharmacy was notified and the medication was delivered to the home. Corrective action indicated "Communicate between PD and [Pharmacy name] to make sure all meds (medications) are accounted before to eliminate future occurrences." A follow up report dated 3/18/14 indicated client #7's medication order for Glimeperide had been faxed to the pharmacy, but the staff and the group home and the house manager did not follow up to</p>						

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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>ensure that it was delivered. "All staff and the home manager were in-serviced on the protocol that must take place when faxing in orders. The home manager will ensure that all faxed orders will be followed up by her as well as the staff are to alert her as to all orders that have been faxed in to the pharmacy. The home manager will follow up the same day and receive confirmation that the medicine was delivered."</p> <p>A BDDS report dated 3/14/14 indicated "a script (prescription) was written for consumer (client #3) because of a sore under her tongue. The order for oral gel was faxed in but never delivered to the group home." The medication was delivered and "in the future the home manager from this point on will follow up to all scripts to ensure it was delivered and administered as prescribed."</p> <p>The Area Director (AD) was interviewed on 4/8/14 at 12:15 PM. When asked what corrective action had taken place to address the medication administration errors at the home, she stated, "We are meeting with the pharmacy periodically to resolve the situation." She indicated a full list of clients' medications is delivered the month prior for the home manager to review to ensure medications are available. She indicated the system in place had not yet prevented all medication errors.</p> <p>2. BDDS reports for clients #1, #2, #4, #5, #6, #7 and #8 dated 12/3/13 (no BDDS report for client #3) indicated staff discovered that monies were missing from clients' financial books totaling \$289.09 and the incident was reported to the police.</p> <p>An investigation into the incident was</p>			

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 04/10/2014	
NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214			
(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			
W000159	<p>reviewed on 4/8/14 at 10:30 AM. The investigation indicated client #1's funds were missing an accounting of \$215.34. Client #2 was missing \$128.21, client #3 was missing \$31.81, client #4 was missing \$33.68, client #6 was missing \$74.18, client #7 was missing \$55.59 and client #8 was missing \$74.18. Recommendations indicated "Reimburse clients for transactions missing receipts and unaccounted funds."</p> <p>The Area Director (AD) was interviewed on 4/8/14 at 12:15 PM and indicated the clients funds were reimbursed and she would provide documentation.</p> <p>The AD was interviewed again on 4/10/14 at 3:00 PM and indicated she was unable to produce evidence the funds had been repaid to clients #1, #2, #3, #4, #6, #7 and #8 though she remembered seeing the checks which had been deposited into the clients' accounts.</p> <p>9-3-2(a) 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based upon record review and interview, the QIDP (Qualified Intellectual Disabilities Professional) failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) to ensure completed timely reviews of their progress on ISP (Individual Support Plan) objectives.</p> <p>Findings include:</p>	W000159	The Program Director will be retrained on QIDP responsibilities. This retraining will include completing monthly reviews on each client. These reviews will include the total number of trials and completions of each target goal, a list of doctor's appointments and outcomes, day placement review, reviews of any reportable	05/10/2014			

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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 #1's record was reviewed on 4/8/14 at 12:55 PM. An ISP dated 11/11/13 indicated objectives to dust his room, count money, increase skills in wearing and caring for his glasses, brush teeth, look at menus and gather needed items, decrease personal space issues, and decrease incidents of disrupting production. The QIDP reviewed client #1's objectives to determine progress on 4/13/13. There was no evidence of more recent reviews in the record.</p> <p>Client #2's record was reviewed on 4/8/14 at 1:45 PM. An ISP dated 1/24/14 indicated objectives to increase skills in money management, self administration of medication, oral hygiene, and meal time activities. The QIDP reviewed client #2's objectives to determine progress on 4/13/13. There was no evidence of more recent reviews in the record.</p> <p>Client #3's record was reviewed on 4/8/14 at 11:38 AM. An ISP dated 12/16/13 indicated objectives to increase skills in money management, bathing, clean room, self administration of medication, oral hygiene and meal time activities. There was no evidence of a QIDP review of client #3's objectives to determine progress.</p> <p>Client #4's record was reviewed on 4/8/14 at 1:35 PM. An ISP dated 1/24/14 indicated objectives to increase skills in money management, household chores, self administration of medication, oral hygiene and meal time activities. There was one review in December, 2012 by the QIDP. There was no evidence of more recent reviews in the record.</p> <p>The Area Director was interviewed on 4/9/14</p>		<p>incidents and the outcomes, completed activities and family visits, and a follow up plan for the following month. The Program Director will complete a monthly review for each of the 8 clients in this home by the 10th of the following month. All reviews will include the total number of trials and completions of each target goal, a list of doctor's appointments and outcomes, day placement review, reviews of any reportable incidents and the outcomes, completed activities and family visits, and a follow up plan for the following month. Ongoing, all monthly reviews will be turned in to the Area Director by the 10th of the following month for review.</p>	

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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
W000209	<p>at 2:20 PM and indicated there had been QIDP staff turnover and there were no QIDP reviews for the missing time period.</p> <p>9-3-3(a) 483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.</p> <p>Based upon record review and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) to ensure participation by guardians in their annual Individual Support Plan meetings.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 4/8/14 at 12:55 PM. The record indicated client #1 had a guardian. An ISP dated 11/11/13 indicated objectives to dust his room, count money, increase skills in wearing and caring for his glasses, brush teeth, look at menus and gather needed items, decrease personal space issues, and decrease incidents of disrupting production. There was no evidence of a guardian signature in the ISP to indicate client #1's guardian had participated in his ISP. There was no other evidence in the record to indicate client #1's guardian had been involved in the ISP.</p> <p>Client #2's record was reviewed on 4/8/14 at 1:45 PM. The record indicated client #2 had two co-guardians. An ISP dated 1/24/14 indicated objectives to increase skills in money management, self administration of medication, oral hygiene, and meal time</p>	W000209	The Home Manager and Program Director will be retrained on Indiana MENTOR's policy and procedures regarding ongoing guardian and family contact. The Program Director will send out a letter to all guardians and/or family members introducing himself and the House Manager, and ensure that everyone has correct contact information. A documented invitation will be sent out to each guardian and family member for the upcoming annual meeting with an RSVP for attendance. If the family/guardian is unable to attend, the meeting will either be rescheduled to accommodate the schedule, or a final draft of the letter will be sent out for review and signature after the meeting. According to Indiana MENTOR's policy and procedure, an ISP is considered incomplete if a guardian signature is required but not obtained. At each client's annual team meeting, the amount of communication between Indiana MENTOR and the family is discussed and agreed upon.	05/10/2014

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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>activities. There was no evidence of a guardian signature in the ISP to indicate client #2's co-guardians had participated in her ISP. There was no other evidence in the record to indicate client #2's guardian had been involved in the ISP.</p> <p>Client #3's record was reviewed on 4/8/14 at 11:38 AM. The record indicated client #3 had a guardian. An ISP dated 12/16/13 indicated objectives to increase skills in money management, bathing, clean room, self administration of medication, oral hygiene and meal time activities. There was no evidence of a guardian signature in the ISP to indicate client #3's guardian had participated in her ISP. There was no other evidence in the record to indicate client #3's guardian had been involved in the ISP.</p> <p>Client #4's record was reviewed on 4/8/14 at 1:35 PM. The record indicated client #4 had a guardian. An ISP dated 1/24/14 indicated objectives to increase skills in money management, household chores, self administration of medication, oral hygiene and meal time activities. There was no evidence of a guardian signature in the ISP to indicate client #4's guardian had participated in her ISP. There was no other evidence in the record to indicate client #4's guardian had been involved in the ISP.</p> <p>The Area Director was interviewed on 4/9/14 at 2:20 PM and indicated she would need to locate the signature sheets for the clients' ISPs.</p> <p>Client #2's guardian was interviewed on 4/10/14 at 1:45 PM and indicated she had not been notified of client #2's meetings and would like to be involved. She indicated client</p>		<p>The Area Director will meet with the Home Manager and Program Director once a week for the first four weeks to review all communication between Indiana MENTOR and the guardians/family members, and to discuss any upcoming annual meetings that need to be scheduled. After the initial four weeks, the Area Director, Program Director, and Home Manager will continue to meet twice a month for three months to continue to review and discuss the ongoing communication between the guardians/family members and Indiana MENTOR and the upcoming annual meetings and the communication regarding them. Ongoing, the Area Director reviews all completed ISPs and team meeting notes to ensure accuracy and completion, on time and guardian/family involvement.</p>	

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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
W000263	<p>#2's co-guardian may have been notified, but she was not.</p> <p>The Area Director was interviewed on 4/10/14 at 3:00 PM and indicated there was no evidence clients #1, #2, #3 and #4 guardians had participated in their ISPs.</p> <p>9-3-4(a) 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.</p> <p>Based upon record review and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) to ensure guardian consent was obtained for their restrictive behavior support plans (BSP).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 4/8/14 at 12:55 PM. The record indicated client #1 had a guardian. A BSP dated 8/1/12 indicated target objectives of irritability (fretful, angry), teasing, refusal to eat at scheduled mealtime and phone misuse (using cell phone to call/text another individual in a manner that can be construed as harassment). The plan included restriction of his phone. There was no evidence client #1's guardian consented to the plan or of the facility's human rights committee (HRC) review and approval of the plan.</p> <p>Client #2's record was reviewed on 4/8/14 at</p>	W000263	<p>The Home Manager and Program Director will be retrained on Indiana MENTOR's policy and procedures regarding ongoing guardian and family contact. The Program Director will be retrained on obtaining guardian approval on all restrictive plans (Behavior Support Plans) before retrieving Human Rights Committee approvals and before implementation. This retraining will include the need for the guardian to be actively involved in the creation and maintenance of the annual behavior support plan. The Program Director will send out a letter to all guardians and/or family members introducing himself and the House Manager, and ensure that everyone has correct contact information. A documented invitation will be sent out to each guardian and family member for the upcoming annual meeting with an RSVP for</p>	05/10/2014

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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>1:45 PM. The record indicated client #2 had two co-guardians. A BSP dated 1/24/14 indicated target behaviors of resistance (refusals to comply with a request), instigating (attempting to engage housemates into arguments), extreme irritability (fretful, angry), physical aggression (hitting, spitting, scratching, pinching, kicking, biting, pulling hair, head-butting, pushing, and/or striking with objects), temper outbursts (crying loudly, stamps feet, kicks), inappropriate urination (urination or defecation any area except the interior of a toilet), inappropriate boundary/inventing others space. The plan included the use of clonazepam (anxiety), risperidone (anti-psychotic), buspirone (anxiety) and klonopin (anxiety). There was no evidence client #2's co-guardians consented to the plan or of the facility's human rights committee (HRC) review and approval of the plan.</p> <p>Client #3's record was reviewed on 4/8/14 at 11:38 AM. The record indicated client #3 had a guardian. A BSP dated 4/21/13 indicated target behaviors of resistance (refusal to comply with request), stealing (taking others' property), verbal aggression (threats, giving others the middle finger), physical aggression (hitting, spitting, scratching, pinching, kicking, biting, pulling hair, head-butting, pushing, and/or striking with a held or propelled object), spitting, inappropriate urination (urination or defecation outside of the toilet), hoarding food (hiding food or drink in her room), and destroys property (purposely damaging others property). The plan included the use of room and personal searches for hoarded items, restitution for damaged property and physical techniques (unspecified) to address physical aggression.</p>		<p>attendance. If the family/guardian is unable to attend, the meeting will either be rescheduled to accommodate the schedule, or a final draft of the letter will be sent out for review and signature after the meeting. According to Indiana MENTOR's policy and procedure, an Behavior Support Plan is considered incomplete if a guardian signature is required but not obtained. At each client's annual team meeting, the amount of communication between Indiana MENTOR and the family is discussed and agreed upon. The Area Director will meet with the Home Manager and Program Director once a week for the first four weeks to review all communication between Indiana MENTOR and the guardians/family members, and to discuss any upcoming annual meetings that need to be scheduled. After the initial four weeks, the Area Director, Program Director, and Home Manager will continue to meet twice a month for three months to continue to review and discuss the ongoing communication between the guardians/family members and Indiana MENTOR and the upcoming annual meetings and the communication regarding them. Ongoing, the Area Director reviews all completed BSPs and team meeting notes to ensure accuracy and completion, on time, and</p>	

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 04/10/2014	
NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214			
(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			
W000289	<p>There was no evidence client #3's guardian consented to the plan or of the facility's human rights committee (HRC) review and approval of the plan.</p> <p>Client #4's record was reviewed on 4/8/14 at 1:35 PM. The record indicated client #4 had a guardian. A Behavior Support Plan (BSP) dated 6/14/13 indicated target objectives of inappropriate boundaries (invading others personal space), inappropriate sexual behavior (touching others), and extreme irritability (fretful, angry). The plan included the use of physical techniques (not specified) to address physical aggression. There was no evidence in the plan of guardian consent for the BSP or of the facility's Human Rights Committee's review and approval of the plan.</p> <p>The Area Director was interviewed on 4/9/14 at 2:20 PM and indicated she would need to locate the signature sheets for the clients' BSPs.</p> <p>Client #2's guardian was interviewed on 4/10/14 at 9:00 AM and indicated she had not been notified of client #2's planning meetings and would like to be involved.</p> <p>The Area Director indicated on 4/10/14 at 1:13 PM there was no evidence client #1, #2, #3 and #4 guardians had consented to the plans or of the HRC review and approval of their plans.</p> <p>9-3-4(a) 483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual</p>		guardian/family involvement.				

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 04/10/2014
NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214		
(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>program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based upon record review and interview for 2 of 4 sampled clients (clients #3 and #4), the facility failed to ensure physical techniques to manage behavior were specifically identified and a hierarchy of their use was included in their behavior plans.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 4/8/14 at 11:38 AM. A BSP (Behavior Support Plan) dated 4/21/13 indicated target behaviors of resistance (refusal to comply with request), stealing, verbal aggression (threats, giving others the middle finger), physical aggression (hitting, spitting, scratching, pinching, kicking, biting, pulling hair, head-butting, pushing, and/or striking with a held or propelled object), spitting, inappropriate urination (urination or defecation outside of the toilet), hoarding food (hiding food or drink in her room), and destroys property (purposely damaging others property) . The plan included the use of room, personal searches for hoarded items, restitution for damaged property and the use of "Indiana Mentor-approved PIA (physical intervention alternatives)" physical techniques to address physical aggression. There was no evidence of which techniques to use or a hierarchy for their use.</p> <p>Client #4's record was reviewed on 4/8/14 at 1:35 PM. A BSP dated 6/14/13 indicated target objectives of inappropriate boundaries (invading others personal space), inappropriate sexual behavior (touching</p>	W000289	All Behavior Support Plans will be reviewed for the use of Indiana MENTOR's restrictive use of Physical Interventions Alternatives (PIA). If PIA is included in the BSP, and addendum will be included that will address the specific techniques that may or may not be used, along with the hierarchy for their use. All Direct Support Professionals are trained on Indiana MENTOR's PIA policy and procedures upon hire, and then again annual each year afterwards. This training includes the use of each client's specific behavior support plan first, and then only implementing the PIA techniques if and when aggression increases and someone's health and safety are at risk. All behavior support plans are written together between the Program Director and the Behavior Specialist, and then reviewed by the Area Director before being approved by the guardian and the Human Rights Committee. Ongoing, the Behavior Specialists and Program Director will include the PIA specific techniques and a hierarchy of use.	05/10/2014	

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 04/10/2014	
NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214			
(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			
W000323	<p>others), physical aggression (striking, kicking, pulling hair, violently pulling clothing or glasses, biting or throwing objects) and extreme irritability (fretful, angry). The plan included the use of "Indiana Mentor-approved PIA (physical intervention alternatives)" physical techniques to address physical aggression. There was no evidence of which techniques to use or a hierarchy for their use.</p> <p>The Area Director (AD) was interviewed on 4/9/14 at 2:16 PM and indicated the clients' behavioral clinicians were updating the clients' plans as they were due after a previous survey citation regarding the need to include specific physical techniques and a hierarchy for their use.</p> <p>9-3-5(a) 483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based upon record review and interview, the facility failed for 1 of 4 sampled clients (client #4) to ensure a vision screening was completed annually.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 4/9/14 at 2:45 PM. A vision exam dated 1/24/12 indicated "Cataracts somewhat worse. Continue to follow...Follow up appointment date: 1-2 years." There was no evidence of a more recent eye examination for client #4.</p>	W000323	Client #4's appointment for an annual eye exam was rescheduled. The new Home Manager will be retrained on ensuring that follow up for all appointments are noted to the nurse and completed in a timely manner. The Program Nurse reviews books for each client every other week. During this time the Program Nurse will make a list of incomplete items at the end of the month. The Home Manager then has one month to get everything all caught up. This 'incomplete list' will include any follow up on medical	05/10/2014			

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 04/10/2014
NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214		
(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	
W000368	<p>The Area Director indicated on 4/10/14 at 1:13 PM there had not been an updated eye examination for client #4 and her eye examination was out of date.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p>	W000368	<p>appointments, appointments that need to be scheduled, and any medication requirements that need follow ups. For the following three months, the Program Nurse and Home Manager will meet at the beginning of the month to discuss the incomplete items from the month before and put a plan of action in place to ensure that all incomplete items are completed within the following 2 weeks. For these same three months, the Area Director will review the notes and action plan created and follow up at the end of that following month and the Home Manager will show proof that all items were followed up on. For example, in the beginning of May, the PN and HM will meet to discuss all incomplete items from the month of April. The HM will have all items completed by May 23, 2014. The HM and AD will meet before May 30, 2014 to discuss all items that were incomplete but now caught upon. After these three months and ongoing, the Home Manager and Program Nurse will continue to meet at the beginning of the month and make a list of all incomplete items that need follow up.</p> <p>Indiana MENTOR and the</p>	05/10/2014	

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 04/10/2014
NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214		
(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>Based upon record review and interview, the facility failed to ensure medications were administered without error for 3 of 4 sampled clients (clients #1, #2 and #3) and 1 additional client (client #7).</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 4/8/14 at 9:50 AM and indicated the following:</p> <p>A BDDS report dated 1/1/14 indicated client #2's Clonazepam (anti-anxiety) .5 mg (milligrams) was missing "and no where to be found." Client #2 missed doses at 7:00 AM, 5:00 PM and 9:00 PM. The Program Director (PD) contacted the police department and a police report was filed. "Annotation was made in the communication log book, but staff did not read the book which resulted in the client not receiving the medications for the day." The report indicated the nurse re-ordered client #2's medication and staff would be trained on reading the communication log.</p> <p>A BDDS report dated 1/4/14 indicated client #2 missed her 7:00 AM dose of Klonopin (Clonazepam) on 1/4/14 as the medication was not available in the house "because they ran out the night before." The pharmacy was notified and delivered client #2's medication. Plan to resolve indicated the Program Director (PD) over the group home was notified of the medication error and is aware of the pills the pharmacy sent. A follow up report dated 1/4/14 indicated the pharmacist did not send enough medication which</p>		<p>Williams Brother's Pharmacy completed another meeting on April 28, 2014 to discuss the ongoing medication errors. The following plan(s) were put into place:</p> <ul style="list-style-type: none"> ·All medication administration sheets are sent to the Program Nurse for review. All rewrites and corrections will be sent back to the pharmacy for corrections for the following month. ·All medications that are not covered by Medicaid will not automatically be delivered to the house, but will instead be reviewed by the doctor and either a Medicaid Prior Authorization will be obtained or a new medication will be prescribed. ·A Fill List will be emailed to the House Manager for review of all medications to be delivered for the normal cycle fill, and if any errors are noted, the HM will have 24 hours to return the list to the pharmacy for review and corrections. ·Upon delivery of all cycle fill meds, the House manager will have 24 hour to check in the medications and let the pharmacy know if any errors persist. ·Any errors found by the pharmacy will be taken to the Area Director for distribution and immediate follow up. <p>If any medications errors consist, a BDDS report will be completed, and it will be specified what the reason is for the medication error, and what is in place to fix it. All</p>		

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 04/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214
--	--

(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>resulted in the missed medication. "A meeting was held with the pharmacist and the issue was addressed. The pharmacist will in the future call the PD and house manager as to the number of pills required so that this will not happen again."</p> <p>A BDDS report dated 1/29/14 indicated client #1 had not received Levofloxacin (antibiotic) 500 mg (milligrams) as was prescribed by his physician since 1/24/14 for a diagnosis of bronchitis. The report indicated the medication had been delivered to the group home, but had not been given to client #1.</p> <p>A BDDS report dated 3/1/14 indicated client #7 did not take her Glimeperide (diabetes) 2 mg at 7:00 AM as the medication was not available in the home. The pharmacy was notified and the medication was delivered to the home. Corrective action indicated "Communicate between PD and [Pharmacy name] to make sure all meds (medications) are accounted before to eliminate future occurrences." A follow up report dated 3/18/14 indicated client #7's medication order for Glimeperide had been faxed to the pharmacy, but the staff and the group home and the house manager did not follow up to ensure that it was delivered. "All staff and the home manager were in-serviced on the protocol that must take place when faxing in orders. The home manager will ensure that all faxed orders will be followed up by her as well as the staff are to alert her as to all orders that have been faxed in to the pharmacy. The home manager will follow up the same day and receive confirmation that the medicine was delivered."</p> <p>A BDDS report dated 3/14/14 indicated "a script (prescription) was written for consumer</p>		<p>Program Directors and Home Managers will be retrained on these pharmacy changes in the monthly meeting on May 14, 2014. These changes will take place immediately. Ongoing, Indiana MENTOR Regional Director, Area Director, and Program Nurses will continue to meet with the pharmacy every 2 months to discuss the current plan, or change anything that is not working.</p>	

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 04/10/2014	
NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214			
(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			
W000440	<p>(client #3) because of a sore under her tongue. The order for oral gel was faxed in but never delivered to the group home." The medication was delivered and "in the future the home manager from this point on will follow up to all scripts to ensure it was delivered and administered as prescribed."</p> <p>The Area Director (AD) was interviewed on 4/8/14 at 12:15 PM. She stated "We are meeting with the pharmacy periodically to resolve the situation." She indicated a full list of clients' medications was delivered the month prior for the home manager to review to ensure medications are available. She indicated the system in place had not yet prevented all medication errors.</p> <p>9-3-6(a) 483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based upon record review and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4), and for 4 additional clients (clients #5, #6, #7 and #8) to conduct quarterly evacuation drills for the 2:00 PM to 10:00 PM shift and for the 10:00 PM to 6:00 AM shift.</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 4/8/14 at 1:50 PM. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, #5, #6, #7 and #8 for the 2:00 PM to 10:00 PM shift from 8/29/13 to 2/10/14 and on the 10:00 PM to 6:00 AM shift from 6/20/13 to 4/8/14.</p>	W000440	All direct support professionals will be retrained on Indiana MENTOR's policy and procedures regarding fire drills. The Home Manager and Program Director will be retrained on Indiana MENTOR's policy and procedures for fire drills. The Home Manager will ensure that all direct support professionals complete a fire drill each month, according to the Indiana MENTOR fire drill schedule. All fire drills are scheduled randomly to ensure that a drill is completed on each shift for 2014. All fire drills are reviewed by the Quality Assurance Manager. If errors are found, then the drills are returned	05/10/2014			

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 04/10/2014
NAME OF PROVIDER OR SUPPLIER REM- INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7044 CASTLE MANOR INDIANAPOLIS, IN 46214		
(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 Area Director (AD) was interviewed on 4/9/14 at 2:05 PM and indicated there were no drills during the 2:00 PM to 10:00 PM shift from 8/29/13 to 2/10/14 and on the 10:00 PM to 6:00 AM shift from 6/20/13 to 4/8/14. 9-3-7(a)		and the staff must complete them again. A monthly spreadsheet is sent out to the Area Director and the Program Directors for review of any drills that are outstanding, incomplete, or wrong. If any remain out of compliance, the Home Manager will retrain all DSPs on fire drills, again.		