

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G538	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/24/2012
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1221 E CR 75 N LOGANSPOORT, IN 46947		
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W0000	<p>This visit was for investigation of complaint #IN00103102.</p> <p>Complaint #IN00103102: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W104, W149, W268, W318, and W331.</p> <p>Dates of Survey: February 16, 17, 20, 21, 22, 23, and 24, 2012.</p> <p>Provider Number: 15G538 Facility Number: 001052 AIM Number: 100239830</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed 3/1/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000	All corrections will be made by the March 25, 2012 deadline.		

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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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review, and interview, the governing body failed to exercise operating direction over the facility to provide oversight of personal expenditures for 1 of 2 sample clients (client B).</p> <p>Findings include:</p> <p>On 2/16/12 from 6:15am until 8:15am, client B was observed at the group home. Client B was non verbal and did not watch television. Each time client B walked in and out of the living room, television room, bathroom, and bedroom of the facility she was redirected to the living room and to sit down in a square chair by the facility staff. The living room had one brown square chair, one brown round chair, and one brown sofa. At 6:30am, DCS (Direct Care Staff) #2 and the House Manager (HM) both indicated client B had purchased the square chair in the living room during the previous year, the round chair in the living room in July, 2011, and the new large screen television in the television room during 2011. At 6:45am, the HM and DCS #2 both stated client B's square</p>	W0104	<p>The facility currently trains all employees and supervisors upon hire on the mandated financial system. The financial system ensures all client purchases are documented and monitored by the oversight of a supervisor to ensure client funds are protected. The House Manager will re-train the staff in the home to ensure that all client purchases from client checkbooks are approved by a supervisor prior to expenditures being made. The training will include directives to only purchase items with client funds that are directly used by the client and not used by all in the common areas of the home. The client purchases of the television and chair have been reimbursed in full by Indiana MENTOR. The House Manager and Program Director will be retrained on finances and appropriate purchases for group home clients funds vs purchases to be made by Indiana Mentor. The chair that was described as being covered in mucus and urine has been disposed of. In the future, The House Manager will make purchases and the Program Director will review all purchases monthly for accuracy of funds and appropriateness of purchases. Upon Program Director review,</p>	03/23/2012	

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	<p>chair in the living room had "dried drool" (mucus) and urine embedded in the chair. Both the HM and DCS #2 stated the square chair "stunk, had worn fabric, and smelled real bad." The HM indicated the previous HM had purchased the new round chair and large screen television for client B from her personal funds. At 6:45am, DCS #2 and DCS #3 both indicated client B did not sit in the round chair because she was incontinent of urine. Both DCS #2 and DCS #3 indicated client B did not watch television.</p> <p>On 2/16/12 at 6:30am, client B's personal fund receipts at the group home were reviewed. Client B's 7/2011 "Check Register Record" indicated a receipt on 7/5/11 to the furniture store for a chair in the amount of "517.50." Client B's 6/2011 "Check Register Record" indicated a receipt on 6/1/11 to the electronics store for a "TV (Television) and DVD player" in the amount of \$1050.70. Both receipts were signed for by the previous House Manager.</p> <p>On 2/16/12 at 10:30am, client B's record was reviewed. Client B's 1/29/12 "Risk Management Plan" indicated "Financial" did not manage own finances and did "not understand money or its use, staff assist with purchases." The plan indicated the</p>		<p>the finances will be forwarded to the Chief Financial Specialist who will also review the purchases monthly to ensure they are appropriate. Responsible Person: Area Director Completion Date: 3/25/12.</p>	

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	<p>HM was responsible to obtain receipts and reconcile client B's account monthly.</p> <p>On 2/16/12 at 9:05am, an interview with the Program Director (PD) was conducted. The PD indicated client B was non verbal, did not understand money, and did not watch television. The PD indicated client B had purchased a new round brown chair and a new large screen television. The PD indicated both items were in common shared areas of the group home and not used by client B. The PD indicated the previous HM had purchased the items for the group home from client B's personal funds account. The PD stated the agency oversight was "only" to check for receipts for client B's purchases "not what the purchase was." The PD indicated the agency financial officer reviewed the receipts to match the items purchased to the receipts. The PD indicated no policy was available for review regarding large purchases from client personal funds accounts.</p> <p>This federal tag relates to complaint #IN00103102.</p> <p>9-3-1(a)</p>						

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W0149	<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.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 2 sample clients (client B), to implement their policy to protect her from financial exploitation from her personal fund account.</p> <p>Findings include:</p> <p>On 2/16/12 from 6:15am until 8:15am, client B was observed at the group home. Client B was non verbal and did not watch television. Each time client B walked in and out of the living room, television room, bathroom, and bedroom of the facility she was redirected to the living room and to sit down in a square chair by the facility staff. The living room had one brown square chair, one brown round chair, and one brown sofa. At 6:30am, DCS (Direct Care Staff) #2 and the House Manager (HM) both indicated client B had purchased the square chair in the living room during the previous year, the round chair in the living room in July, 2011, and the new large screen television in the television room during 2011. At 6:45am, the HM indicated the previous HM had purchased</p>	W0149	<p>The facility currently trains all employees and supervisors upon hire on the mandated financial system. The financial system ensures all client purchases are documented and monitored by the oversight of a supervisor to ensure client funds are protected. The House Manager will re-train the staff in the home to ensure that all client purchases from client checkbooks are approved by a supervisor prior to expenditures being made. The training will include directives to only purchase items with client funds that are directly used by the client and not used by all in the common areas of the home. The client purchases of the television and chair have been reimbursed in full by Indiana MENTOR. The House Manager and Program Director will be retrained on finances and appropriate purchases for group home clients funds vs purchases to be made by Indiana Mentor. The chair that was described as being covered in mucus and urine has been disposed of. In the future, The House Manager will make purchases and the Program Director will review all purchases monthly for accuracy of funds and appropriateness of purchases. Upon Program Director review,</p>	03/23/2012	

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	<p>the new round chair and large screen television for client B from her personal funds. At 6:45am, DCS #2 and DCS #3 both indicated client B did not sit in the round chair because she was incontinent of urine. Both DCS #2 and DCS #3 indicated client B did not watch television.</p> <p>On 2/16/12 at 6:30am, client B's personal fund receipts at the group home were reviewed. Client B's 7/2011 "Check Register Record" indicated a receipt on 7/5/11 to the furniture store for a chair in the amount of "517.50." Client B's 6/2011 "Check Register Record" indicated a receipt on 6/1/11 to the electronics store for a "TV (Television) and DVD player" in the amount of \$1050.70. Both receipts were signed for by the previous House Manager.</p> <p>On 2/16/12 at 10:30am, client B's record was reviewed. Client B's 1/29/12 "Risk Management Plan" indicated "Financial" did not manage own finances and did "not understand money or its use, staff assist with purchases." The plan indicated the HM was responsible to obtain receipts and reconcile client B's account monthly.</p> <p>On 2/16/12 at 9:05am, an interview with the Program Director (PD) was conducted. The PD indicated client B</p>		<p>the finances will be forwarded to the Chief Financial Specialist who will also review the purchases monthly to ensure they are appropriate. Responsible Person: Area Director Completion Date: 3/25/12</p>				

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	<p>was non verbal, did not understand money, and did not watch television. The PD indicated client B had purchased a new round brown chair and a new large screen television. The PD indicated both items were in common shared areas of the group home and not used by client B. The PD indicated the previous HM had purchased the items for the group home from client B's personal funds account. The PD stated the agency oversight was "only" to check for receipts for client B's purchases "not what the purchase was."</p> <p>On 2/16/12 at 9am, a record review of the facility's 7/2006 "Quality and Risk Management" indicated the company prohibited neglect of clients which included exploitation and indicated the clients would be protected from exploitation.</p> <p>This federal tag relates to complaint #IN00103102.</p> <p>9-3-2(a)</p>				

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W0268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 2 sample clients (client B), to promote client B's dignity in regard to using a clean chair, wiping her mouth, and to wear a clean shirt.</p> <p>Findings include:</p> <p>On 2/16/12 from 6:15am until 8:15am, client B was observed at the group home. Client B was non verbal and wore an adult incontinent brief. Each time client B walked in and out of the living room, television room, bathroom, and bedroom of the facility she was redirected to the living room and to sit down in a square chair by the facility staff. The living room had one brown square chair, one brown round chair, and one brown sofa. From 6:15am until 8:15am, client B drooled from her mouth onto her shirt without staff assistance. The front of client B's shirt was wet from the neck line to her stomach of the shirt. At 6:30am, DCS (Direct Care Staff) #2 and the House Manager (HM) both indicated client B had purchased the square chair in the living room during the previous year, the</p>	W0268	<p>The facility currently trains all employees upon hire and at least annual updates on client rights, human dignity and care for endangered adults. The staff are trained to assist the clients with hygiene, cleanliness and overall care of the client to ensure human rights and dignity. The Home Manager will re-train the staff to assist client B with hygiene, dressing, eating and all other living skills to ensure human dignity and appropriate sanitary client care. The training will include cleanliness for the home and furniture as well. The staff will be trained on a new goal for client B, that encourages the client to work on independence of wiping her face as needed. In the future, the Home Manager will moniotr client hygiene including goals on a daily basis. The home manager will monitor the home environment on a weekly basis. The Program Director will monitor by observation and home visits at least monthly as additional oversight. Responsible Person: Program DirectorCompletion date: 3-25-12</p>	03/25/2012	

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	<p>round chair in the living room in July, 2011, and the new large screen television in the television room during 2011. At 6:45am, the HM and DCS #2 both stated client B's square chair in the living room had "dried drool" (mucus) and urine embedded in the chair. Both the HM and DCS #2 stated the square chair "stunk, had worn fabric, and smelled real bad." The HM indicated the previous HM had purchased the new round chair and large screen television for client B from her personal funds. At 6:45am, DCS #2 and DCS #3 both indicated client B did not sit in the round chair because she was incontinent of urine. Both DCS #2 and DCS #3 indicated client B did not watch television.</p> <p>On 2/16/12 at 10:30am, client B's record was reviewed. Client B's 1/29/12 "Risk Management Plan" indicated she was incontinent of urine, drooled mucus onto herself and objects, and was dependent on staff to assist her with hygiene.</p> <p>On 2/16/12 at 9:05am, an interview with the Program Director (PD) was conducted. The PD indicated client B was non verbal, incontinent of urine, and drooled mucus. The PD indicated client B required staff assistance and encouragement to use a napkin to wipe the drool, to assist her to and from</p>			

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W0318	<p>bathroom for toileting, and for her personal hygiene needs.</p> <p>This federal tag relates to complaint #IN00103102.</p> <p>9-3-5(a)</p> <p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on record review and interview, the Condition of Participation: Health Care Services, was not met as the facility failed to provide health care monitoring and oversight of nursing services for 1 of 1 sample client (client C) with an identified risk of pneumonia.</p> <p>Findings include:</p> <p>Please refer to W331. The facility's nursing services failed to ensure client C received nursing services according to his identified risk of pneumonia.</p> <p>This federal tag relates to complaint #IN00103102.</p> <p>9-3-6(a)</p>	W0318	W 318:See W 331	03/23/2012			

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on interview and record review, for 1 of 1 client (client C) with identified medical needs, the facility's nursing services failed to ensure client C received nursing services according to his identified risk of pneumonia.</p> <p>Findings include:</p> <p>On 2/16/12 at 9:05am, the facility's BDDS (Bureau of Developmental Disability Services) Reports from 11/1/2011 through 2/16/12 were reviewed and indicated the following for client C:</p> <p>-A 12/11/2011 BDDS report for an incident on 12/10/11 at 6:45pm, indicated client C was taken to the ER (Emergency Room) based on "staff finding him laying on the couch, unresponsive, and his lips and fingertips blue (sic)." The report indicated client C was "breathing, but his breathing was shallow. 9-1-1 was called around 6:47pm" and client C was admitted to the ICU (Intensive Care Unit).</p> <p>-A 12/8/2011 BDDS report for an incident on 12/7/11 at 10:45pm, indicated client C was taken to the ER "based on a</p>	W0331	<p><b>W331:</b> The facility provides nursing services for the clients in the group home on a daily basis to ensure medical needs of the clients are being met. The facility nurse trains staff upon hire and as needed on medical treatments and procedures necessary to ensure the client medical needs are being met. The nurse monitors the documentation of medical orders to weekly to ensure procedures are being carried out as ordered by the doctor. The facility had followed up to reschedule the appointment for client C as enclosed. Indiana Mentor investigated the 12/7/12 incident of choking immediately upon it being reported which did not occur until 12/10/12 upon the clients admittance to the hospital. The investigation indicated the failure to report by the previous House Manager at which time he was terminated per Mentor policy. The direct support staff have been re-trained to implement medical procedures and protocols as written for client C prior to his return from the hospital. The Home Manager and Program Director have been trained to monitor medical documentation and doctor's orders to ensure client care is carried out. In the future, the client medical information will be</p>	03/25/2012			

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	<p>temperature of 103 degrees and shaking" and client C was diagnosed with "developing pneumonia. [Client C] is to follow up with his family physician on Friday (12/9/11)."</p> <p>On 2/16/12 at 9:05am, the facility's Investigations were reviewed and indicated the following for client C: -A 12/19/11 investigation for client C's incident on 12/11/11 indicated client C was admitted to the hospital on 12/11/11 with "Aspiration Pneumonia." The investigation indicated client C had a "choking incident on 12/7/11" at supper and "eventually coughed out some biscuit." Client C had choked and the staff removed his plate from use twice during the meal and the HM (House Manager) had not reported the choking event. The investigation indicated on 12/10/11, client C "started eating, started to cough, and staff took away the plate, gave [client C] some liquids, and then gave [client C] his plate back...[client C] took a few bites and started to cough again. Staff took the plate away from [client C] a second time according to choking protocol...." The investigation indicated client C "went to lay down" and "dinner was around 5pm." The investigation indicated client C was found at "6:45pm" and "when [client C] was found, he was laying on the couch on his</p>		<p>monitored by the home manager on a daily basis, by the nurse on a weekly basis and by the program director on a weekly basis. After one month, the monitoring will continue at the frequency of nurse on a monthly basis, home manager on a weekly basis, and program director on monthly basis to ensure all medical practices are being carried out correctly and documented as per doctor's orders. Responsible Person: Area Director Completion Date: 3/25/12</p>	

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	<p>back...fingertips and mouth were blue but he was breathing shallow breaths and 9-1-1 was called."</p> <p>The 12/19/11 investigation for client C's 12/10/11 incident included a witness statement from the HM which indicated he took client C to his physician's appointment on 12/9/11, indicated client C refused to exit the vehicle, the HM texted the agency nurse, and the nurse indicated "the staff need to do whatever they needed to (for) [client C] to see the doctor." The HM indicated he "was not comfortable with that since we can not make the client do anything" and indicated he had "payroll to complete" for the group home. Client C's doctor's appointment was canceled by the HM with no follow up documentation available for review and no documentation was available for review that the agency nurse was notified.</p> <p>The 12/19/11 investigation "Conclusion" indicated: -"Evidence supports that [client C] exhibited an uncorrected coughing episode on 12/7/11 during dinner and staff did stop the meal according to choking protocol." -"Evidence supports that staff did not notify the Program Director or Nurse according to the choking protocol."</p>			

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(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>- "Evidence supports that staff did communicate to the House Manager that something had occurred during dinner with [client C] that resulted in staff removing his plate and stopping the meal."</p> <p>- "Evidence supports that [client C] missed a follow up appointment from the ER visit that occurred on 12/7/11-12/8/11 and was diagnosed with pneumonia."</p> <p>- A 12/8/11 Investigation for client C's incident on 12/7/11 at 10:45pm, indicated client C was taken to the ER "based on a temperature of 103 degrees and shaking." The investigation indicated client C had been given another client's seizure medication earlier in the day, staff were monitoring his vital signs, client C went to bed "around 7pm," and client C was "not acting right." The investigation indicated client C's "fingertips were freezing" and he was wearing a jacket at the time his temperature was taken to be 103 degrees. Client C was taken to the ER after "the Program Director and and Area Director" were contacted. The investigation indicated the "nurse on duty" was contacted after client C went to the ER. Client C was given medication and diagnosed with "developing pneumonia. [Client C] is to follow up with his family physician on Friday (12/9/11)."</p>				

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	<p>On 2/22/12 at 5pm, client C's 11/5/11 through 2/16/12 "Nursing Progress Notes" were reviewed and did not indicate the date the agency nurse physically saw client C. Client C's Nursing Progress Notes indicated the agency nurse documented when the facility staff contacted her after the 12/10/11 incident and the information the facility staff provided regarding client C. The Nursing Progress Notes indicated the nurse's contact person was the previous House Manager who relayed client C's information which the staff had told him.</p> <p>On 2/16/12 at 10am, client C's record was reviewed. Client C's record indicated he was non verbal. Client C's 3/5/11 ISP (Individual Support Plan) indicated he had an identified risk of choking on food and had a history of refusing to exit the vehicle for medical appointments. Client C's 1/19/11 "Risk Management Plan" indicated he "presents a risk" of "choking risk, stuffs food in mouth and has had choking incident in the past, has a trigger sheet and choking protocol in place. (Client C's Choking Protocol indicated) Staff serving meals and encouraging [client C] to take small bites and thoroughly chew food (sic)." The plan included staff were to remove client C's plate if client C coughed or began rapid</p>			

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	<p>eating. The plan indicated staff were to call the HM, then the HM would contact the Program Director and the agency nurse.</p> <p>On 2/16/12 at 1pm, client C's hospital record was reviewed. The record indicated client C was treated on 12/7/11 for a diagnosis "developing pneumonia" and was treated a second time and admitted on 12/10/11 for a diagnosis of aspiration pneumonia.</p> <p>On 2/24/12 at 11:10am, an interview with the Program Director (PD) was completed. The PD indicated she "knows the LPN (Licensed Practical Nurse) was present and saw [client C] on 12/8/11" at the group home. The PD indicated no documentation was available for review to indicate when the agency nursing services saw client C in person. The PD indicated the agency nurse was not available for interview. The PD indicated no documentation was available for review to indicate if client C's medical appointment was rescheduled on 12/9/11 when he had refused to exit the vehicle. The PD stated client C had "a long history" of refusing to exit the vehicle during medical appointments. The PD indicated no documentation was available for review to determine if client C's choking protocols were reviewed after the</p>			

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	<p>first choking with aspiration incident on 12/7/11. The PD provided client C's 2/14/2012 "Aspiration Protocol" and stated "we developed it before [client C] will be readmitted" to the group home. The PD indicated client C did not receive nursing services based on his identified risk of aspirating his food.</p> <p>This federal tag relates to complaint #IN00103102.</p> <p>9-3-6(a)</p>			