

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  03/01/2012	
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
W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: February 27, 28, March 1, 2012</p> <p>Facility number: 000883 Provider number: 15G369 Aim number: 100244300</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 3/9/12 by Ruth Shackelford, Medical Surveyor III.</p>			W0000			

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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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 4 sampled clients (#1) to ensure the client's dining training program was implemented when opportunities were present.</p> <p>Findings include:</p> <p>An observation at the group home was done on 2/27/12 from 4:08p.m. to 6:09p.m. At 5:21p.m., client #1 was served her supper. Client #1 did not eat her garlic bread which was served as a whole piece, not cut up.</p> <p>The record of client #1 was reviewed on 2/28/12 at 11:18a.m. Client #1's 11/16/11 "staff meeting notes" indicated client #1 was to receive her food cut up.</p> <p>Interview of staff #1 on 2/28/12 at 1:34p.m. indicated client #1's dietary program (food cut up) should have been implemented at all opportunities.</p> <p>9-3-4(a)</p>	W0249	<p>After client #1 had a choking incident, the IDT met and determined that until her swallow study was completed; she would need all of her food to be cut up. Client # 1 had a swallow study completed 12-1-2011 and the Primary Care Physician determined based on those results that her diet would not need to be changed and that she could go back to a regular diet, but still with her current aspiration protocol in place. See attachment 1. Ongoing, Home Manager and/or Program Director will complete 2 weekly meal time observations to ensure that all staff are following Client # 1's aspiration protocol as it is written, and also to ensure that no further recommendations are needed. Completion Date: March 31, 2012 Responsible Party: Home Manager and Program Director</p>	03/31/2012			

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