

| | | | |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/02/2015 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

| | |
|-----------------------------------------------------|----------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410 |
|-----------------------------------------------------|----------------------------------------------------------------------------------|

| (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 |
|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| W 000 Bldg. 00 | <p>This visit was for the post certification revisit to an annual recertification and state licensure survey conducted on January 16, 2015.</p> <p>Dates of survey: March 26, 27 and April 2, 2015.</p> <p>Facility Number: 001113 AIM Number: 100245610 Provider Number: 15G599</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9.</p> | W 000 | | |
| W 125 Bldg. 00 | <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview, the facility failed for 7 of 8 clients residing at the group home (clients #1, #2, #3, #5, #6, #7 and #8) to provide assistance to exercise their rights by restricting access to knives.</p> | W 125 | <p>W125: The facility ensures the rights of all clients. The facility advocates for and encourages each individual to exercise their rights as clients and citizens including the right to file complaints and the right to due process. The knives in the home</p> | 05/02/2015 |

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: 15G599 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 04/02/2015 |
|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------|

| | |
|-----------------------------------------------------|----------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410 |
|-----------------------------------------------------|----------------------------------------------------------------------------------|

| (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>Findings include:</p> <p>An evening observation was conducted at clients #1, #2, #3, #5, #6, #7 and #8's home on 3/27/15 from 5:00 P.M. until 6:00 P.M.. At 5:25 P.M., a container of knives was observed in the locked hall closet.</p> <p>A review of client #1's records was conducted on 4/2/15 at 12:00 P.M.. The review failed to indicate the need for the restriction to knives for client #1. Further review of the record failed to indicate measures were in place to teach the client to access the knives.</p> <p>A review of client #2's records was conducted on 4/2/15 at 12:10 P.M.. The review failed to indicate the need for the restriction to knives for client #2. Further review of the record failed to indicate measures were in place to teach the client to access the knives.</p> <p>A review of client #3's records was conducted on 4/2/15 at 12:15 P.M.. The review failed to indicate the need for the restriction to knives for client #3. Further review of the record failed to indicate measures were in place to teach the client to access the knives.</p> <p>A review of client #5's records was</p> | | <p>were locked due to a client historical incident. The client behavior has not occurred in years therefore not deemed by the team as an active behavior. Therefore, the knives in the home have been unlocked to allow free access by all clients in the home. The staff will continue to work with the clients use safety in handling all sharp objects. In the future, the facility home manager will continue to train the staff on client rights to ensure the clients' have access to all areas of their home. The home manager will check the knives during weekly home checks to ensure the knives remain unlocked and accessible. The Program Director will review the home manager checklists weekly. Person Responsible: Program Director Completion Date: 5/2/15</p> | |

| | | | |
|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 04/02/2015 |
|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------|

| | |
|-----------------------------------------------------|----------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410 |
|-----------------------------------------------------|----------------------------------------------------------------------------------|

| (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>conducted on 4/2/15 at 12:20 P.M.. The review failed to indicate the need for the restriction to knives for client #5. Further review of the record failed to indicate measures were in place to teach the client to access the knives.</p> <p>A review of client #6's records was conducted on 4/2/15 at 12:25 P.M.. The review failed to indicate the need for the restriction to knives for client #6. Further review of the record failed to indicate measures were in place to teach the client to access the knives.</p> <p>A review of client #7's records was conducted on 4/2/15 at 12:30 P.M.. The review failed to indicate the need for the restriction to knives for client #7. Further review of the record failed to indicate measures were in place to teach the client to access the knives.</p> <p>A review of client #8's records was conducted on 4/2/15 at 12:35 P.M.. The review failed to indicate the need for the restriction to knives for client #8. Further review of the record failed to indicate measures were in place to teach the client to access the knives.</p> <p>An interview with the Program Director (PD) was conducted on 4/2/15 at 2:25 P.M.. The PD indicated the restriction of</p> | | | |

| | | | |
|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 04/02/2015 |
|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------|

| | |
|-----------------------------------------------------|----------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410 |
|-----------------------------------------------------|----------------------------------------------------------------------------------|

| (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 |
|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|----------------------|
| | knives was approved due to client #4 requiring a restriction to the access to knives. The PD further indicated there were no measures in place to teach each client to access the knives. This deficiency was cited on 1/16/15. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a) | | | |
| W 210 Bldg. 00 | 483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, record review and | W 210 | W210 The facility currently meets with the client interdisciplinary | 05/11/2015 |

| | | | |
|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 04/02/2015 |
|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------|

| | |
|-----------------------------------------------------|----------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410 |
|-----------------------------------------------------|----------------------------------------------------------------------------------|

| (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>interview for 2 of 2 clients who used wheelchairs (clients #6 and #7), the facility failed to assess/reassess the clients' use of a wheelchair.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 3/27/15 from 5:00 P.M. until 6:00 P.M.. During the entire observation, clients #2 and #6 were observed sitting in standard wheelchairs.</p> <p>A facility owned day program observation was conducted on 4/2/15 from 10:00 A.M. until 12:45 P.M.. During the entire observation client #2 sat in a standard wheelchair. Client #6 was observed sitting in a different wheelchair than the one she was observed sitting in during the 3/27/15 observation.</p> <p>A review of client #2's records was conducted on 4/2/15 at 12:10 P.M.. Review of client #2's record failed to indicate an assessment was completed to indicate which type of wheelchair she should use for mobility needs.</p> <p>A review of client #6's records was conducted on 4/2/15 at 12:25 P.M.. Review of client #6's record failed to indicate an assessment was completed to indicate which type of wheelchair she</p> | | <p>team 30 days after admission and at least annually to review assessment of the client progress and areas for potential needs. The facility nurse reviews the assessment to ensure the medical needs of the clients are met. The facility completes assessments on the adaptive equipment of clients at least annually or as required. The Program Director and nurse have scheduled the needed client mobility evaluations for clients 2 and 6 to assess mobility and equipment/ wheelchairs specific to each client. The Program Director will follow through to implement the recommendations resulting from the assessments upon completion. The results will be shared with day program to ensure the client information is consistent in both forums. The nurse and Program Director have been trained to complete a monthly list of client appointments and assessments needed to ensure all clients receive the care required. In the future, the Program Director and the facility nurse will review what assessments are required for each person prior to the client annual review date and on-going throughout the year. The Program Director will complete goals that correspond with needs of the client based on the outcome of the assessments as needed. The Home Manager, nurse and Program Director will</p> | |

| | | | |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/02/2015 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

| | |
|-----------------------------------------------------|----------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410 |
|-----------------------------------------------------|----------------------------------------------------------------------------------|

| (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>should use for her mobility needs.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/2/15 at 2:15 P.M.. The QIDP indicated there was no documentation available for review to indicate clients #2 and #6 had assessments completed for the use of wheelchairs.</p> <p>This deficiency was cited on 1/16/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> | | <p>monthly review a list of client needed appointments. The Nurse will notify the Area Director regarding any problems with client appointments. The Area Director will meet monthly with the PD to follow up to ensure client appointments have been carried out. The Program Director will ensure client wheelchairs are assessed by a physician or other wheelchair specialist at least annually by reviewing the medical assessment checklist. Person Responsible: Area Director Completion Date: 5/11/15</p> | |
| W 249 Bldg. 00 | <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</p> | | | |

| | | | |
|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 04/02/2015 |
|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------|

| | |
|-----------------------------------------------------|----------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410 |
|-----------------------------------------------------|----------------------------------------------------------------------------------|

| (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>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, interview and record review for 2 of 4 sampled clients and 2 additional clients (clients #1, #3, #5 and #7), the facility failed to implement the clients' Individual Support Plan (ISPs) objectives when formal and/or informal opportunities for training existed.</p> <p>Findings include:</p> <p>A facility owned day program observation was conducted on 4/2/15 from 10:00 A.M. until 12:45 P.M.. During the entire observation period, clients #1 and #5 were non-verbal in communication in that the clients did not speak. No communication training was provided and/or encouraged. Client #3 only used 1 word answers during the entire observation. No communication training was provided and/or encouraged. During the entire observation period clients #1, #3 and #7 sat with no activity and client #5 slept on a recliner.</p> <p>A review of client #1's records was conducted on 4/2/15 at 12:00 P.M.. The ISP dated 12/20/14 indicated the following training objectives could have been implemented: "Every med pass will</p> | W 249 | <p>W249</p> <p>The facility meets with the Interdisciplinary Team to determine the specific objectives necessary to meet the client's needs. The client goals and objectives are based on client and team input as well as comprehensive assessment results incorporated in the comprehensive functional assessment of the Individual Support Plan. The facility has put new tools in place to assist the direct support employees to implement the client goals and provide continual active treatment. The Program Director has trained the direct support employees to implement the client's objectives and goals formally and on informal opportunities as well. The goals for clients 1, 2, 5, and 7 were reviewed to ensure the clients are encouraged to complete the goals in formal and informal opportunities. The Home Manager has trained the day program staff on the clients' goal implementation formal and informally including communication.</p> <p>In the future, a facility manager will complete observations at least 5 times weekly to ensure the clients are challenged according to their abilities and ensure client</p> | 05/11/2015 |

| | | | |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/02/2015 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

| | |
|-----------------------------------------------------|----------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410 |
|-----------------------------------------------------|----------------------------------------------------------------------------------|

| (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>dispose of her cup...Will learn new site (sic) words...Will press the blender button...Will engage in meaningful activity...Will engage in some form of exercise."</p> <p>A review of client #3's records was conducted on 4/2/15 at 12:15 P.M.. The Individual Support Plan (ISP) dated 3/20/14 indicated the following training objectives could have been implemented: "Med Administration: Daily [client #3] will get his cup of (sic) water...Will write his name...Will engage in some form of exercise...Staff will show [client #3] pictures and ask him to tell staff what each picture is."</p> <p>A review of client #5's records was conducted on 4/2/15 at 12:20 P.M.. The ISP dated 11/14/14 indicated the following training objectives could have been implemented: "Will punch out one of her medications...Will exercise...Staff will show and sign pictures to [client #5]."</p> <p>A review of client #7's records was conducted on 4/2/15 at 12:30 P.M.. The ISP dated 8/24/14 indicated the following training objectives could have been implemented: "Medication Administration: Daily [client #7] will get his cup of water...Will engage in some</p> | | <p>goals are being implemented formally and informally. A manager will monitor the goal implementation and documentation on a three times weekly basis. After 30 days of continual compliance, observations will reduce to 3 times weekly by a member of management then the management team will meet to review further necessity. Responsible Person: Area Director Completion Date: 5/11/15</p> | |

| | | | |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/02/2015 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

| | |
|-----------------------------------------------------|----------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410 |
|-----------------------------------------------------|----------------------------------------------------------------------------------|

| (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 |
|-----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|----------------------|
| W 259 Bldg. 00 | <p>form of exercise..."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/2/15 at 2:25 P.M.. The QIDP indicated the facility staff should implement clients #1, #3, #5 and 7's communication training and training objectives at all times of opportunity.</p> <p>This deficiency was cited on 1/16/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p> | | | |

| | | | |
|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 04/02/2015 |
|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------|

| | |
|-----------------------------------------------------|----------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410 |
|-----------------------------------------------------|----------------------------------------------------------------------------------|

| (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 on record review and interview, the facility failed to assure a Comprehensive Functional Assessment (CFA) was completed for 2 of 4 sampled clients and 1 additional client (clients #3, #4 and #5).</p> <p>Findings include:</p> <p>A review of client #3's records was conducted on 4/2/15 at 12:15 P.M.. The review indicated a CFA had not been completed for client #3.</p> <p>A review of client #4's record was conducted on 4/2/15 at 12:30 P.M.. The review indicated a CFA was not completed for client #4.</p> <p>A review of client #5's records was conducted on 4/2/15 at 12:20 P.M.. The review indicated a CFA was not completed for client #5.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/2/15 at 2:25 P.M.. The QIDP indicated the facility did not have documentation of CFAs being conducted for clients #3, #4 and #5.</p> <p>This deficiency was cited on 1/16/15. The facility failed to implement a</p> | W 259 | <p>W259: The facility has an established policy and procedures in place that requires each client's individual program plan should be updated at least annually.</p> <p>The Program Director will be trained the guidelines that Individual Program Plans must be updated within 365 days of the previous Individual Program Plan and revised as needed through the year. The training will include ensuring all the Comprehensive Functional Assessment is included in the written plan for each client. The Comprehensive Functional Assessments for clients 3, 4. And 5 will be revised. The Program goals and objectives for clients will be updated in the program books to ensure the current goals and objectives are being implemented by direct support professionals.</p> <p>In the future, the Area Director will review the next 3 Individual Support Plans to ensure all components are included from completed assessments regarding each client.</p> <p>Responsible Party: Program Director Completion Date: 5/2/15</p> | 05/02/2015 |

| | | | |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/02/2015 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

| | |
|-----------------------------------------------------|----------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410 |
|-----------------------------------------------------|----------------------------------------------------------------------------------|

| (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 |
|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| W 268 Bldg. 00 | <p>systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (client #1) who lived in the group home, to promote dignity by not ensuring client #1 had a hair cut and her fingernails and toenails were clipped.</p> <p>Findings include: A facility owned day program observation was conducted on 4/2/15 from 10:00 A.M. until 12:45 P.M.. During the entire the observation period,</p> | W 268 | <p>W268: The facility provides training to newly hired staff to incorporate the mission statement of promotion of and ensure client respect and dignity. The staff are refreshed on training of client rights, dignity and respect at least yearly thereafter. The Home Manager will train the staff to adhere to a haircut schedule for the clients in the home and completion of the healthcare checklist for client nail care/clipping to ensure client grooming occurs when needed. In the future, the Home Manager will monitor the client support</p> | 05/02/2015 |

| | | | |
|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 04/02/2015 |
|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------|

| | |
|-----------------------------------------------------|----------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410 |
|-----------------------------------------------------|----------------------------------------------------------------------------------|

| (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 |
|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| W 436 | <p>client #1 was observed squinting her eyes. Client #1's bangs reached to the middle of her eye lids. Client #1's fingernails and toenails were observed to be long, needing to be clipped.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/2/15 at 2:15 P.M.. The QIDP indicated she wasn't sure when the last time client #1 had her hair cut. The QIDP indicated clients should at least go monthly to get their haircut. The QIDP indicated client #1 should have her fingernails and toenails clipped on a regular basis.</p> <p>This deficiency was cited on 1/16/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-5(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> | | <p>documents/ healthcare checklist and appearance on a weekly basis to ensure the clients receive grooming/ haircuts as needed to ensure dignity.</p> <p>Responsible Party: Area Director Completion Date: 5/2/15</p> | |

| | | | |
|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 04/02/2015 |
|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------|

| | |
|-----------------------------------------------------|----------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410 |
|-----------------------------------------------------|----------------------------------------------------------------------------------|

| (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 |
|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| Bldg. 00 | <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview, the facility failed to assure the repair of adaptive equipment for 2 of 2 clients (clients #2 and #6) who used a wheelchair for mobility.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 3/27/15 from 5:00 P.M. until 6:00 P.M.. During the entire observation, clients #2 and #6 were observed sitting in standard wheelchairs. Both arm rests were observed to be torn and ripped to the metal.</p> <p>A facility owned day program observation was conducted on 4/2/15 from 10:00 A.M. until 12:45 P.M.. During the entire observation client #2 sat in a standard wheelchair. Both wheelchair arm rests were observed to be torn and ripped.</p> <p>An interview with clients #2 and #6 was conducted at the day program on 3/27/15 at 5:45 P.M.. Clients #2 and #6 stated their arm rests had been torn for a "long"</p> | W 436 | <p>W436 The facility will furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces and other devices identified by the interdisciplinary team as needed by the client. The program director has contacted the health organization to schedule an appointment for client 2 and 6 wheelchairs to have the arm pads repaired. The facility has purchased back up wheelchairs to use additionally. The Program Director will follow through with taking the chairs in for repair. In the future, home manager will complete a weekly checklist to observe the home, client equipment and items in need of maintenance. The home manager will address the needs by contacting the appropriate repair person to ensure good working order of the client equipment and the home. The Program Director will review the home manager checklist each week and follow up as needed. Person Responsible: Program Director Completion Date: 5/2/15</p> | 05/02/2015 |

| | | | |
|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 04/02/2015 |
|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------|

| | |
|-----------------------------------------------------|----------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC | STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410 |
|-----------------------------------------------------|----------------------------------------------------------------------------------|

| (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>time.</p> <p>A review of client #2's records was conducted on 4/2/15 at 12:10 P.M..Review of client #2's record indicated she used a wheelchair at all times for mobility.</p> <p>A review of client #6's records was conducted on 4/2/15 at 12:25 P.M.. Review of client #6's record indicated she used a wheelchair at all times for mobility.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/2/15 at 2:15 P.M.. The QIDP indicated clients #2 and #6's wheelchair arm rests should be repaired. When asked when the wheelchairs would be repaired, the QIDP indicated she did not know.</p> <p>This deficiency was cited on 1/16/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-7(a)</p> | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 04/02/2015 |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410 | | |
| (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 | |
| W 999 Bldg. 00 | | W 999 | Blank Tag | 05/02/2015 | |