

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G495	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/06/2012
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6338 GRAHAM RD INDIANAPOLIS, IN 46220		
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W0000	<p>This visit was for a recertification and state licensure survey.</p> <p>Survey Dates: August 27, 29, 30, September 4, 5, 6, 2012</p> <p>Facility number: 001009 Provider number: 15G495 Aim number: 100244970</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/18/12 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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W0126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (#2, #3) to ensure clients #2 and #3 had a training program for their identified financial training needs.</p> <p>Findings include:</p> <p>The record of client #2 was reviewed on 9/4/12 at 1:31p.m. Client #2's 1/23/12 individual support plan (ISP) indicated client #2 lacked financial knowledge and was in need of goals developed for money management. Client #2 did not have any money skills training programs currently in place.</p> <p>The record of client #3 was reviewed on 9/4/12 at 1:48p.m. Client #3's 7/13/12 ISP indicated client #3 lacked financial knowledge and was in need of goals developed for money management. Client #3 did not have any money skills training programs currently in place.</p> <p>Interview of staff #1 on 9/4/12 at 2:43p.m. indicated clients #2 and #3 had money training needs and did not have</p>	W0126	<p>The Program Director will be retrained on writing client goals and objectives based on their individual needs.</p> <p>The Program Director, in conjunction with the Interdisciplinary teams, will create a money goal for clients 2 and 3. Ongoing, the Program Director will work with the interdisciplinary teams to ensure that each client has training goal to identify their specific areas of need.</p> <p>Ongoing, all Individualized Support Plans will be reviewed by the Area Director and/or Quality Assurance Manager, to ensure accuracy and to ensure that all areas of need are met for each client.</p> <p>Completion Date: 10-6-2012 Responsible Party: Program Director, Area Director, and Quality Assurance Manager.</p>	10/06/2012			

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	current money training programs in place. 9-3-2(a)				

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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 2 of 4 sampled clients (#3, #4) to ensure the clients' (#4) dining skills training program and privacy (#3) were implemented when opportunities were present.</p> <p>Findings include:</p> <p>An observation was done on 8/29/12 from 4:36p.m. to 6:40p.m. at the group home. Client #4 ate supper at 6:02p.m. Client #4 ate supper with his face lowered over his plate. Client #4 forked large pieces of pork and bit off large bites without redirection. Client #4 did not cut up his meat into small pieces.</p> <p>An observation was done on 8/30/12 from 5:52a.m. to 8:04a.m. At 6:21a.m. client #3 used the bathroom with the door open. Client #3 then went to his bedroom and changed clothes with his bedroom door open. Staff #7 was interviewed on 8/30/12 at 6:22a.m. Staff #7 indicated client #3 leaves doors open and needs</p>	W0249	<p>The Program Director will retrain the Direct Care Staff on all dining plans to ensure that they are appropriately being followed. All Direct Care Staff will be retrained on prompting clients to slow down when they eat, assist with cutting up foods, etc during meal times. The Program Director will complete 2 weekly meal time observations for 4 weeks, and then 1 per week afterwards to ensure that all dining plans are being followed as written, and to ensure that staff are appropriately assisting the clients based on their individual needs. The Program Director will retrain staff on client rights and dignity. Indiana MENTOR's policy and procedure states that "all clients' provided each client with the opportunity for personal privacy and ensure privacy during treatment and care of personal needs". The Program Director will complete 2 weekly active treatment observations for 4 weeks, and then 1 per week afterwards to ensure that the privacy policy is being instructed and utilized as expected.</p>	10/06/2012	

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	<p>redirection to close the door. Client #3 then went to his bedroom and changed his clothes with his bedroom door open, and could be seen naked from hallway. Staff did not prompt him to shut his door.</p> <p>The record of client #4 was reviewed on 9/4/12 at 11:42a.m. Client #4's 8/30/12 individual support plan (ISP) indicated client #4 had dining protocols to cut his meat into small bites and to encourage him to not eat too fast.</p> <p>The record of client #3 was reviewed on 9/4/12 at 1:48p.m. Client #3's 7/13/12 ISP indicated client #3 had a training program for inappropriate nudity.</p> <p>Interview of professional staff #1 on 9/4/12 at 2:43p.m. indicated client #4's identified dining training program and client #3's privacy program should have been implemented at all opportunities. 9-3-4(a)</p>		<p>Ongoing, the Area Director will complete quarterly pop in visits to ensure that all policies and procedures are being followed. Completion Date: 10-6-2012 Responsible Party: Program Director and Area Director</p>		

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W0455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation and interview, the facility failed for 2 of 4 sampled clients (#2, #3) and 2 non-sampled clients (#5, #7) to ensure clients' combs/brushes and electric razors were used and stored in a sanitary environment.</p> <p>Findings include:</p> <p>An observation was done at the group home on 8/30/12 from 5:52a.m. to 8:04a.m. At 6:42a.m. staff #4 shaved client #2 with an electric razor. At 6:46a.m. staff #4 shaved clients #3 and #7 with the same electric razor. At 7:20a.m. staff #8 shaved client #5 with the same electric razor. At 7:31a.m. staff #8 got a comb from a file cabinet drawer and combed client #5's hair and returned the comb to the file cabinet drawer. The drawer contained combs and a hairbrush which were loosely stored and mixed together, none with client names on them. The drawer also had 3 electric razors with no names on them and were stored touching each other. Staff #8 indicated the clients were shaved with the same electric razor and they were loosely stored with the combs and brushes.</p>	W0455	<p>All Direct Support Professionals will be retrained on Indiana MENTOR's policy and Procedure regarding Infection Control.</p> <p>The Home Manager and/or Program Director will purchase new electric razors and combs for each male client to use.</p> <p>The DSPs will be retrained on not sharing the combs and razors between clients.</p> <p>The DSPs will be retrained on not storing the used combs and razors together.</p> <p>The DSPs will be retrained on the proper place and time to be utilizing the combs and razors.</p> <p>The Program Director will complete 2 weekly active treatment observations for 4 weeks, and then 1 per week afterwards to ensure that the privacy policy is being instructed and utilized as expected.</p> <p>Ongoing, the Area Director will complete quarterly pop in visits to ensure that all policies and procedures are being followed.</p> <p>Completion Date: 10-6-2012</p> <p>Responsible Party: Home Manager, Program Director, and Area Director.</p>	10/06/2012			

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	<p>Interview on 9/4/12 at 2:43p.m. of staff #1 indicated the used combs, brushes and electric razors should be stored separately and identified as to ownership. Staff #1 indicated the clients should be shaved with their own electric razor.</p> <p>9-3-7(a)</p>			

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W9999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule is not met.</p> <p>460 IAC 9-3-3(e) Facility Staffing</p> <p>(e) Prior to assuming duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (STU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered.</p> <p>This State Rule was not met evidenced by:</p> <p>Based on record review and interview for 2 of 6 facility staff personnel files (staff #5, #6) reviewed, the facility failed to ensure staff #5 and #6 had written evidence of annual Mantoux/chest x-rays.</p> <p>Findings include:</p> <p>Staff personnel files were reviewed on 8/27/12 at 4:12p.m. Staff #5 and #6's most recent documented Mantoux/chest x-rays were completed on 7/28/11.</p> <p>Interview of staff #2 on 8/27/12 at 4:22p.m., indicated there was no written evidence of a mantoux/chest X-ray for staff #5 and #6 since their 7/28/11 Mantoux. 9-3-3(e)</p>	W9999	<p>All staff are given reminders as to when their annual training requirements are due to expire. Those that fail to keep them up to date receive suspension until completed.</p> <p>Ongoing, the Administrative Assistant, with the help of HR, will keep the Home Manager and Direct Care staff up to date with the staff annual training expiration dates, including but not limited to annual Mantoux tests, or x-rays.</p> <p>Completion Date: 10-6-2012 Responsible Party: Home Manager, Administrative Assistant, Program Director, and Area Director.</p>	10/06/2012			

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