

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: March 18, 19 and 20, 2013.</p> <p>Facility number: 004445 Provider number: 15G722 AIM number: 200518250</p> <p>Surveyor: Steven Schwing, Medical Surveyor III.</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 27, 2013 by Dotty Walton, Medical Surveyor III.</p>	W000000			

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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W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to keep an accurate accounting of the clients' funds.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted with the assistance of the Qualified Mental Retardation Professional (QMRP) on 3/18/13 at 4:43 PM.</p> <p>Client #1's Cash on Hand ledger, dated March 2013, indicated client #1 should have \$66.99 in her account. Upon counting the money in her account, client #1 had \$56.29. The QMRP had a receipt for \$10.70 dated 3/16/13 from a local store. The QMRP had a piece of paper (not the Cash on Hand ledger) indicating \$25.00 was taken out of client #1's Cash on Hand on 3/15/13 but not accounted for on the ledger. The facility failed to document the account withdrawal of \$25.00 on 3/15/13.</p> <p>Client #2's Cash on Hand ledger, dated</p>	W000140	Area Director will retrain program director and home manager on client finances.Home Manager will review client finances weekly to ensure they are being managed correctly according to State policy.Program Director will review client finances monthly to ensure they are being managed correctly per State Policy.Area Director will review client finances quarterly to ensure they are being managed correctly per State Policy. Responsible Parties: Area Director, Program Director, Home Manager	04/19/2013			

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	<p>March 2013, indicated client #2 should have \$32.40 in his account. Upon counting the money in his account, client #2 had \$27.05. The QMRP had a receipt for \$5.35 from a local store. The QMRP had a piece of paper (not the Cash on Hand ledger) indicating \$20.00 was taken out of client #2's Cash on Hand on 3/15/13 but not accounted for on the ledger. The facility failed to document the account withdrawal of \$20.00 on 3/15/13.</p> <p>Client #3's Cash on Hand ledger, dated March 2013, indicated client #3 should have \$33.28 in his account. Upon counting the money in his account, client #2 had \$27.93. The QMRP had a receipt for \$5.35 from a local store. The QMRP had a piece of paper (not the Cash on Hand ledger) indicating \$13.00 was taken out of client #3's Cash on Hand on 3/15/13 but not accounted for on the ledger. The facility failed to document the account withdrawal of \$13.00 on 3/15/13.</p> <p>Client #4's Cash on Hand ledger, dated March 2013, indicated client #4 should have \$23.07 in his account. Upon counting the money in her account, client #4 had \$17.72. The QMRP had a receipt for \$5.35 from a local store. The QMRP had a piece of paper (not the Cash on</p>						

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	<p>Hand ledger) indicating \$20.00 was taken out of client #4's Cash on Hand on 3/15/13 but not accounted for on the ledger. The facility failed to document the account withdrawal of \$20.00 on 3/15/13.</p> <p>An interview with the QMRP was conducted on 3/18/13 at 4:48 PM. The QMRP indicated the Cash on Hand ledgers did not match the actual money in the accounts. The QMRP indicated the facility was not accounting for the withdrawal of money from the clients' accounts when money was taken out for a community outing. The QMRP indicated the facility accounted for the money after the money was spent and then the extra money was returned to the clients' accounts. The QMRP stated she had "always done it that way."</p> <p>9-3-2(a)</p>				

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W000149	<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. Based on record review and interview for 1 of 21 incident/investigative reports reviewed affecting client #4, the facility failed to implement its policies and procedures to investigate an injury of unknown origin and to report the injury of unknown origin to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 3/18/13 at 2:23 PM and indicated the following in The Mentor Network - Incident Report: On 2/4/13 at 11:30 AM when client #4 was being changed at the facility-operated day program, staff "noticed dark blue bruise on [client #4's] right leg above her knee." The report indicated the origin of the bruise was "unknown." The report indicated the bruise was "approximately" 3 inches long by 1.5 inches wide. The facility reported the bruise to BDDS on 2/6/13. The facility did not have documentation of an investigation into the origin of the bruise.</p>	W000149	Area Director will retrain Program Director for group home and day program on investigation procedures. Area Director will review all incident reports to ensure any incidents that require an investigation are completed by the Program Director or required investigator. Quality Assurance Manager will review incident reports monthly to ensure all needed investigations have been completed. Responsible Parties: Area Director, Program Director, Quality Assurance Manager	04/19/2013			

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	<p>A review of the facility's abuse and neglect policy, dated April 2011, was conducted on 3/18/13 at 2:19 PM. The policy indicated the following, "Any allegation of abuse or human rights violation is thoroughly investigated by the Area Director in consultation with Human Resources Department and/or Quality Assurance/Risk Management Department." The policy indicated, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e. Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment...". The policy indicated, in part, "Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident." The policy indicated, in part, "An initial report regarding an incident shall be submitted within twenty-four (24) hours of: the occurrence of the incident; or the reporter becoming aware of or receiving information about an incident."</p>			

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	<p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/19/13 at 11:55 AM. The QMRP indicated the day program should have conducted the investigation. The QMRP indicated the injury of unknown origin should have been reported to BDDS within 24 hours.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 3/18/13 at 3:12 PM. AS #1 indicated she was unable to locate an investigation for the bruise. AS #1 indicated an investigation should have been conducted. AS #1 stated, "It fell between the cracks" between the day program and residential staff conducting the investigation.</p> <p>9-3-2(a)</p>				

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 21 incident/investigative reports reviewed affecting client #4, the facility failed to report an injury of unknown origin to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 3/18/13 at 2:23 PM and indicated the following in The Mentor Network - Incident Report: On 2/4/13 at 11:30 AM when client #4 was being changed at the facility-operated day program, staff "noticed dark blue bruise on [client #4's] right leg above her knee." The report indicated the origin of the bruise was "unknown." The report indicated the bruise was "approximately" 3 inches long by 1.5 inches wide. The facility reported the bruise to BDDS on 2/6/13.</p> <p>An interview with the Qualified Mental</p>	W000153	Area Director will retrain Program Director for group home and day program on incident reporting procedures to ensure they are being completed within 24 hours. Area Director will review all incident reports weekly to ensure they are being completed within 24 hours. Quality Assurance Manager will review all incident report smothly to ensure they are being completed within 24 hours. Responsible Parties: Area Director, Program director, quality assurance manager	04/19/2013	

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	<p>Retardation Professional (QMRP) was conducted on 3/19/13 at 11:55 AM. The QMRP indicated the injury of unknown origin should have been reported to BDDS within 24 hours.</p> <p>9-3-2(a)</p>			

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 21 incident/investigative reports reviewed affecting client #4, the facility failed to investigate an injury of unknown origin.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 3/18/13 at 2:23 PM and indicated the following in The Mentor Network - Incident Report: On 2/4/13 at 11:30 AM when client #4 was being changed at the facility-operated day program, staff "noticed dark blue bruise on [client #4's] right leg above her knee." The report indicated the origin of the bruise was "unknown." The report indicated the bruise was "approximately" 3 inches long by 1.5 inches wide. The facility did not have documentation of an investigation into the origin of the bruise.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/19/13 at 11:55 AM. The QMRP indicated the day program should have conducted an investigation.</p>	W000154	Area Director will retrain Program Director for group home and day program on investigation procedures. Area Director will review all incident reports to ensure any incidents that require an investigation are completed by the Program Director or required investigator. Quality Assurance Manager will review incident reports monthly to ensure all needed investigations have been completed. Responsible Parties: Area Director, Program Director, Quality Assurance Manager	04/19/2013			

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	<p>An interview with Administrative Staff (AS) #1 was conducted on 3/18/13 at 3:12 PM. AS #1 indicated she was unable to locate an investigation for the bruise. AS #1 indicated an investigation should have been conducted. AS #1 stated, "It fell between the cracks" between the day program and residential staff conducting the investigation.</p> <p>9-3-2(a)</p>			

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W000192	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation and interview for 2 of 2 clients (#2 and #3) observed to receive medications crushed in a pill crusher from staff #4, the facility failed to ensure staff cleaned the pill crusher between uses.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 3/19/13 from 6:21 AM to 8:29 AM. At 6:36 AM, client #2 received his medications from staff #4. Staff #4 used the pill crusher for one of client #2's medications. At 7:04 AM, client #3 received his medications from staff #4. Staff #4 used the pill crusher for client #3's medications. In between the medication passes, staff #4 did not wash the pill crusher. Upon examination after client #3's medication pass, the pill crusher had residue on top portion of the crusher. Staff placed the pill crusher back in the location in the medication room to be used again at the next medication pass without washing the pill crusher.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was</p>	W000192	<p>Program director will purchase individual pill crushers for all clients required their medication to be crushed. Pill crushers will be labeled with clients name. Program director will retrain staff on use of pill crushers for each individual client, including washing pill crushers after each use. Home Manager will complete medication observations 1x a week for 4 weeks to ensure that pill crushers are being used appropriately. program director will complete medication observation 1x a week for 4 weeks to ensure that pill crushers are being used appropriately responsible parties; program director home manager</p>	04/19/2013			

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	<p>conducted on 3/19/13 at 10:23 AM. The QMRP indicated the pill crusher should be washed after each use. The QMRP indicated the staff should be using a souffle cup on each end of the device to keep the pill crusher clean.</p> <p>An interview with the nurse was conducted on 3/20/13 at 11:52 AM. The nurse indicated the pill crusher should be washed after each use.</p> <p>9-3-3(a)</p>			

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 2 clients in the sample (#1), the nurse failed to address the pharmacist's recommendation to obtain signed Physician's Orders (PO).</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 3/19/13 at 10:28 AM. On 2/23/13, the pharmacist documented, "PO need signed way overdue." There were no signed Physician's Orders in client #1's record.</p> <p>An interview with the nurse was conducted on 3/20/13 at 11:52 AM. The nurse indicated at client #1's last appointment, the physician indicated he was busy and to schedule her follow-up appointment for 6 months instead of 3 months. The nurse indicated the home manager took the Physician's Orders to the doctor's office to be signed after the pharmacist made the recommendation however the group home had not received the signed Physician's Orders. The nurse indicated the Physician's Orders were at the doctor's office waiting for a signature. The nurse indicated the group home needed to get the Physician's Orders</p>	W000331	Area director will retrain nurse, program director and home manager on physician orders and needing them signed monthly. Nurse will review physician orders monthly to ensure they are signed per state regulations program director will review physician orders monthly to ensure they are signed per state regulations home manager will review physician orders monthly to ensure they are signed per state regulations responsible parties: area director, nurse, program director, home manager	04/19/2013			

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W000440	<p>signed.</p> <p>9-3-6(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to conduct quarterly evacuation drills for the night shift of personnel.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 3/18/13 at 4:22 PM. For the night shift (11:00 PM to 7:00 AM), there were no drills conducted from 9/7/12 to 3/18/13. This affected clients #1, #2, #3 and #4.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/18/13 at 4:42 PM. The QMRP indicated there should have been an overnight drill conducted in December 2012. The QMRP indicated there should be one drill per shift per quarter for each shift of personnel.</p> <p>9-3-7(a)</p>	W000440	<p>Area director will retrain program director and home manager on evacuation drill procedures and schedule program director and home manager will retrain all staff on evacuation drill procedurs and schedule home manager will review evacuation drills monthly to ensure they are being completed correctly program direcotor will review evacuation drills monthly to ensure they are being completed correctly responsible parties: area director, program director, home manager</p>	04/19/2013
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W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(a) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division. (An emergency intervention for the individual resulting from: A physical symptom; a medical or psychiatric condition; Any other event.)</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 21 incident reports reviewed affecting client #2, the facility failed to ensure an emergency room visit was reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours.</p> <p>Findings include:</p> <p>A review of the facility's</p>	W009999	Area Director will retrain Program Director for group home and day program on incident reporting procedures to ensure they are being completed within 24 hours. Area Director will review all incident reports weekly to ensure they are being completed within 24 hours. Quality Assurance Manager will review all incident report smonthly to ensure they are being completed within 24 hours. Responsible Parties: Area Director, Program director, quality assurance manager	04/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220		
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	<p>incident/investigative reports was conducted on 3/18/13 at 2:23 PM.</p> <p>On 9/14/12 at 9:00 PM, client #2's J-port (jejunostomy) and G-port (gastrostomy) feeding tubes were clogged requiring a visit to the emergency room. A product was administered to remove the clogs. The incident was reported to BDDS on 9/16/12.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/19/13 at 11:55 AM. The QMRP indicated the incident should have been reported to BDDS within 24 hours.</p> <p>9-3-1(b)</p>				