STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for the Post Certification Revisit (PCR) to the pre-determined full recertification and state licensure survey and the COVID-19 focused infection control survey completed on 2/15/22. This visit was done in conjunction with the investigation of complaint #IN00383687. Dates of Survey: August 11, 12, 15, 16, and 17, 2022. Facility Number: 001113 Provider Number: 15G599 Aims Number: 100245610 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/6/22.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review, and interview for 3 of 3 sample clients (A, B, and C), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to exercise general policy, budget, and operating direction over the facility to ensure implementation of its written policy and procedure to ensure client A was properly secured in the transportation vehicle and to prevent a pattern of falls and injuries for clients A, B, and C, to thoroughly investigate a pattern of	W 0102	**102-** **The facility currently has written policy and procedures to identify, report, and thoroughly investigate to prevent abuse, neglect, and/or exploitation. All new employees and supervisors are trained on the policy and its full implementation there-of. Additionally, the facility has policy and procedures to report**	09/19/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	falls for clients A, B, and C, and to implement effective corrective action to ensure client A was properly secured in the transportation vehicle and to address a pattern of falls for clients A, B, and C. Findings include: 1. The governing body failed to exercise general policy, budget, and operating direction over the facility to ensure implementation of its written policy and procedure to ensure client A was properly secured in the transportation vehicle and to prevent a pattern of falls and injuries for clients A, B, and C, to thoroughly investigate a pattern of falls for clients A, B, and C, and to implement effective corrective action to ensure client A was properly secured in the transportation vehicle and to address a pattern of falls for clients A, B, and C. Please see W104. 2. The governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to exercise general policy, budget, and operating direction over the facility to ensure implementation of its written policy and procedure to ensure client A was properly secured in the transportation vehicle and to prevent a pattern of falls and injuries for clients A, B, and C, to thoroughly investigate a pattern of falls for clients A, B, and C, and to implement effective corrective action to ensure client A was properly secured in the transportation vehicle and to address a pattern of falls for clients A, B, and C. Please see W122. 9-3-1(a)		**to the Bureau of Developmental Disabilities Services when any reportable instance occurs. The facility provides training and teaching necessary to prevent neglect in regard to falls with injuries. In addition, the facility has policies and procedures in place to address the need to put preventive measures in place to protect the individuals. The facility also has policy and procedures in place to ensure the healthcare services of all individuals are being met and that the prescribed physician's orders are followed.** **The facility will continue the implementation of the policy and procedure on mistreatment, neglect or abuse of a client including to identify, report, thoroughly investigate and prevent neglect and/or abuse. The facility has put proactive and corrective measures in place to prevent the recurrence of falls with injury. The facility staff will be trained on the client support plans prior to implementation to ensure full knowledge of the protocols in place to assist the client.** **The Program Director will monitor incidents and implement preventive measures to protect the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			individuals, complete thorough investigations, ensure due process for IDT discussion to prevent re-occurring incidents/injuries. The facility will continue to ensure the nursing services and healthcare needs of the individuals are met including, but not limited to, ensuring proper medication administration, assessing/monitoring/documenting clients with fractures, seeking clarification of physician orders, and developing protocols as needed. **Responsible Staff: Program Supervisor, Program Director, Area Director**	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview for 3 of 3 sample clients (A, B, and C), the governing body failed to exercise general policy, budget, and operating direction over the facility to ensure implementation of its written policy and procedure to ensure client A was properly secured in the transportation vehicle and to prevent a pattern of falls and injuries for clients A, B, and C, to thoroughly investigate a pattern of falls for clients A, B, and C, and to implement effective corrective action to ensure client A was properly secured in the transportation vehicle and to address a pattern of falls for clients A, B, and C.	W 0104	**104-** **Currently the governing body and management exercises general policy, and operating direction over the facilities use of vans, securing individuals in vans, and training Direct Support Professionals in these processes.** **Direct Support Professionals will all be trained on safely securing individuals served**	09/19/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Findings include: 1. The governing body neglected to implement its policy and procedure to ensure client A was properly secured in the transportation vehicle and to prevent a pattern of falls and injuries for clients A, B, and C. Please see W149. 2. The governing body failed to thoroughly investigate a pattern of falls for clients A, B, and C. Please see W154. 3. The governing body failed to implement effective corrective action to ensure client A was properly secured in the transportation vehicle and to address a pattern of falls for clients A, B, and C. Please see W157. This deficiency was cited on 2/15/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a)		**and their wheelchairs in vans. Verification that each Direct Support Professional has completed training and been observed completing the task of safely securing individuals served and their wheelchairs will be completed. Direct Support Professionals will use a check off sheet on a clipboard, which will be kept in the van, to ensure they have completed every step required to secure individual served and their wheelchairs once they have been secured.** **The Program Supervisor and Program Director, and Area Director will be trained to complete bi-weekly safety checks to ensure Direct Support Professionals are following all training and securing individuals served and their wheelchairs appropriately and walk-throughs/observations of the day service and home to observe for proper program implementation and maintenance needs pertaining to safety and functionality.** **Program Director and Area Director will be trained to complete a thorough investigation of all falls, any incident that results in injury, and IDT will discuss**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			reoccurring incidents to find alternate ways to prevent similar incidents going forward. **Responsible Person: Regional Director, Program Director, Area Director**	
W 0122 Bldg. 00	483.420(a) CLIENT PROTECTIONS The facility must ensure the rights of all clients. Therefore the facility must Based on observation, record review, and interview for 3 of 3 sample clients (A, B, and C), the facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement its policy and procedure to ensure client A was properly secured in the transportation vehicle and to prevent a pattern of falls and injuries for clients A, B, and C, to thoroughly investigate a pattern of falls for clients A, B, and C, and to implement effective corrective action to ensure client A was properly secured in the transportation vehicle and to address a pattern of falls for clients A, B, and C. Findings include: 1. The facility neglected to implement its policy and procedure to ensure client A was properly secured in the transportation vehicle and to prevent a pattern of falls and injuries for clients A, B, and C. Please see W149. 2. The facility failed to thoroughly investigate a pattern of falls for clients A, B, and C. Please see W154.	W 0122	**122-** **The facility currently has protocols and policies mandated specifically to ensure the protection of clients within the facility. The facility currently mandates that all staff adhere to the policy and procedure on mistreatment, neglect or abuse to protect the clients. All new employees and supervisors are trained on the policy and the procedure for protecting clients from harm. The facility follows protocol including assessment, review and revision of client adaptive needs and supports/protocols to protect the clients.** **Direct Support Professionals will all be trained on safely securing individuals served and their wheelchairs in vans. Verification that each Direct Support Professional has**	09/19/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	3. The facility failed to implement effective corrective action to ensure client A was properly secured in the transportation vehicle and to address a pattern of falls for clients A, B, and C. Please see W157. 9-3-2(a)		**completed training and been observed completing the task of safely securing individuals served and their wheelchairs will be completed. Direct Support Professionals will use a check off sheet on a clipboard, which will be kept in the van, to ensure they have completed every step required to secure individual served and their wheelchairs once they have been secured.** **The Program Supervisor and Program Director, and Area Director will be trained to complete bi-weekly safety checks to ensure Direct Support Professionals are following all training and securing individuals served and their wheelchairs appropriately and walk-throughs/observations of the day service and home to observe for proper program implementation and maintenance needs pertaining to safety and functionality.** **The facility will ensure implementation of all Fall Prevention Plans. The Regional Director will train, Area Director and Program Director on thoroughness of investigations and preventive measures that need to be implemented to protect**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			individuals served. **Responsible Staff: Area Director**	
W 0149 Bldg. 00	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 observation, record review, and interview for 7 of 27 incidents of abuse, neglect, and exploitation reviewed, the facility neglected to implement its policy and procedure to ensure client A was properly secured in the transportation vehicle and to prevent a pattern of falls and injuries for clients A, B, and C. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 8/11/22 at 10:03 am. 1. A BDDS report dated 6/21/22 indicated the following: "It has been reported, as staff was transporting individuals to day service (sic). [Direct Support Professional (DSP) #1] slammed on the brakes to avoid an accident. [Client A] fell out of her wheelchair onto her knees. Staff is suspended pending further investigation." DSP #1 was interviewed on 8/11/22 at 7:45 am and stated, "I was driving [on 6/21/22]. I had to hit the brakes because someone pulled in front of me. She fell out of the wheelchair and scraped her knees. She was buckled." DSP #1 stated, "There are 4 things on the floor that lock onto the wheelchair. She was in an old wheelchair, and the	W 0149	**149-** **The facility has and implements written policies and procedures that prohibit mistreatment, neglect or abuse of the client.** **The facility will retrain Program Supervisor, Program Director, and Direct Support Professionals, on Indiana Mentor's Abuse, Neglect, and Exploitation policy; including immediate reporting, their responsibility to understand and ensure proper supervision levels; including line of sight as described in safety plan.** **The Program Supervisor will complete unannounced site visits twice weekly to ensure safety plan continues to be implemented for one month.** **The Program Director will complete unannounced site visits twice weekly to ensure safety plan continues to be implemented for one month.** **Responsible Staff: Program Supervisor, Program Director, Area Director**	09/19/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	buckle for that one was all twisted and loose. It came off, too. If it was tight, she wouldn't have fallen out. She fell and scraped her knees." DSP #1 stated, "I didn't know how to latch it." DSP #1 stated, "[HM (House Manager) #1] retrained me. It was one hour of training. There was hands on. There was a pamphlet and videos. She showed me how to move the floor locks, so they fit properly with the new wheelchair." HM #1 was interviewed on 8/11/22 at 8:10 am and stated, "There have been 2 different accidents in the van when [client A] has come out of her wheelchair. According to [DSP #1], another driver got in front of her without signaling. She stepped on the brakes hard, and [client A] came out of her wheelchair. [DSP #1] reported it to the day service manager. [Qualified Intellectual Disabilities Professional (QIDP) #1 did an investigation. [DSP #1] was suspended and retrained on the vehicle training. It's a packet, video, and hands-on with me. I observed her putting on the Q-straints and the seat belt." HM #1 indicated all new staff are trained at the time of hire. HM #1 stated, "When they're shadowing, it's a hands on training. I watch them load and unload and drive." HM #1 stated, "How [client A] was buckled today is not how staff are trained." An investigation dated 6/23/22 was reviewed on 8/11/22 at 11:50 am and indicated the following: "[DSP #1] has been employed since 9/13/21. [Client A] utilizes a wheelchair and a gait belt.... Statement from [DSP #1] taken by [QIDP #1] and [HM #1] 6/23/22 at 9:23 am: '[On 6/21/22] it was about 7:30 am and [DSP #3] and myself were loading the individuals. When buckling [client A], I thought I heard the belt click. I then started to transport the individuals to day			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	service. While driving south on [street], a car that was driving on the right side of the van switch (sic) lanes without notice causing me to slam on the brakes. [Client A] flew forward, and that's when I noticed the seatbelt was detached. I continued to drive to [restaurant] parking lot to assist her back into position. It took at least 20 minutes to assist her back into position. I asked her if she was ok, and she said her knees hurt. I then took her to day service and reported what had happened. [Day Program Supervisor #1] gave directives to go to the ER (emergency room). Upon arriving to the ER, they asked [client A] what hurts, and she replied just her knees. They gave an x-ray of her knees and diagnosed her with arthritis. They wrapped both knees with ace bandages, and I then transported her back to day service.' Was [client A] still in her seat when she fell? No. Was [client A's] wheelchair seatbelt latched? No, staff stated that the wheelchair belts were stuck in the sides of the chair. Who buckled [client A] in her chair? 'I [DSP #1] did.'... HM #1 statement: June 21, 2022, I [HM #1] was notified by [Day Program Supervisor #1] stating [client A] was dropped off by staff with her knees scraped up and her face red and swollen. I then contacted [DSP #1] and asked her what happened.... I look [client A] over. There wasn't any bruising to her face at all. [Client A] had very minimal scraping to the knees. Upon checking her out, I also checked her wheelchair, and the belt was entangled in the seat.... Conclusion of fact: It is substantiated based upon witness statement, [client A] was not buckled in her wheelchair.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	There was not documentation showing [DSP #1] had completed van training. At the time of (sic) incident, [client A] was not using her own wheelchair. [HM #1] was in the process of getting [client A] her own wheelchair since Nov. (November) 2021. [Client A] was taken to [emergency room[for knee pain. Imaging test of knee/obliques of left and right x-ray were completed. Medication given was acetaminophen (pain reliever). Diagnosis of osteoarthritis of both knees." The investigation included an Auto Incident/Accident Report was completed by DSP #1 on 7/10/22 and reviewed by QIDP #1 on 7/13/22. The investigation included an undated Investigation Action Response Plan indicated the following: "Corrective Action Resulting from Investigation: - In-service [DSP #1] on van/wheelchair safety. Person Responsible: [HM #1/QIDP #1]. Completed Date: 7/6/22. - Corrective action - [DSP #1] on van/wheelchair safety. Person Responsible: [HM #1/QIDP #1]. Completed Date: 7/6/22. - Re-train [DSP #1] on van/wheelchair safety. Personal Responsible: [HM #1/QIDP #1]. Completed Dated: 7/6/22." The investigation included a Corrective Action Plan dated 7/6/22 indicated the following: "Expectations for Improvement and/or Action Being Taken: [DSP #1] will double check and ensure individuals are properly buckled prior to any vehicle being in motion." - The review indicated the investigation did not indicate it was reviewed by the AD. An observation was conducted at the group home on 8/11/22 from 7:45 am to 8:45 am. Client A was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	present in the home throughout the observation period. On 8/11/22, client A used a wheel chair to ambulate through the home and required staff assistance with a gait belt to transfer in and out of her wheelchair. At 7:56 am, client A was seated in her wheelchair with her lap belt buckled. DSP #1 assisted client A from the home and to the lift of the transport van. DSP #1 stood behind client A and used the motorized lift to raise client A to the floor of the van. DSP #1 maneuvered client A into place and secured her wheelchair in the van using 4 Q-straints (straps used to secure the wheelchair in the van). DSP #1 placed the hooked ends of the Q-straints through the large, back wheels of the wheel chair and secured the hooks to the frame of the wheelchair. DSP #1 locked the 4 floor locks and ensured they were tight. DSP #1 placed the shoulder strap of the wheelchair under both of client A's arms. The lap belt was placed across the top of the arm rests of client A's wheel chair. DSP #1 secured the end of the strap to the floor lock. DSP #1 indicated client A was correctly secured in the van. At 8:03 am, House Manager (HM) #1 was asked to check client A's seat belt. HM #1 removed the shoulder belt and added an extender strap with a buckle (similar to one used for a car seat belt). HM #1 secured the extender to the floor lock and buckled the extender to the shoulder and lab belt. HM #1 placed the shoulder strap under both of client A's arms and secured the lap belt around the front of the arm rests of client A's wheelchair. HM #1 indicated client A was correctly secured in the van. The facility's Adaptive Vehicle Lift - Wheelchair Restraint and Safe Transportation Combined Training dated 6/7/2019 was reviewed on 8/11/22 at 11:50 am and indicated the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	"Positioning seatbelts across the pelvis versus high on the stomach: - Thread the lap belt around the passenger and through the opening between the seat back and bottom or between the seat back and the arm rests. - The lap belt must never pass over or around arm rests, side panels, or other devices that will prevent the belt from lying directly on the body of the passenger. Always use shoulder belts in vans. Wheelchair positing support straps do not take the place of shoulder belts. Positing straps are not designed to provide restraint during a collision. - Located behind and above the passengers shoulder [about] 41 inches...." A recertification and state licensure survey conducted on 2/15/22 indicated the facility failed to secure client A and her wheelchair into the transportation vehicle on 8/27/21. The vehicle was in a wreck, and client A fell from wheelchair and broke her femur. In an observation on 2/9/22 the staff of the facility owned and operated day service failed to use the wheelchair lap belt and the lap and shoulder belts connected to the transportation vehicle. The facility's Plan of Correction (POC) dated 3/16/22 was reviewed on 8/11/22 at 10:00 am and indicated the following: "The facility has written policy and procedures that prohibit mistreatment, neglect of (sic) abuse of the individuals. All staff will be trained in the facilities (sic) abuse, neglect, and mistreatment policy.... All staff will be trained in the procedures for securing a wheelchair for safe transport. In addition, all staff will be trained in their responsibility for monitoring the adaptive equipment and/or assistive device for safety and good repair. This would include ensuring there			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	are no obstructive parts that could obstruct the proper functioning and notifying a supervisor if it is noted to not be in good repair.... Responsible Person: Area Director (AD)." The facility's training records were reviewed on 8/11/22 at 11:50 am. The review did not include trainings for staff or administration related to the facility's abuse and neglect policy. A training dated 7/13/22 indicated AD #1, QIDP #1, and HM #1 were trained on the facility's Incident-Investigation Policy and Procedure. A training dated 2/17/22 indicated house staff attended a training titled: Van (Driving) & Safety directed by [HM #1]. The training documentation indicated: "How to properly use van, Q Straints, & Seatbelts, Gas fill up, maintenance, cleaning the van." The review indicated DSP #1 did not attend the training on 2/17/22 and had not been trained at the time of hire, 9/13/21. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/15/22 at 1:45 pm and stated, "Generally, in NEO (New Employee Orientation), they would do the online videos on vans. The program supervisor trains them afterwards with a skills check (hands on training)." QIDP #1 stated, "I didn't find documentation that [DSP #1] was trained. She did say she was trained by [HM #1], but I didn't find documentation to support it." QIDP #1 stated, "[HM #1] does the training for the staff." When asked about the facility's plan of correction, QIDP #1 stated, "I wasn't aware of the checks. I didn't know that was something I was supposed to do." QIDP #1 indicated she had been trained as an investigator. QIDP #1 indicated she had not interviewed client A as part of the investigation. QIDP #1 stated, "[Client A] is able to speak and to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	tell what is going on." Area Director (AD) #1 was interviewed on 8/15/22 at 12:11 pm and stated, "Wheelchair training is part of the on-shadowing for new staff. Through orientation, there is an online video they have to watch. When they get to the house for their shadowing, they learn about the individual's risk plans. They go through van driving safety. The day program staff also have to be trained before they can drive. They have to know how to properly buckle, use the lifts, and use the wheelchair restraints." AD #1 stated, "On 6/21/22, [client A's] seatbelt wasn't latched properly. She slid forward when the staff slammed on the brakes." AD #1 stated, "[DSP #1] was supposed to have been trained on the vans and the seatbelts. They could not find the documentation. If there's no documentation, we count that as not being trained." AD #1 indicated the house staff were trained to use the wheelchair restraints as part of the facility's POC dated 3/16/22. AD #1 stated, "If her name isn't on the training attendance, she didn't get trained, and that's a problem for sure." AD #1 looked at training records and stated, "[DSP #1] was not trained." AD #1 stated, "[HM #1] does the training. She would have been trained previously by a prior program director when she started." AD #1 stated, "I haven't physically done it (secured a client with a wheelchair in the transportation vehicle). I've gone through all of the readings and training, but I haven't physically done it." The surveyor asked AD #1 to look at a diagram in the vehicle safety training. The surveyor described how client A was buckled in the van on 8/15/22. AD #1 stated, "That's definitely wrong. It makes a gap there, and it's not safe. It's not how they were trained." AD #1 stated, "[HM #1] should be retrained.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Immediately." When asked about the facility's POC dated 3/16/22, AD #1 stated, "I've done visits, but I haven't seen [client A] getting on and off of the van. It hasn't been in that time frame." AD #1 stated, "The HM and QIDP do the investigations. They are completed within 7 days and are reviewed by the AD, Quality Improvement, and the Regional Director. They make a decision of how to go forward." AD #1 stated, "It looks like [QIDP #1] completed this investigation on 6/23/22." AD #1 stated, "We did substantiate neglect. Obviously it was neglect." AD #1 stated, "We should have interviewed [client A]. She's definitely verbal. She could certainly say. We don't have her statement in here. It should be." 2. On 8/11/22 at 7:30 am, client A had a 2 inch by 1/2 inch bandage in front of her left ear. There was dried blood around the outside of the bandage. Client A stated, "I was trying to get up by myself and fell out of bed and cracked my ear. I'm not supposed to get up by myself." Client A stated, "I don't know what I hit my ear on. I don't know what staff was here. They came when I called after I fell." Client A stated, "I've fallen a couple of other times. My balance isn't like it used to be. I've always been so independent, I don't like to ask for help. I want do to things on my own. I forget to ask for help." DSP #1 was interviewed on 8/11/22 at 7:45 am and stated, "I came in at 6:00 am. I wasn't here. They said she was trying to get up and hit her head on the side table. They took her to the hospital. She has butterfly stitches." HM #1 was interviewed on 8/11/22 at 8:03 am and stated, "It happened last night. She was taken to the ER. [QIDP #1] was contacted last night. Staff			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	called me, and I notified [QIDP #1]." HM #1 indicated she did not recall any other falls for client A. QIDP #1 was interviewed on 8/15/22 at 1:45 pm and stated, "[Client A] has a fall risk plan. Generally, one person helps her. She does require staff assistance to go from her bed to her wheelchair. She does ask for help when she needs it." QIDP #1 indicated she had not begun an investigation for client A's fall. QIDP #1 stated, "I got the initial information of what happened from [HM #1]. I used that to do the BDDS report." RN #1 was interviewed on 8/15/22 at 1:35 pm and stated, "I'm not aware of any discussion about encouraging [client A] to communicate or to ask for help. I'm not aware of any discussion to address her changes in condition." AD #1 was interviewed on 8/15/22 at 12:11 pm and stated, "[Client A] does have a fall risk plan. she does need assistance with ambulating and transfers. That would include getting out of bed." AD #1 stated, "I don't have exact details. I was told she rolled out of bed accidentally and hit her head. I wasn't told she was trying to get up." AD #1 stated, "She does have her gait belt and her wheelchair." AD #1 stated, "[HM #1] is always talking to her about how she needs to ask for help. She's going to do what she wants to do. Staff need to be constantly reminding and training her to ask for help." AD #1 stated, "We might need to put a bell in there, if staff aren't hearing her or are assisting with other people. [Client A] is not able to do as much as she used to." Client A's record was reviewed on 8/11/22 at 9:32 am.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Client A's Fall Protocol dated 5/3/22 indicated the following: "How do you know this person is at risk for falls? Are there any special considerations? Needs standby assistance for ambulation. [Client A] is at risk due to unsteady gait and weakness. Can they walk independently? No. Do they use: Gait belt, wheelchair." 3. A BDDS report dated 6/8/22 indicated the following: "On June 7, 2022, [client B] was coming back home from an outing at 8:15 pm. [Client B] was getting off the van and walking towards the home (sic) tripped and fell (sic) falling face forward. [Client B] was taken to [urgent care]. She had no visible signs of injury. [Client B] was prescribed Ibuprofen (pain reliever) 800 mg (milligrams) take 1 tablet twice per day and Domiciling (antibiotic) 500 mg take 2 tablet twice daily. The physician wrote scripts for a head CT (computed tomography) and x-ray of nose and face. On June 8, 2022, [client B] had x-ray of her nose and face. The results of the x-ray are pending. The head CT is to be scheduled." An undated follow up indicated the following: "Please provide the x-ray and CT scan results. Indiana Mentor nurse reports CT scan results were fine. X-ray of the face/nose showed a nasal fracture. On June 23, 2022, [client B] followed up with her primary care physician. Her primary care physician ordered lab work and for [client B] to follow up with neurology due to her frequent falls. Primary care physician noted [client B] would benefit from a two person assist." - The review did not include an investigation or a plan of corrective action to prevent falls for client B.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	4. A BDDS report dated 4/26/22 indicated the following: "On 4/24/22, staff reported [client B] fell in her bedroom. [Client B] got up out of bed without staff assistance. She has a red bruise on her face, and a cut over her eye. Indiana Mentor nurse was informed and instructed staff to take [client B] to the emergency room. [Client B] was taken to [ER] for further evaluation. [ER] completed CT scan of head. CT scan is normal. Clean wound, required no stitches. [Client B] was discharged from [ER]." - The review did not include an investigation or a plan of corrective action to prevent falls for client B. 5. A BDDS report dated 4/18/22 indicated the following: "On 4/17/22, staff reported two bruises on [client B]. One on her right lower arm about 1 1/2 inches, and the second one on her chin about quarter size. Two individuals reported to staff they seen (sic) [client B] fall at the home. No present injuries or sign of pain at the time. [Client B] was seen by Indiana Mentor nurse. Indiana Mentor nurse reported, '[Client B] appears stable, found additional bruise on her back right side about dime size.' [Client B] wears a gait belt and tried to get up without staff assistance." - The review did not include an investigation or a plan of corrective action to prevent falls for client B. Client B's record was reviewed on 8/15/22 at 1:15 pm. Client B's Fall Protocol dated 1/11/21 indicated the following: "[Client B] has cerebral palsy and unsteady gait.... [Client B] will try to walk independently.... For [client B's] safety, staff must always assist her			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	with a gait belt...." Client B's Gait Belt Protocol dated 1/11/21 indicated the following: "[Client B] has cerebral palsy and unsteady gait. She is very prone to falling. Preventive Measures: - [Client B] is to wear a gait belt at all times, except when sleeping and bathing. - [Client B] is to have gait belt assistance at all times for any distance. - Use proper gait belt technique at all times as outlined below: Grip the back of the belt from the bottom, palm up. Have [client B] slightly extend her arm on the side which you are standing. Place your other hand under her hand and wrist of the extended arm. - Encourage [client B] to walk upright and slowly. - If [client B] starts to lean or walk to fast, ask her to stop for a moment. Begin again with a verbal reminder to walk upright and slowly. - After meals at home, assist [client B] to stand by the kitchen table. Support [client B] as she places her dirty dishes in the service window to the kitchen. - Assist [client B] to the kitchen to provide support as she finishes cleaning up her dishes." QIDP #1 was interviewed on 8/15/22 at 1:45 pm and stated, "On 4/17/22, I did talk to staff, but they didn't know what happened. It wasn't an injury of unknown origin because the individuals told us what happened. When we found it, we talked to all of the staff, and nobody knew. When we questioned the individuals, they said she fell." QIDP#1 stated, "On 4/24/22, I didn't do an investigation. She fell from bed and went to the hospital. There was an injury." QIDP #1 stated, "On 6/7/22, When [client B] got out of the van and was walking, she fell. I think it was at night			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	time. Staff were with her. I'm not sure if they were using the gait belt. She does have a gait belt in her plan." QIDP #1 stated, "The investigation wouldn't have told us if staff were using the gait belt. Even if they were using it, she still would have tumbled over. She's gained weight. It would depend on the staff if they were able to hold her up. I would say she needs more support to prevent falls. I haven't discussed it with the team." QIDP #1 indicated Client B did fall and fracture her nose. QIDP #1 indicated an investigation was not completed. QIDP #1 indicated an investigation would not have indicated whether staff implemented client B's high risk plans or whether the plans needed to be revised. RN #1 was interviewed on 8/15/22 at 1:35 pm and stated, "Staff assist [client B] at all times when she's walking. She doesn't tell them when she needs help. She should have line of sight supervision." AD #1 was interviewed on 8/15/22 at 12:11 pm and stated, "With [client B's] fall protocol, we're supposed to be there at all times. She's a fast mover. She'll get up quick. Staff should be right there with her." AD #1 stated, "The plan doesn't specify line of sight. Staff must always assist with a gait belt. The prevention part of our plan is pretty vague." AD #1 stated, "Her plan has not been reviewed. They should have reviewed and updated the plans after her falls." 6. A BDDS report dated 3/28/22 indicated the following: "[Client C] was assisted to the main area after arriving at day program. [Day Program Staff #1] walked by saying, 'Hi [client C]' [Day Program Staff #2] had his back to [client C] when [client C]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	stood up and fell forward on to the floor. [Day Program Staff #2] assisted [client C] up and noticed a cut above her left eye brow the length of a half dollar bill. [Client C] was transported to [ER] by ambulance as per policy. [Day Program Staff #3] followed the ambulance. At the time of this report, [client C] is still in the emergency room." - The review did not include an investigation or a plan of corrective action to prevent fall for client C. 7. A BDDS report dated 3/24/22 indicated the following: "At 11:45 am on March 23rd, 2022 [Day Program Staff #2] and [Day Program Staff #4] were in the kitchen assisting the individuals with their lunches. [Day Program Staff #2] went to go check on the other individuals outside of the kitchen and [Day Program Staff #4] assisted another individual returning to her activity. That's when they heard a thud come from the kitchen, [Day Program Staff #4] arrived in the kitchen first and found [client C] on the floor. [Client C] was on her right side, and the chair was knocked over as well. [Day Program Staff #2 and #4] checked [client C] for injuries then assisted her up.... Staff transported [client C] to [ER]." Client C's record was reviewed on 8/15/22 at 2:00 pm. Client C's Gait Belt Protocol dated 11/24/21 indicated the following: "[Client C] has an unsteady gait and a history of falls.... Preventive Measures: Encourage and remind client that gait belt and assistance is needed. Always use gait belt when walking with or transferring client."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Client C's Fall Protocol dated 11/24/21 indicated the following: "[Client C] has an unsteady gait and wears a gait belt. She also wears an AFO (special shoe) and brace on her left side.... [Client C's] gait has become increasingly unsteady. Therefore, staff are to always to (sic) assist her, and must stay in the bathroom with her for assistance and safety." QIDP #1 was interviewed on 8/15/22 at 1:45 pm and stated, "I was not aware of her falling." RN #1 was interviewed on 8/15/22 at 1:35 pm and stated, "[Client C] has a fall risk plan. She cannot ask for assistance." RN #1 stated, "She needs assistance with walking and holding onto her gait belt." When asked if client C had line of sight supervision, RN #1 stated, "I'm not sure how the group homes are doing it for her." AD #1 was interviewed on 8/15/22 at 12:11 pm and stated, "The falls and injuries of unknown origin were not investigated. They should have been investigated. We don't know what happened. They should be investigated." The facility's Quality and Risk Management policy dated September 2017 was reviewed on 8/11/22 at 12:00 pm and indicated the following: "Indiana Mentor follows the BDDS Incident Reporting policy as outlined in the Provider Standards. An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS: Alleged, suspected, or actual abuse, neglect, or exploitation of any individual.... The provider shall suspend staff involved in an incident from duty pending investigation by the provider. This may include:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A service delivery site that compromises the health and safety of an individual while the individual is receiving services from the following causes: - A significant injury to an individual, including: (1) A fracture; ... ; (6) Contusions or lacerations which require more than basic first aid; (7) Any injuries requiring more than first aid; ... - A fall resulting in injury, regardless of severity of injury; ... - Inadequate staff support for an individual including inadequate supervision, with the potential for: (1) Significant harm or injury to an individual; ... - Inadequate medical support for an individual including failure to obtain:.... Medication timely resulting in missed medications.... Indiana Mentor is committed to ensuring the individuals we serve are provided with a safe and quality living environment. In order to ensure the highest standard of service delivery specific staff will be assigned to the monitoring and review of Quality Improvement. These staff will assist in providing Individual Support Teams with corporate supports, recommendations and resources for incident management and will review the effectiveness of the recommendations.... 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 (sic). - Investigations will be completed for all deaths, allegations of abuse, neglect, exploitation, or mistreatment. Additional investigations will be completed for incidents with significant injuries of unknown origin and incidents that may be requested by outside entities. - Investigations will be completed using the Indiana Mentor Investigator Minimum Standards guidelines.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	- Investigation summary report will minimally include: a) Immediate safety measures put into place following event/alleged event; b) Nature of the allegation; c) A collection of all interviews; witness statements, pictures, or any physical evidence; d) Review of all information reviewed - e.g. daily support records, staff notes, medication administration records, behavior tracking or any other evidence reviewed; e) Resolution of any discrepancies; f) Summary of conclusion/findings to include when allegation of abuse, neglect or exploitation and whether allegation is substantiated or unsubstantiated. - All staff completing investigation will receive Indiana Mentor core training for investigations. - All investigations require a reviewer to ensure investigation is completed thoroughly and completely and meet minimum standards.... - Investigations will be signed/dated by Investigator and Reviewer. - Area Director will be notified of the completion of (sic) investigation by the investigator within 5 business days. - Response Action plans will be developed by Area Directors to address any action that needs to be taken in response to the incidents and results of the investigation." This deficiency was cited on 2/15/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 3 of 3 sample clients (A, B, and C), the facility failed to	W 0154	**154-** **The facility will have evidence**	09/19/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	thoroughly investigate a pattern of falls for clients A, B, and C. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 8/11/22 at 10:03 am. 1. A BDDS report dated 6/21/22 indicated the following: "It has been reported, as staff was transporting individuals to day service (sic). [Direct Support Professional (DSP) #1] slammed on the brakes to avoid an accident. [Client A] fell out of her wheelchair onto her knees. Staff is suspended pending further investigation." DSP #1 was interviewed on 8/11/22 at 7:45 am and stated, "I was driving [on 6/21/22]. I had to hit the brakes because someone pulled in front of me. She fell out of the wheelchair and scraped her knees. She was buckled." DSP #1 stated, "There are 4 things on the floor that lock onto the wheelchair. She was in an old wheelchair, and the buckle for that one was all twisted and loose. It came off, too. If it was tight, she wouldn't have fallen out. She fell and scraped her knees." DSP #1 stated, "I didn't know how to latch it." DSP #1 stated, "[HM (House Manager) #1] retrained me. It was one hour of training. There was hands on. There was a pamphlet and videos. She showed me how to move the floor locks, so they fit properly with the new wheelchair." HM #1 was interviewed on 8/11/22 at 8:10 am and stated, "There have been 2 different accidents in the van when [client A] has come out of her wheelchair. According to [DSP #1], staff got in		**that all alleged violations are thoroughly investigated. The facility has procedures which includes completion of a thorough investigation of all allegations of abuse, neglect, and exploitation; and suspension of any alleged staff person. The facility will train on interviewing all involved parties, all housemates, and all staff when completing a thorough investigation. Area Director will review next two investigations to ensure thoroughness of investigations. Responsible Staff: Program Supervisor, Program Director, Area Director, Regional Director**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	front of her without signaling. She stepped on the brakes hard, and [client A] came out of her wheelchair. [DSP #1] reported it to the day service manager. [Qualified Intellectual Disabilities Professional (QIDP) #1 did an investigation. [DSP #1] was suspended and retrained on the vehicle training. It's a packet, video, and hands-on with me. I observed her putting on the Q-straints and the seat belt." HM #1 indicated all new staff are trained at the time of hire. HM #1 stated, "When they're shadowing, it's a hands on training. I watch them load and unload and drive." HM #1 stated, "How [client A] was buckled today is not how staff are trained." An investigation dated 6/23/22 was reviewed on 8/11/22 at 11:50 am and indicated the following: "[DSP #1] has been employed since 9/13/21. [Client A] utilizes a wheelchair and a gait belt.... Statement from [DSP #1] taken by [QIDP #1] and [HM #1] 6/23/22 at 9:23 am: '[On 6/21/22] it was about 7:30 am and [DSP #3] and myself were loading the individuals. When buckling [client A], I thought I heard the belt click. I then started to transport the individuals to day service. While driving south on [street], a car that was driving on the right side of the van switch (sic) lanes without notice causing me to slam on the brakes. [Client A] flew forward, and that's when I noticed the seatbelt was detached. I continued to drive to [restaurant] parking lot to assist her back into position. It took at least 20 minutes to assist her back into position. I asked her if she was ok, and she said her knees hurt. I then took her to day service and reported what had happened. [Day Program Supervisor #1] gave directives to go to the ER (emergency room). Upon arriving to the ER, they asked [client A] what hurts, and she replied just her knees. They			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	gave an x-ray of her knees and diagnosed her with arthritis. They wrapped both knees with ace bandages, and I then transported her back to day service.' Was [client A] still in her seat when she fell? No. Was [client A's] wheelchair seatbelt latched? No, staff stated that the wheelchair belts were stuck in the sides of the chair. Who buckled [client A] in her chair? 'I [DSP #1] did.'... HM #1 statement: June 21, 2022, I [HM #1] was notified by [Day Program Supervisor #1] stating [client A] was dropped off by staff with her knees scraped up and her face red and swollen. I then contacted [DSP #1] and asked her what happened.... I look [client A] over. There wasn't any bruising to her face at all. [Client A] had very minimal scraping to the knees. Upon checking her out, I also checked her wheelchair, and the belt was entangled in the seat.... Conclusion of fact: It is substantiated based upon witness statement, [client A] was not buckled in her wheelchair. There was not documentation showing [DSP #1] had completed van training. At the time of (sic) incident, [client A] was not using her own wheelchair. [HM #1] was in the process of getting [client A] her own wheelchair since Nov. (November) 2021. [Client A] was taken to [emergency room] for knee pain. Imaging test of knee/obliques of left and right x-ray were completed. Medication given was acetaminophen (pain reliever). Diagnosis of osteoarthritis of both knees." The investigation included an Auto Incident/Accident Report was completed by DSP			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	#1 on 7/10/22 and reviewed by QIDP #1 on 7/13/22. The investigation included an undated Investigation Action Response Plan indicated the following: "Corrective Action Resulting from Investigation: - In-service [DSP #1] on van/wheelchair safety. Person Responsible: [HM #1/QIDP #1]. Completed Date: 7/6/22. - Corrective action - [DSP #1] on van/wheelchair safety. Person Responsible: [HM #1/QIDP #1]. Completed Date: 7/6/22. - Re-train [DSP #1] on van/wheelchair safety. Personal Responsible: [HM #1/QIDP #1]. Completed Dated: 7/6/22." The investigation included a Corrective Action Plan dated 7/6/22 indicated the following: "Expectations for Improvement and/or Action Being Taken: [DSP #1] will double check and ensure individuals are properly buckled prior to any vehicle being in motion." - The review indicated the investigation did not indicate it was reviewed by the AD. A recertification and state licensure survey conducted on 2/15/22 indicated the facility failed to secure client A and her wheelchair into the transportation vehicle on 8/27/21. The vehicle was in a wreck, and client A fell from wheelchair and broke her femur. In an observation on 2/9/22 the staff of the facility owned and operated day serve failed to use a The facility's Plan of Correction (POC) dated 3/16/22 was reviewed on 8/11/22 at 10:00 am and indicated the following: "The facility has written policy and procedures that prohibit mistreatment, neglect of (sic) abuse of the individuals. All staff will be trained in the facilities (sic) abuse, neglect, and mistreatment policy.... All staff will be trained in the procedures for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	securing a wheelchair for safe transport. In addition, all staff will be trained in their responsibility for monitoring the adaptive equipment and/or assistive device for safety and good repair. This would include ensuring there are no obstructive parts that could obstruct the proper functioning and notifying a supervisor if it is noted to not be in good repair.... Responsible Person: Area Director (AD)." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/15/22 at 1:45 pm and indicated she had been trained as an investigator. QIDP #1 indicated she had not interviewed client A as part of the investigation. QIDP #1 stated, "[Client A] is able to speak and to tell what is going on." Area Director (AD) #1 was interviewed on 8/15/22 at 12:11 pm and, "We did substantiate neglect. Obviously it was neglect." AD #1 stated, "We should have interviewed [client A]. She's definitely verbal. She could certainly say. We don't have her statement in here. It should be." 2. A BDDS report dated 6/8/22 indicated the following: "On June 7, 2022, [client B] was coming back home from an outing at 8:15 pm. [Client B] was getting off the van and walking towards the home (sic) tripped and fell (sic) falling face forward. [Client B] was taken to [urgent care]. She had no visible signs of injury. [Client B] was prescribed Ibuprofen (pain reliever) 800 mg (milligrams) take 1 tablet twice per day and Amoxicillin (antibiotic) 500 mg take 2 tablet twice daily. The physician wrote scripts for a head CT (computed tomography) and x-ray of nose and face. On June 8, 2022, [client B] had x-ray of her nose and face. The results of the x-ray are pending. The head CT			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	is to be scheduled." An undated follow up indicated the following: "Please provide the x-ray and CT scan results. Indiana Mentor nurse reports CT scan results were fine. X-ray of the face/nose showed a nasal fracture. On June 23, 2022, [client B] followed up with her primary care physician. Her primary care physician ordered lab work and for [client B] to follow up with neurology due to her frequent falls. Primary care physician noted [client B] would benefit from a two person assist." - The review did not include an investigation. 3. A BDDS report dated 4/26/22 indicated the following: "On 4/24/22, staff reported [client B] fell in her bedroom. [Client B] got up out of bed without staff assistance. She has a red bruise on her face, and a cut over her eye. Indiana Mentor nurse was informed and instructed staff to take [client B] to the emergency room. [Client B] was taken to [ER] for further evaluation. [ER] completed CT scan of head. CT scan is normal. Clean wound, required no stitches. [Client B] was discharged from [ER]." - The review did not include an investigation. 4. A BDDS report dated 4/18/22 indicated the following: "On 4/17/22, staff reported two bruises on [client B]. One on her right lower arm about 1 1/2 inches, and the second one on her chin about quarter size. Two individuals reported to staff they seen (sic) [client B] fall at the home. No present injuries or sign of pain at the time. [Client B] was seen by Indiana Mentor nurse. Indiana Mentor nurse reported, '[Client B] appears stable, found additional bruise on her back right side about dime size.' [Client B] wears a gait belt and tried to get up without staff assistance."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	- The review did not include an investigation. QIDP #1 was interviewed on 8/15/22 at 1:45 pm and stated, "On 4/17/22, I did talk to staff, but they didn't know what happened. It wasn't an injury of unknown origin because the individuals told us what happened. When we found it, we talked to all of the staff, and nobody knew. When we questioned the individuals, they said she fell." QIDP#1 stated, "On 4/24/22, I didn't do an investigation. She fell from bed and went to the hospital. There was an injury." QIDP #1 stated, "On 6/7/22, When [client B] got out of the van and was walking, she fell. I think it was at night time. Staff were with her. I'm not sure if they were using the gait belt. She does have a gait belt in her plan." QIDP #1 stated, "The investigation wouldn't have told us if staff were using the gait belt. Even if they were using it, she still would have tumbled over. She's gained weight. It would depend on the staff if they were able to hold her up. I would say she needs more support to prevent falls. I haven't discussed it with the team." QIDP #1 indicated Client B did fall and fracture her nose. QIDP #1 indicated an investigation was not completed. QIDP #1 indicated an investigation would not have indicated whether staff implemented client B's high risk plans or whether the plans needed to be revised. RN #1 was interviewed on 8/15/22 at 1:35 pm and stated, "Staff assist [client B] at all times when she's walking. She doesn't tell them when she needs help. She should have line of sight supervision." 5. A BDDS report dated 3/28/22 indicated the following: "[Client C] was assisted to the main area after			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	arriving at day program. [Day Program Staff #1] walked by saying, 'Hi [client C]' [Day Program Staff #2] had his back to [client C] when [client C] stood up and fell forward on to the floor. [Day Program Staff #2] assisted [client C] up and noticed a cut above her left eye brow the length of a half dollar bill. [Client C] was transported to [ER] by ambulance as per policy. [Day Program Staff #3] followed the ambulance. At the time of this report, [client C] is still in the emergency room." - The review did not include an investigation. 6. A BDDS report dated 3/24/22 indicated the following: "At 11:45 am on March 23 rd, 2022 [Day Program Staff #2] and [Day Program Staff #4] were in the kitchen assisting the individuals with their lunches. [Day Program Staff #2] went to go check on the other individuals outside of the kitchen and [Day Program Staff #4] assisted another individual returning to her activity. That's when they heard a thud come from the kitchen, [Day Program Staff #4] arrived in the kitchen first and found [client C] on the floor. [Client C] was on her right side, and the chair was knocked over as well. [Day Program Staff #2 and #4] checked [client C] for injuries then assisted her up.... Staff transported [client C] to [ER]." - The review did not include an investigation. QIDP #1 was interviewed on 8/15/22 at 1:45 pm and stated, "I was not aware of her falling." AD #1 was interviewed on 8/15/22 at 12:11 pm and stated, "The falls and injuries of unknown origin were not investigated. They should have been investigated. We don't know what happened. They should be investigated."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	This deficiency was cited on 2/15/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 3 of 3 sample clients (A, B, and C), the facility failed to implement effective corrective action to ensure client A was properly secured in the transportation vehicle and to address a pattern of falls for clients A, B, and C. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 8/11/22 at 10:03 am. 1. A BDDS report dated 6/21/22 indicated the following: "It has been reported, as staff was transporting individuals to day service. (sic) [Direct Support Professional (DSP) #1] slammed on the brakes to avoid an accident. [Client A] fell out of her wheelchair onto her knees. Staff is suspended pending further investigation." DSP #1 was interviewed on 8/11/22 at 7:45 am and stated, "I was driving [on 6/21/22]. I had to hit the brakes because someone pulled in front of me. She fell out of the wheelchair and scraped her knees. She was buckled." DSP #1 stated, "There are 4 things on the floor that lock onto the	W 0157	**157-** **When the alleged violation is verified, appropriate corrective action must be taken.** **The facility will provided re-training to Program Supervisor, Program Director, and Direct Support Professionals on the safety plan created to protect all individuals residing in the home from further potential falls. When falls do occur, IDT will discuss and ensure updates to safety plans are trained upon and observed for follow through.** **The Program Supervisor will complete unannounced site visits twice weekly to ensure safety plan continues to be implemented for one month.** **The Program Director will complete unannounced site visits twice weekly to ensure safety plan continues to be properly implemented for one month.** **Responsible Staff: Program**	09/19/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	wheelchair. She was in an old wheelchair, and the buckle for that one was all twisted and loose. It came off, too. If it was tight, she wouldn't have fallen out. She fell and scraped her knees." DSP #1 stated, "I didn't know how to latch it." DSP #1 stated, "[HM (House Manager) #1] retrained me. It was one hour of training. There was hands on. There was a pamphlet and videos. She showed me how to move the floor locks, so they fit properly with the new wheelchair." HM #1 was interviewed on 8/11/22 at 8:10 am and stated, "There have been 2 different accidents in the van when [client A] has come out of her wheelchair. According to [DSP #1], another driver got in front of her without signaling. She stepped on the brakes hard, and [client A] came out of her wheelchair. [DSP #1] reported it to the day service manager. [Qualified Intellectual Disabilities Professional (QIDP) #1 did an investigation. [DSP #1] was suspended and retrained on the vehicle training. It's a packet, video, and hands-on with me. I observed her putting on the Q-straints and the seat belt." HM #1 indicated all new staff are trained at the time of hire. HM #1 stated, "When they're shadowing, it's a hands on training. I watch them load and unload and drive." HM #1 stated, "How [client A] was buckled today is not how staff are trained." An investigation dated 6/23/22 was reviewed on 8/11/22 at 11:50 am and indicated the following: "[DSP #1] has been employed since 9/13/21. [Client A] utilizes a wheelchair and a gait belt.... Statement from [DSP #1] taken by [QIDP #1] and [HM #1] 6/23/22 at 9:23 am: '[On 6/21/22] it was about 7:30 am and [DSP #3] and myself were loading the individuals. When buckling [client A], I thought I heard the belt click.		**Supervisor, Program Director**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	I then started to transport the individuals to day service. While driving south on [street], a car that was driving on the right side of the van switch (sic) lanes without notice causing me to slam on the brakes. [Client A] flew forward, and that's when I noticed the seatbelt was detached. I continued to drive to [restaurant] parking lot to assist her back into position. It took at least 20 minutes to assist her back into position. I asked her if she was ok, and she said her knees hurt. I then took her to day service and reported what had happened. [Day Program Supervisor #1] gave directives to go to the ER (emergency room). Upon arriving to the ER, they asked [client A] what hurts, and she replied just her knees. They gave an x-ray of her knees and diagnosed her with arthritis. They wrapped both knees with ace bandages, and I then transported her back to day service.' Was [client A] still in her seat when she fell? No. Was [client A's] wheelchair seatbelt latched? No, staff stated that the wheelchair belts were stuck in the sides of the chair. Who buckled [client A] in her chair? 'I [DSP #1] did.'... HM #1 statement: June 21, 2022, I [HM #1] was notified by [Day Program Supervisor #1] stating [client A] was dropped off by staff with her knees scraped up and her face red and swollen. I then contacted [DSP #1] and asked her what happened.... I look [client A] over. There wasn't any bruising to her face at all. [Client A] had very minimal scraping to the knees. Upon checking her out, I also checked her wheelchair, and the belt was entangled in the seat.... Conclusion of fact: It is substantiated based upon witness statement,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	[client A] was not buckled in her wheelchair. There was not documentation showing [DSP #1] had completed van training. At the time of (sic) incident, [client A] was not using her own wheelchair. [HM #1] was in the process of getting [client A] her own wheelchair since Nov. (November) 2021. [Client A] was taken to [emergency room[for knee pain. Imaging test of knee/obliques of left and right x-ray were completed. Medication given was acetaminophen (pain reliever). Diagnosis of osteoarthritis of both knees." The investigation included an Auto Incident/Accident Report was completed by DSP #1 on 7/10/22 and reviewed by QIDP #1 on 7/13/22. The investigation included an undated Investigation Action Response Plan indicated the following: "Corrective Action Resulting from Investigation: - In-service [DSP #1] on van/wheelchair safety. Person Responsible: [HM #1/QIDP #1]. Completed Date: 7/6/22. - Corrective action - [DSP #1] on van/wheelchair safety. Person Responsible: [HM #1/QIDP #1]. Completed Date: 7/6/22. - Re-train [DSP #1] on van/wheelchair safety. Personal Responsible: [HM #1/QIDP #1]. Completed Dated: 7/6/22." The investigation included a Corrective Action Plan dated 7/6/22 indicated the following: "Expectations for Improvement and/or Action Being Taken: [DSP #1] will double check and ensure individuals are properly buckled prior to any vehicle being in motion." - The review indicated the investigation did not indicate it was reviewed by the AD. A recertification and state licensure survey			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	conducted on 2/15/22 indicated the facility failed to secure client A and her wheelchair into the transportation vehicle on 8/27/21. The vehicle was in a wreck, and client A fell from wheelchair and broke her femur. In an observation on 2/9/22 the staff of the facility owned and operated day serve failed to use a The facility's Plan of Correction (POC) dated 3/16/22 was reviewed on 8/11/22 at 10:00 am and indicated the following: "The facility has written policy and procedures that prohibit mistreatment, neglect of (sic) abuse of the individuals. All staff will be trained in the facilities (sic) abuse, neglect, and mistreatment policy.... All staff will be trained in the procedures for securing a wheelchair for safe transport. In addition, all staff will be trained in their responsibility for monitoring the adaptive equipment and/or assistive device for safety and good repair. This would include ensuring there are no obstructive parts that could obstruct the proper functioning and notifying a supervisor if it is noted to not be in good repair.... Responsible Person: Area Director (AD)." The facility's training records were reviewed on 8/11/22 at 11:50 am. The review did not include trainings for staff or administration related to the facility's abuse and neglect policy. A training dated 7/13/22 indicated [AD #1], [QIDP #1], and [HM #1] were trained on the facility's Incident-Investigation Policy and Procedure." A training dated 2/17/22 indicated house staff attended a training titled: Van (Driving) & Safety directed by [HM #1]. The training documentation indicated: "How to properly use van, Q Straints, & Seatbelts, Gas fill up, maintenance, cleaning the van." The review indicated [DSP #1] did not attend the training on 2/17/22 and had not been trained at the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	time of hire, 9/13/21. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/15/22 at 1:45 pm and stated, "Generally, in NEO (New Employee Orientation), they would do the online videos on vans. The program supervisor trains them afterwards with a skills check (hands on training)." QIDP #1 stated, "I didn't find documentation that [DSP #1] was trained. She did say she was trained by [HM #1], but I didn't find documentation to support it." QIDP #1 stated, "[HM #1] does the training for the staff." When asked about the facility's plan of correction, QIDP #1 stated, "I wasn't aware of the checks. I didn't know that was something I was supposed to do." QIDP #1 indicated she had been trained as an investigator. QIDP #1 indicated she had not interviewed client A as part of the investigation. QIDP #1 stated, "[Client A] is able to speak and to tell what is going on." Area Director (AD) #1 was interviewed on 8/15/22 at 12:11 pm and stated, "Wheelchair training is part of the on-shadowing for new staff. Through orientation, there is an online video they have to watch. When they get to the house for their shadowing, they learn about the individual's risk plans. They go through van driving safety. The day program staff also have to be trained before they can drive. They have to know how to properly buckle, use the lifts, and use the wheelchair restraints." AD #1 stated, "On 6/21/22, [client A's] seatbelt wasn't latched properly. She slid forward when the staff slammed on the brakes." AD #1 stated, "[DSP #1] was supposed to have been trained on the vans and the seatbelts. They could not find the documentation. If there's no documentation, we count that as not being trained." AD #1 indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	the house staff were trained to use the wheelchair restraints as part of the facility's POC dated 3/16/22. AD #1 stated, "If her name isn't on the training attendance, she didn't get trained, and that's a problem for sure." AD #1 looked at training records and stated, "[DSP #1] was not trained." AD #1 stated, "[HM #1] does the training. She would have been trained previously by a prior program director when she started." AD #1 stated, "The HM and QIDP do the investigations. They are completed within 7 days and are reviewed by the AD, Quality Improvement, and the Regional Director. They make a decision of how to go forward." AD #1 stated, "It looks like [QIDP #1] completed this investigation on 6/23/22." AD #1 stated, "We did substantiate neglect. Obviously it was neglect." AD #1 stated, "We should have interviewed [client A]. She's definitely verbal. She could certainly say. We don't have her statement in here. It should be." 2. A BDDS report dated 6/8/22 indicated the following: "On June 7, 2022, [client B] was coming back home from an outing at 8:15 pm. [Client B] was getting off the van and walking towards the home (sic) tripped and fell (sic) falling face forward. [Client B] was taken to [urgent care]. She had no visible signs of injury. [Client B] was prescribed Ibuprofen (pain reliever) 800 mg (milligrams) take 1 tablet twice per day and Amoxicillin (antibiotic) 500 mg take 2 tablet twice daily. The physician wrote scripts for a head CT (computed tomography) and x-ray of nose and face. On June 8, 2022, [client B] had x-ray of her nose and face. The results of the x-ray are pending. The head CT is to be scheduled." An undated follow up indicated the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	"Please provide the x-ray and CT scan results. Indiana Mentor nurse reports CT scan results were fine. X-ray of the face/nose showed a nasal fracture. On June 23, 2022, [client B] followed up with her primary care physician. Her primary care physician ordered lab work and for [client B] to follow up with neurology due to her frequent falls. Primary care physician noted [client B] would benefit from a two person assist." - The review did not include an investigation or a plan of corrective action to prevent falls for client B. 3. A BDDS report dated 4/26/22 indicated the following: "On 4/24/22, staff reported [client B] fell in her bedroom. [Client B] got up out of bed without staff assistance. She has a red bruise on her face, and a cut over her eye. Indiana Mentor nurse was informed and instructed staff to take [client B] to the emergency room. [Client B] was taken to [ER] for further evaluation. [ER] completed CT scan of head. CT scan is normal. Clean wound, required no stitches. [Client B] was discharged from [ER]." - The review did not include an investigation or a plan of corrective action to prevent falls for client B. 4. A BDDS report dated 4/18/22 indicated the following: "On 4/17/22, staff reported two bruises on [client B]. One on her right lower arm about 1 1/2 inches, and the second one on her chin about quarter size. Two individuals reported to staff they seen (sic) [client B] fall at the home. No present injuries or sign of pain at the time. [Client B] was seen by Indiana Mentor nurse. Indiana Mentor nurse reported, '[Client B] appears stable, found additional bruise on her back right side about dime size.' [Client B] wears a gait belt and tried to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	get up without staff assistance." - The review did not include an investigation or a plan of corrective action to prevent falls for client B. Client B's record was reviewed on 8/15/22 at 1:15 pm. Client B's Fall Protocol dated 1/11/21 indicated the following: "[Client B] has cerebral palsy and unsteady gait.... [Client B] will try to walk independently.... For [client B's] safety, staff must always assist her with a gait belt...." Client B's Gait Belt Protocol dated 1/11/21 indicated the following: "[Client B] has cerebral palsy and unsteady gait. She is very prone to falling. Preventive Measures: - [Client B] is to wear a gait belt at all times, except when sleeping and bathing. - [Client B] is to have gait belt assistance at all times for any distance. - Use proper gait belt technique at all times as outlined below: Grip the back of the belt from the bottom, palm up. Have [client B] slightly extend her arm on the side which you are standing. Place your other hand under her hand and wrist of the extended arm. - Encourage [client B] to walk upright and slowly. - If [client B] starts to lean or walk to fast, ask her to stop for a moment. Begin again with a verbal reminder to walk upright and slowly. - After meals at home, assist [client B] to stand by the kitchen table. Support [client B] as she places her dirty dishes in the service window to the kitchen. - Assist [client B] to the kitchen to provide support as she finishes cleaning up her dishes."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	QIDP #1 was interviewed on 8/15/22 at 1:45 pm and stated, "On 4/17/22, I did talk to staff, but they didn't know what happened. It wasn't an injury of unknown origin because the individuals told us what happened. When we found it, we talked to all of the staff, and nobody knew. When we questioned the individuals, they said she fell." QIDP#1 stated, "On 4/24/22, I didn't do an investigation. She fell from bed and went to the hospital. There was an injury." QIDP #1 stated, "On 6/7/22, When [client B] got out of the van and was walking, she fell. I think it was at night time. Staff were with her. I'm not sure if they were using the gait belt. She does have a gait belt in her plan." QIDP #1 stated, "The investigation wouldn't have told us if staff were using the gait belt. Even if they were using it, she still would have tumbled over. She's gained weight. It would depend on the staff if they were able to hold her up. I would say she needs more support to prevent falls. I haven't discussed it with the team." QIDP #1 indicated Client B did fall and fracture her nose. QIDP #1 indicated an investigation was not completed. QIDP #1 indicated an investigation would not have indicated whether staff implemented client B's high risk plans or whether the plans needed to be revised. RN #1 was interviewed on 8/15/22 at 1:35 pm and stated, "Staff assist [client B] at all times when she's walking. She doesn't tell them when she needs help. She should have line of sight supervision." AD #1 was interviewed on 8/15/22 at 12:11 pm and stated, "With [client B's] fall protocol, we're supposed to be there at all times. She's a fast mover. She'll get up quick. Staff should be right there with her." AD #1 stated, "The plan doesn't			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	specify line of sight. Staff must always assist with a gait belt. the prevention part of our plan is pretty vague." AD #1 stated, "Her plan has not been reviewed. They should have reviewed and updated the plans after her falls." 5. A BDDS report dated 3/28/22 indicated the following: "[Client C] was assisted tot he main area after arriving at day program. [Day Program Staff #1] walked by saying, 'Hi [client C]' [Day Program Staff #2] had his back to [client C] when [client C] stood up and fell forward on to the floor. [Day Program Staff #2] assisted [client C] up and noticed a cut above her left eye brow the length of a half dollar bill. [Client C] was transported to [ER] by ambulance as per policy. [Day Program Staff #3] followed the ambulance. At the time of this report, [client C] is still in the emergency room." - The review did not include an investigation or a plan of corrective action to prevent falls for client C. 6. A BDDS report dated 3/24/22 indicated the following: "At 11:45 am on March 23 rd, 2022 [Day Program Staff #2] and [Day Program Staff #4] were in the kitchen assisting the individuals with their lunches. [Day Program Staff #2] went to go check on the other individuals outside of the kitchen and [Day Program Staff #4] assisted another individual returning to her activity. That's when they heard a thud come from the kitchen, [Day Program Staff #4] arrived in the kitchen first and found [client C] on the floor. [Client C] was on her right side, and the chair was knocked over as well. [Day Program Staff #2 and #4] checked [client C] for injuries then assisted her up.... Staff transported [client C] to [ER]."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	- The review did not include an investigation or a plan of corrective action to prevent falls for client C. Client C's record was reviewed on 8/15/22 at 2:00 pm. Client C's Gait Belt Protocol dated 11/24/21 indicated the following: "[Client C] has an unsteady gait and a history of falls.... Preventive Measures: Encourage and remind client that gait belt and assistance is needed. Always use gait belt when walking with or transferring client." Client C's Fall Protocol dated 11/24/21 indicated the following: "[Client C] has an unsteady gait and wears a gait belt. She also wears an AFO (special shoe) and brace on her left side.... [Client C's] gait has become increasingly unsteady. Therefore, staff are to always to (sic) assist her, and must stay in the bathroom with her for assistance and safety." QIDP #1 was interviewed on 8/15/22 at 1:45 pm and stated, "I was not aware of her falling." RN #1 was interviewed on 8/15/22 at 1:35 pm and stated, "[Client C] has a fall risk plan. She cannot ask for assistance." RN #1 stated, "She needs assistance with walking and holding onto her gait belt." When asked if client C had line of sight supervision, RN #1 stated, "I'm not sure how the group homes are doing it for her." AD #1 was interviewed on 8/15/22 at 12:11 pm and stated, "The falls and injuries of unknown origin were not investigated. They should have been investigated. We don't know what happened.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	They should be investigated." This deficiency was cited on 2/15/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 2 of 3 sample clients (A and C), the facility's nursing services failed to ensure clients A and C had access to their medications as needed. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) Reports were reviewed on 8/11/22 at 10:03 am. 1. A BDDS report dated 4/26/22 indicated the following: "On April 25, 2022, staff reported [client A] didn't have her albuterol nebulizer treatment (prevents and treats difficulty breathing due to Chronic Obstructive Pulmonary Disease (COPD) for 7 pm medication pass and 7 am medication pass on April 26, 2022. Indiana Mentor nurse was notified. The hospital faxed the scripts to the pharmacy. The pharmacy put the medication on hold due to needing to contact (sic) physician for clarification on (sic) script." 2. A BDDS report dated 6/14/22 indicated the following: "Staff reported [client A] to be out of her albuterol nebulizer treatment. [Client A's] primary care	W 0331	**331-** **The facility provides individuals served with nursing services in accordance with their needs. The facility provides nursing services for individuals served in the group home to ensure medical needs of the individuals served are being met. The facility nurse trains staff upon hire and as needed on medical treatments and procedures necessary to ensure the individuals served medical needs including prescriptions are being met. The nurse monitors the documentation of medical orders weekly to ensure procedures are being carried out as ordered by the doctor.** **The nurse will be trained to ensure conflicting information is clarified between provider reports and pharmacy, along with corresponding prescriptions and paperwork.**	09/19/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	physician was notified. [Client A] was taken to [emergency room] for a refill prescription. [Client A] received a script for 30 day refill of medication. The script was filled by [pharmacy]. [Client A] missed her albuterol medication treatment on 6/13/22 at 7 pm and 6/14/22 at 7 am, therefore resulting in a medication error. [Client A] did not experience any adverse effects due to missed medication." 3. A BDDS report dated 6/16/22 indicated the following: "[Client A] missed three doses of her albuterol medication on 6/14/22 at 7 pm, 6/15/22 at 7 am, and 6/15/22 at 7 pm. The pharmacy was not able to fill the script due to the script missing diagnosis code, from her Emergency Room visit on 6/13/22. Indiana Mentor nurse requested an appointment be made in order to get a refill on her medication. An appointment has been made for 6/17/22. At this time, [client A] has not experienced any adverse effects due to missed medication. [Client A] has a relief medication treatment if needed." 4. A BDDS report dated 6/17/22 indicated the following: "[Client A] missed two doses of her Budesonide Susp (suspension) (treats Crohn's disease, ulcerative colitis, and asthma) 0.5 mg (milligrams) and Arfomotheronol Neb (nebulizer) (treats COPD) on 6/16/22 at 7 pm and on 6/17/22 at 7 am. She has an appointment with her primary care physician on 6/17/22 to get a refill on medication. At this time, she is not experiencing any adverse effects due to missed medication. [Client A] has a relief medication treatment if needed." 5. A BDDS report dated 6/8/22 indicated the following: "[Client C] did not receive her Januvia (treats		**Clarifications will be documented in the clients' record on the nurse notes. This task will be completed monthly by the 15th of the month for the upcoming month. The nurse will contact compliance hotline with physician's office if refills are not provided in a timely manner to ensure no interruption to medications as prescribed.** /b> **/b>** /b>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	diabetes) tab (tablet) 25 mg medication on June 7 and June 8 at 7 am. This resulted in a medication error. The pharmacy delivered the medication, however, staff were unable to locate the medication. [Client C] was taken to [hospital] to get a refill script on her medication. The refill medication was filled by [pharmacy] for 5 days paid for by Indiana Mentor. After 5 days, the rest of the medication will be filled and paid for by [client C's] insurance." 6. A BDDS report dated 7/1/22 indicated the following: "On 7/1/22 (client C) did not receive her Sucralfate (treats ulcers) 1 gm (gram) at 7:00 am due to the medication not being present in the home. [Client C] is prescribed this medication at 7:00 am and 7:00 pm daily. The pharmacy has requested the refill this (sic) from [doctor]. Nurse sent fax request on 6/28/22 to (sic) doctor's office. Nurse called (sic) doctor office on 6/29/22 and 6/30/22 about medication refills. On 7/1/22 Program Supervisor stated that both meds (medications) were not received. Nurse called again on 7/1/22 for refills and emphasized the number of times (sic) refills were requested and still no response. [Client C] still has not received refill prescription for the missing medication. The nurse will continue to contact the doctor about the missing medication." 7. A BDDS report dated 7/6/22 indicated the following: "On 7/5/22, staff informed [Qualified Intellectual Disabilities Professional (QIDP)] that [client C] was taking Metformin (treats diabetes) twice daily as stated on the Medication Administration Record (MAR). [QIDP] contacted Indiana Mentor nurse. Indiana Mentor nurse stated [client C] is off Metformin and only on Januvia. [Client C] was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	given Metformin on 7/1/22 to 7/5/22 resulting in a medication error(s). The medication was pulled to prevent further medication error(s)." Client A's record was reviewed on 8/11/22 at 12:30 pm. Client A's Physician's Orders (PO) for June 2022 indicated the following: "Arformoterol Neb 15/2 ML (milliliters), Inhale 2 ML per Nebulizer twice daily - COPD. Orig: (Original) 4/28/22." "Budesonide Sus 0.5 mg/2, Inhale 2 ML per Nebulizer twice daily - COPD. Orig: 4/28/22." "Albuterol, Inhale 2 puffs every 4 hours by inhalation route as needed for shortness of breath/wheezing. Orig: 1/21/22." Albuterol, Inhale the contents of 1 vial (3 ML) per Nebulizer every 6 hours as needed for cough/wheezing. Orig: 1/21/22." Client C's record was reviewed on 8/11/22 at 1:00 pm. Client C's PO for June 2022 indicated the following: "Januvia Tab, 25 mg, Take one tablet by mouth every day - Diabetes. Orig: 3/31/22." "Metformin Tab, 500 mg ER (extended release), Take one tablet by mouth twice daily with meals - Type II Diabetes. Orig: 4/13/22." "Sucralfate Tab, 1 gm, Take one tablet by mouth twice daily [for] 60 days. Orig: 2/28/22." Registered Nurse (RN) #1 was interviewed on 8/15/22 at 1:35 pm and stated, "The doctor is not getting the medications filled on time for them. Per our policy, they go to the ER for a refill." RN #1 stated, "The medications are filled monthly unless the doctor wants more. Every month, they need a new prescription from the doctor. The pharmacy notifies the doctor. I notify the doctor.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	It could take over 2 weeks." RN #1 stated, "All medications are on the same cycle. When we get the medications in, I check through them. If something is not there, I compare it with the pharmacy, and they reach out to the doctor. I'm usually contacting the doctor 2 or 3 times." RN #1 stated, "My plan to correct it is to keep calling them. We bug them until we get the medications." Area Director (AD) #1 was interviewed on 8/15/22 at 12:11 pm and stated, "When we've tried to get in touch with the doctor, he doesn't return the call or doesn't give the right prescription to the pharmacy. To avoid them being out of their meds for a long time, we've taken them to the ER to get meds refilled. It's definitely happened more than once. The nurse has reached out to the doctors a couple of times. " AD #1 stated, "It's not a good reason to go to the ER. It's not an emergency. It could become one if they're without their meds for a period of time." AD #1 stated, "The nurse has been working with the pharmacist to get a list of people whose refills are coming up, so we can do it ahead of time." AD #1 stated, "Everyone who works here is responsible for making sure everyone gets their medications. When they see that the med is not in the home, the DSP (Direct Support Professional) needs to report it, the [House Manager] and nurse should be monitoring when the refills are coming up. They should be looking at the errors on the MARs." This deficiency was cited on 2/15/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			
W 0436	483.470(g)(2) SPACE AND EQUIPMENT			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	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. Based on observation, record review, and interview for 1 of 3 sample clients (A), the facility failed to ensure client A's breathing machine was kept clean and to ensure client A's oxygen tubes were kept out of the way of her wheelchair. Findings include: An observation was conducted on 8/11/22 from 7:30 am to 8:30 am. Client A was present in the home throughout the observation period. 1. On 8/11/22 at 7:30 am, client A was in her bedroom. Client A indicated she used a breathing machine at night. Client A indicated a machine on a table next to her bed. The mask of the machine was sitting on top of client A's dresser. The clear mask had a crusty, flaky film on the inside. Client A was interviewed on 8/11/22 at 7:33 am and stated, "I had pneumonia and the flu. It's my oxygen. It's affecting my breathing. I have allergy problems." Client A stated, "Staff clean the mask. I don't know when." House Manager (HM) #1 was interviewed on 8/11/22 at 8:03 am and stated, "[Client A] uses the machine nightly. Different parts are supposed to be cleaned at different times. The clear face part is supposed to be cleaned daily." HM #1 stated, "No, it doesn't look clean now." HM #1 indicated staff do not track when the machine is used or cleaned.	W 0436	**436-** **The facility will furnish, maintain, and teach individuals served to use and to make informed choices about breathing machines, oxygen tubing, and other adaptive equipment.** **Direct Support Professionals will be trained on proper cleaning of breathing machine, tubing, and face mask, along with protecting oxygen tubing from wheelchairs and other items being placed on them, and documenting completion of these tasks daily in Medication Administration Record. Program Supervisor will be retrained on reordering replacement parts as required by manufacturer.** **The Program Supervisor will monitor the client active treatment two times weekly to observe staff properly cleaning breathing equipment and protecting oxygen tubing from being ran over by wheelchair or any other objects. The Program Director will monitor**	09/19/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Registered Nurse (RN) #1 was interviewed on 8/15/22 at 1:35 pm and stated, "[Client A] gets humidified air at night." RN #1 stated, "Staff were trained by a representative from the company who brought the machine in." RN #1 stated, "They clean it weekly, but the mask is wiped out daily." RN #1 indicated staff were not documenting when the machine was used or cleaned. RN #1 stated, "Staff should be noticing when it is dirty and should clean it." 2. On 8/11/22 at 7:30 am, client A was in her bedroom. Client A had an oxygen tank in her bedroom with a long tube which was sprawled across the floor. At 7:42 am, client A asked Direct Support Professional (DSP) #1 to assist her to her wheelchair from her bed. When DSP #1 moved client A's wheelchair around the room, she ran the wheels of the chair over the oxygen tube. At 7:56 am, DSP #1 went to client A's bedroom and prepared her to be transported on the van. DSP #1 ran the wheels of client A's wheelchair over the oxygen tubes connected to client A's oxygen tank. HM #1 was interviewed on 8/11/22 at 8:03 am and stated, "It's ok for the oxygen tubes to be on the floor and run over. They extra long, so she can move around the house. It won't hurt them." RN #1 was interviewed on 8/15/22 at 1:35 pm and stated, "Rolling the chair over the tubing can damage it and flatten it out. They should move the tubing over before they move the wheelchair in the room, so they don't run over it." Client A's record was reviewed on 8/11/22 at 9:32 am. Client A's Low Oxygen Protocol dated 4/21/22		**the client active treatment weekly for one month to ensure clients are being prompted and encouraged to utilize prescribed adaptive equipment.** **Person Responsible: Program Supervisor and Program Director**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G599	A. BUILDING 00 B. WING	08/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	indicated the following: "[Client A] was in the hospital for pneumonia and prolonged oxygen use. She will use an Astral unit at night which is like a c-pap (continuous positive airway pressure) machine. During the day, her oxygen needs to be monitored. Her oxygen saturation is normally around 96%.... Cleaning: The mask should be wiped clean after use. The hose is washed once a week. Place tubing in a sink of warm, soapy water to soak for about an hour. Rinse thoroughly and hang to dry. Do not wash filter that connects hose to the unit. The hose and mask cushion should be changed out to new ones every month." This deficiency was cited on 2/15/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-7(a)			
W 9999 Bldg. 00		W 9999	The facility will complete all action plans with supervision/observations over each step of POC to ensure health and safety of individuals served.	09/19/2022