STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G296	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REM-INDIANA INC	417 W WALNUT ST KOKOMO, IN 46901

(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 a post-certification revisit (PCR) survey to the predetermined full recertification and state licensure survey. This visit included the PCR to the investigation of complaint #IN00235679 completed on 10/5/2017. Complaint #IN00235679: Not Corrected. Survey Dates: 11/20, 11/21, and 11/22/2017. Facility Number: 000815 Provider Number: 15G296 AIM Number: 100249080 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/8/17.	W 0000		
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 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility	W 0149	**W149:** The Facility developed and implements written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The facility policies are	12/22/2017

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

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	failed to implement policy and procedures regarding an allegation of staff abuse by failing to immediately report an allegation to BDDS (Bureau of Developmental Disabilities Services) in accordance to state law and to complete a thorough investigation. Findings include: On 11/20/17 at 2:45pm, the facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations from 10/1/2017 through 11/20/17 were reviewed and did not include an allegation of staff abuse, neglect, and/or mistreatment. On 11/21/17 at 7:25am, clients #5, #6, and #7 asked to speak privately with the surveyor. Clients #5, #6, and #7 stated they "had reported" to the former house manager and another former staff person "that we witnessed [GHS (Group Home Staff) #3] take [client #3's] hand and twist" it. Clients #5, #6, and #7 stated they "witnessed [GHS #3] yell at [client #6]." Client #6 stated "[GHS #3] pointed her finger in [client #3's] face and my face, she yells at me. I told [name of former house manager] last week." Client #7 stated "[GHS #3] yells and points her finger in [client #6's] face." Client #7		written to ensure the best treatment, without neglect or abuse of a client regarding the individual's well-being. The Area Director will train the Program Director to follow the revised Incident Reporting and Investigation Process revised recently by Indiana MENTOR that includes the need of witness statements, questions asked, talking to staff and clients present, listing documents reviewed, the investigation outcome to be listed, conclusion of investigation, and other pertinent information. The Area Director will train the Program Coordinator and Program Director on the abuse/neglect policy including documentation and the immediate reporting of allegations of mistreatment, abuse, or neglect and investigation, BDDS incident reporting/investigation protocols, plus follow through to ensure corrective/protective measures are put in place to prevent re-occurrence of mistreatment, abuse or neglect. In the future, the Area Director will ensure that all allegations of mistreatment, abuse or neglect be reported to BDDS within 24 hours of the incident occurring, and that an investigation into the allegations be initiated within that 24 hour time frame. Investigations will be thoroughly investigated and an investigation will be completed	

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	indicated she did not report it because no one asked her. Client #7 stated GHS #3 "points at someone and used the F word. It's not right." On 11/21/17 from 7:00am until 7:27am, GHS #3 was observed to work in the group home. On 11/21/17 at 12:30pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated she was aware of the allegation against GHS #3 by clients #5, #6, and #7. The QIDP stated she did not report the allegation to the administrator and to BDDS because client #6 "does not like" GHS #3 and client #6 had false reporting as a targeted behavior in her BSP (Behavior Support Plan). The QIDP stated she talked with the staff and the clients in the home and determined "it was not an abusive situation." The QIDP indicated she did not consider the information client #6 reported as an allegation. The QIDP indicated she did not document the allegation, report the allegation, and did not conduct and document a written investigation into the allegation of staff abuse. The QIDP provided written notes from her day planner outlining initials and names of people she spoke to. The QIDP indicated no written		within 5 days of the incident. The Program Coordinator will monitor the Behavior data sheets and client progress notes at least three times weekly. The Program Director will monitor least monthly to ensure incidents are addressed and corrective measures are put in place immediately as needed according to policy. Person responsible: Area Director	

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	witness statements, no questions asked, no documents reviewed during the investigation, no discussions, and no formal reports were documented. On 11/21/17 at 12:30pm, an interview was conducted with the RD (Regional Director). The RD indicated the agency followed the ANE (Abuse, Neglect, and Exploitation) policy and procedure for the agency and from BDDS to immediately report and to thoroughly investigate allegations regarding ANE. The RD indicated there was no documented report and investigation completed for clients #5, #6, and #7's allegation. The RD indicated the investigation was not thorough in that the investigation did not have documented questions asked, narrative witness statements, conclusions to the investigations, staff and clients present during the incidents, and a documented summary from the investigator. On 11/20/17 at 2:45pm, the facility's 4/2011 Quality and Risk Management operating practices was reviewed and indicated it was agency policy to report immediately to BDDS "Indiana Mentor is committed to ensuring the individuals we serve are provided with a safe and quality living environment. In order to ensure the			

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	highest standard of service delivery specific staff will be assigned to the monitoring and review of Quality Assurance. 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...The Area Director will review each incident and Quality Assurance recommendations monthly. This review will be completed with the Program Director and other appropriate staff to assess the effectiveness of each recommendation made per incident...." This deficiency was cited on 10/5/2017. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal tag relates to complaint #IN00235679. 9-3-2(a)			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, record review, and	W 0153	**W153**	12/22/2017

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	interview, for 1 unreported allegation of staff abuse, neglect, and/or mistreatment (clients #1, #2, #3, #4, #5, #6, #7, and #8), the facility failed to immediately report an allegation of staff abuse to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance to state law. Findings include: On 11/20/17 at 2:45pm, the facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations from 10/1/2017 through 11/20/17 were reviewed and did not include an allegation of staff abuse, neglect, and/or mistreatment. On 11/21/17 at 7:25am, clients #5, #6, and #7 asked to speak privately with the surveyor. Clients #5, #6, and #7 stated they "had reported" to the former house manager and another former staff person "that we witnessed [GHS (Group Home Staff) #3] take [client #3's] hand and twist" it. Clients #5, #6, and #7 stated they "witnessed [GHS #3] yell at [client #6]." Client #6 stated "[GHS #3] pointed her finger in [client #3's] face and my face, she yells at me. I told [name of former house manager] last week." Client #7 stated "[GHS #3] yells and points		The facility currently has a written policy and procedure for immediately reporting all allegations of abuse. All new employees are trained on the policy and the procedure for reporting to the proper authorities within and outside the agency. The facility follows a protocol and regulation for the supervisor to be notified and a BDDS report sent for any instance of witnessed or suspected abuse, neglect, or exploitation. The Program Director has been re-trained on the mandated procedures to report any allegations of abuse, neglect, or exploitation to BDDS immediately despite the client retraction of said abuse, and to ensure documentation of the reporting by staff to the supervisor on duty. In the future, the facility staff will follow the policy to immediately notify appropriate supervisor with all allegations of abuse, neglect, or exploitation. The Program Director will follow BDDS guidelines for reporting the allegation as required. The Program Coordinator will monitor the client behavior data sheets and client progress notes three times weekly to ensure that incidents that occur are reported in a timely manner in the future. The Program Director will monitor the behavioral data on a monthly basis to ensure incidents are	

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	her finger in [client #6's] face." Client #7 indicated she did not report it because no one asked her. Client #7 stated GHS #3 "points at someone and used the F word. It's not right." On 11/21/17 at 12:30pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated she was aware of the allegation against GHS #3 by clients #5, #6, and #7. The QIDP stated she did not report the allegation to the administrator and to BDDS because client #6 "does not like" GHS #3 and client #6 had false reporting as a targeted behavior in her BSP (Behavior Support Plan). The QIDP stated she talked with the staff and the clients in the home and "determined it was not an abusive situation." The QIDP indicated she did not consider the information client #6 reported as an allegation. The QIDP indicated she did not document the allegation and report the allegation of staff abuse. On 11/21/17 at 12:30pm, an interview was conducted with the RD (Regional Director). The RD indicated the agency followed the ANE (Abuse, Neglect, and Exploitation) policy and procedure for the agency and from BDDS to immediately report allegations regarding ANE. The RD		reported in a timely manner. The Area Director will follow through on all allegations to ensure the Program Director has reported the allegation to BDDS. Responsible Staff: Area Director	

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	indicated there was no documented report completed for clients #5, #6, and #7's allegation. This deficiency was cited on 10/5/2017. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal tag relates to complaint #IN00235679. 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 observation, record review, and interview, the facility failed to complete a thorough investigation regarding an allegation of staff abuse (for clients #1, #2, #3, #4, #5, #6, #7, and #8). Findings include: On 11/20/17 at 2:45pm, the facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations from 10/1/2017 through 11/20/17 were reviewed and did not include an allegation of staff abuse, neglect, and/or mistreatment.	W 0154	**W154** The facility currently has a written policy and procedure for immediately reporting and investigating all allegations of mistreatment, neglect or abuse and injuries of unknown origin. The newly revised procedures include completion of a thorough investigation per regulations of allegations of abuse, neglect or mistreatment of an individual. All new employees are trained on the policy and the procedure for reporting suspected abuse. The Area Director has trained the Program Director on the requirement to investigate abuse allegations and document a thorough investigation.	12/22/2017

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	On 11/21/17 at 7:25am, clients #5, #6, and #7 asked to speak privately with the surveyor. Clients #5, #6, and #7 stated they "had reported" to the former house manager and another former staff person "that we witnessed [GHS (Group Home Staff) #3] take [client #3's] hand and twist" it. Clients #5, #6, and #7 stated they "witnessed [GHS #3] yell at [client #6]." Client #6 stated "[GHS #3] pointed her finger in [client #3's] face and my face, she yells at me. I told [name of former house manager] last week." Client #7 stated "[GHS #3] yells and points her finger in [client #6's] face." Client #7 indicated she did not report it because no one asked her. Client #7 stated GHS #3 "points at someone and used the F word. It's not right." On 11/21/17 at 12:30pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated she was aware of the allegation against GHS #3 by clients #5, #6, and #7. The QIDP stated she did not report the allegation to the administrator and to BDDS because client #6 "does not like" GHS #3 and client #6 had false reporting as a targeted behavior in her BSP (Behavior Support Plan). The QIDP stated she talked with the staff and the clients in the home and		Supervisors have been trained to follow the Incident Reporting and Investigation Process revised recently by Indiana MENTOR that includes the need of witness statements, questions asked, talking to staff and clients present, listing documents reviewed, the investigation outcome to be listed, conclusion of investigation, and other pertinent information. Staff has been re-trained on notifying a supervisor or the on-call staff to report allegations of abuse. In the future, the facility will follow the protocol and the state regulation for the supervisor to be notified and a BDDS report sent for abuse/neglect allegations, plus completion and documentation of the investigation of said alleged abuse. The Program Coordinator will monitor the client daily support records and client behavioral data three times weekly and the Program Director will monitor weekly the documentation and complete follow up as needed. The Area Director will follow through on all allegations to ensure the Program Director has reported the allegation to BDDS. Responsible Staff: Area Director	

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	"determined it was not an abusive situation." The QIDP indicated she did not consider the information client #6 reported as an allegation. The QIDP indicated she did not document the allegation, report the allegation, and did not conduct and document a written investigation into the allegation of staff abuse. The QIDP provided written notes from her day planner outlining initials and names of people she spoke to. The QIDP indicated no written witness statements, no questions asked, no documents reviewed during the investigation, no discussions, and no formal reports were documented. On 11/21/17 at 12:30pm, an interview was conducted with the RD (Regional Director). The RD indicated the agency followed the ANE (Abuse, Neglect, and Exploitation) policy and procedure for the agency and from BDDS to thoroughly investigate allegations regarding ANE. The RD indicated there was no documented report and investigation completed for clients #5, #6, and #7's allegation. The RD indicated the investigation should include the questions asked, narrative witness statements, conclusions to the investigations, staff and clients present during the incidents, and a documented summary from the investigator.			

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	This deficiency was cited on 10/5/2017. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal tag relates to complaint #IN00235679. 9-3-2(a)			
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility failed to ensure sufficient staff were present to supervise and implement ISPs (Individual Support Plans) when opportunities existed for clients #1, #2, #3, #4, #5, #6, #7, and #8. Findings include: On 11/21/17 from 5:40am until 7:37am, observation and interview were conducted	W 0186	**W186** The facility currently staffs each program based on the functioning level and needs of the clients in the home. The Program Coordinator has been trained to ensure the adequate staff numbers match the needs of the clients. The staff have been trained to call the on call if a staff person scheduled is late or does not arrive. The supervisor will ensure a staff replacement is sent or the supervisor goes to the program for direct care support. The staff have been trained on proper medication administration	12/22/2017

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	at the group home. At 5:40am, GHS (Group Home Staff) #1 answered the door of the group home. The medication room was connected by an open door to the living room, an second open door to the kitchen, and a third access by a connecting hallway with a staircase to the second level of the group home. During the observation period, all three doors were open and accessible. GHS #1 was the one staff on duty with eight clients from 5:40am until 7:00am. At 5:40am, GHS #1 stated "I have to preset meds (medications). I know it's bad. Well, I won't have time for breakfast and all. Meds have to done in an hour and we don't have a 6:00am staff. She doesn't come in until after 7:00am." At 5:40am, there were six medication cups of a green liquid were set out and prepared on the counter in the medication room. GHS #1 indicated the liquid was prescribed mouthwash for clients. At 5:40am, the six medication cups with clients #4, #5, #6, #7, and #8's initials on the paper medication cups with unidentified oral medications inside each cup. At 5:40am, two pre filled medication cups with yogurt and oral tablets sat on the counter in the kitchen. GHS #1 indicated those were for clients #1 and #3. GHS #1 indicated the yogurt became liquid when left in the medication room because the room was hot. GHS #1 stated "It's cooler in the kitchen."		to ensure medication is not left unlocked or preassembled for each client in the future. The staff has been retrained and received disciplinary corrective action. In the future, the Program Director will review the staff schedule bi-weekly to ensure staff pattern per shift equals the needs of the clients to ensure health and safety of the clients. The Program Coordinator will complete home observations three times weekly for one month to ensure proper medication administration and adequate staff are on duty. The Program Director will monitor the home twice monthly. Person responsible: Area Director	

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	At 5:40am, an additional medication cup was in the freezer with oral medications in orange sherbet. GHS #1 indicated she left client #2's oral medications in the sherbet and unlocked in the freezer to keep the ice cream cold and frozen. From 5:50am until 7:30am, clients #1, #2, #3, #4, #5, #6, #7, and #8 walked independently throughout the group home living room, kitchen, dining room, and medication room without staff present. GHS #1 did not stay within line of sight of the unlocked medications. At 7:30am, GHS #1 stated after she preset the medications into medication cups, she passed the medications, the medication cups were not kept within eye sight of the staff, and she "could not definitely" say each client received the correct dose of their prescribed medications. From 5:40am until 7:00am, one facility staff was present. From 7:00am until 7:37am, two facility staff were present. At 7:37am, GHS #1 stated "We usually have three staff in the mornings because of behaviors," passing medications, getting clients ready for the day, cooking breakfast, and preparing lunchboxes. GHS #1 stated clients #1, #3, and #4 were on line of sight staff supervision and clients #2, #5, #6, #7, and #8 "required" staff supervision to know their whereabouts. On 11/21/17 at 8:05am, an interview was			

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(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 with the RN (Registered Nurse). The RN indicated clients #1, #2, #3, #4, #5, #6, #7, and #8's medications should not have been preset and left unlocked in the kitchen freezer, kitchen counter, and the medication room. The RN stated the medications should to be locked at "all times" when not being administered The RN stated she had "not been contacted" by the facility staff to report there was a shortage of facility staff and the presetting of medications. On 11/21/17 at 8:45am, an interview was conducted with the LPN (Licensed Practical Nurse). The LPN indicated clients #1, #2, #3, #4, #5, #6, #7, and #8's medications should not have been preset and left unlocked in the kitchen freezer, kitchen counter, and the medication room. The LPN stated the medications should be locked at "all times" when not being administered The LPN stated she had "not been contacted" by the facility staff to report there was a shortage of facility staff and presetting of medications. On 11/21/17 at 12:30pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated clients #1, #2, #3, #4, #5, #6, #7, and #8's needed staff supervision. The			

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	15G296	A. BUILDING 00 B. WING	11/22/2017

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	QIDP indicated three (3) facility staff should have been present in the morning from 6:00am until clients left for workshop. The QIDP indicated one staff from 5:40am until 7:00am and two staff from 7:00am until 7:37am, were not enough staff to supervise and implement clients #1, #2, #3, #4, #5, #6, #7, and #8's ISPs. 9-3-3(a)			
W 0210 Bldg. 00	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview, for 2 of 4 sampled clients (clients #3 and #4), the facility failed to ensure clients #3 and #4's assessments were completed and training needs identified for clients #3 and #4's ISPs (Individual Support Plans). Findings include: Client #3's record was reviewed on 11/21/17 at 12:30pm and on 11/22/17 at 7:30am. Client #3's 10/18/2016 ISP (Individual Support Plan) indicated he was admitted to the facility on 11/12/1986. Client #3's record did not indicate a CFA	W 0210	**W210:** The facility currently meets with the client interdisciplinary team 30 days after admission and at least annually to review assessment of the client progress and areas for potential needs. The QIDP completes a Comprehensive Functional Assessment for reference of such goals for the future. The Program Director will update client 3 and 4's CFAs to ensure the client goals meet the needs of the client and correlate to the client assessments. In addition the Program Director will ensure each client has the appropriate assessments	12/22/2017

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	(Comprehensive Functional Assessment) or an assessment of his functional abilities related to client #3's identified needs regarding his behaviors, physical skills, and skill acquisition needs. Client #4's record was reviewed on 11/21/17 at 10:00am. Client #4's 11/15/16 ISP (Individual Support Plan) indicated he was admitted to the facility on 9/7/16. Client #4's record did not indicate a CFA (Comprehensive Functional Assessment) or an assessment of his functional abilities related to client #4's identified needs regarding his behaviors, physical skills, and skill acquisition needs. On 11/21/17 at 12:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated the previous QIDP had not completed clients #3 and #4's CFAs. The QIDP indicated clients #3 and #4's CFA's and ISP's were not revised within the past year. On 11/22/17 at 11:15am, an interview was conducted with the QIDP and the Regional Director (RD). The RD and QIDP indicated no completed assessments for clients #3 and #4 were available for review.		completed and in the client file. The staff will be trained on the client 3 and 4's CFAs and on the new goals plus methods to implement. In the future, the Program Director will complete assessments prior the client annual review date. The Program Director will complete goals that correspond with needs of the client and monitor these monthly. The Area Director will review the client Comprehensive Functional Assessment as completed. Responsible Staff: Area Director	

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	This deficiency was cited on 10/5/2017. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview, for 2 of 4 sampled clients (clients #1 and #3), the facility failed to ensure staff provided supervision and implemented clients #1 and #3's ISPs (Individual Support Plans), BSPs (Behavior Support Plans), and Risk Plans when opportunities existed. Findings include: 1. On 11/21/17 from 5:40am until 7:37am, client #1 was observed at the group home. At 6:50am, client #1 was assisted by GHS (Group Home Staff) #1 to serve herself a cinnamon roll at the dining room table. GHS #1 cut the roll into six (6) pieces and walked away from the dining room table. Client	W 0249	The facility follows procedures for an annual Interdisciplinary Team has formulated a client's individual support plan occurs. Based on the Individual Support Plan each client will receive a continuous active treatment program consisting of needed intervention and servicers in sufficient number and frequency to support the achievement of objectives identified in the individual program plan. The staff will be trained on Client 3 and client 1's dining plan including moistening food prior to client consumption of the food, following the prescribed diet including proper food consistency and supervision while eating due to choking risk. The Program	12/22/2017

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	#1's cinnamon roll pieces were not moistened with fluid. From 6:50am until 7:25am, client #1 fed herself the unmoistened cut up cinnamon roll pieces, coughed after swallowing, and no staff supervision was present at the dining room table. GHS #1 walked through the dining room three times during client #1's dining and asked client #1 to take a drink of fluid once during the observation of the meal. From 6:50am until 7:25am, client #3 was served premade pureed foods of a cinnamon roll, cooked cereal, and pineapple by GHS #1. After GHS #1 set client #3's bowls in front of him at the dining room table, GHS #1 walked out of the dining room, and no staff supervision was observed. During the observation period, GHS #1 walked through the dining room three times while client #3 was feeding himself. Client #1's record was reviewed on 11/21/17 at 11:45am. Client #1's 5/3/17 ISP (Individual Support Plan) and 5/2017 Risk Plan indicated client #1 was prescribed a mechanical soft diet with foods to be moistened with liquid and cut up into bite size pieces. Client #1's 10/2017 Physician's Order and 10/16/17 Registered Dietician's review both prescribed a mechanical soft diet. Client #1's 10/4/17 "Dysphagia/Dining		Coordinator will re-train staff on alerting the supervisor and or maintenance in event client # 1's bedroom door alarm is not working so it can be immediately repaired. The Program Coordinator has purchased a new functioning alarm that has been put in place. The staff will verify each shift that the alarm is working by documentation of such. The Program Coordinator will conduct observations and documentation review 3 xs per week to ensure clients are receiving the proper diets and supervision while dining, plus ensure client 1's door alarm is working. The PD will conduct observations 2x weekly to the above. The Program Director /other supervisor/nurse will conduct observations 2x per month. The observations will be reviewed by the Area Director for follow up as needed. Responsible Staff: Area Director	

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	Plan" indicated "Mechanical Soft (Diet) with ground meat...Prompts to put utensils down and to take a drink...History of food thefts...Staff supervision...Diagnosis of Aperstaltic Esophagus (the tube that carries swallowed food from the back of the throat down into the stomach muscle allows the swallowed food to flow back into the throat) and Gerd and (sic) Dysphagia (the discomfort or difficulty swallowing food)." Client #3's record was reviewed on 11/21/17 at 12:35pm and on 11/22/17 at 7:30am. Client #3's 10/18/16 ISP (Individual Support Plan), 5/2017 Risk Plan indicated client #3 was prescribed a pureed diet because he was at risk to choke. Client #3's 5/2017 "Dining Plan" indicated "Pureed Diet...Staff supervision and verbal prompts needed to prevent shoveling and gulping" foods. On 11/21/17 at 8:05am, an interview with the agency RN (Registered Nurse) was conducted. The RN indicated clients #1 and #3 were at risk for choking and their diets were altered for their individual consistencies. The RN indicated client #1 should receive a mechanical soft diet and/or breads soaked/moistened with milk and client #3 should have received a pureed diet. The RN indicated the facility staff should			

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	have been physically present in the dining room and at the dining room table when clients #1 and #3 consumed their meals. The RN indicated the facility staff failed to provide staff supervision to ensure clients #1 and #3 were supervised during dining opportunities. An interview on 11/21/17 at 12:30pm, was conducted with the RD (Regional Director) and the QIDP (Qualified Intellectual Disabilities Professional). The RD and QIDP both indicated clients #1 and #3 were at risk for choking and the staff should have been present in the dining room when clients #1 and #3 were eating. 2. On 11/21/17 from 5:40am until 7:37am, client #1 was observed at the group home and her upstairs bedroom door alarm was not operating. During the observation period, client #1 entered and exited her bedroom without an alarm sounding. During the observation period, client #1's bedroom door alarm was in place on the door casing and the door to her bedroom. At 5:50am, client #1 opened and closed her bedroom door and stated the alarm on the door had batteries which operated the door alarm and the batteries had run down "over a month ago." At 6:00am, GHS (Group Home Staff) #1 stated client #1's "alarm was never fixed			

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	after the last survey" and indicated client #1's bedroom door alarm was not functional. Client #1's record was reviewed on 11/21/17 at 11:45am. Client #1's 5/3/17 ISP (Individual Support Plan), 5/2017 BSP (Behavior Support Plan), and 5/2017 Risk Plans indicated targeted behaviors of physical aggression, taking others belongings, inappropriate sexual behaviors (not defined), false accusations, and invading personal space (not defined). Client #1's BSP indicated "door alarms will be placed on [client #1's] bedroom door and on her bathroom door due to sexual inappropriateness." On 11/21/17 at 12:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated client #1's ISP was not implemented by the facility staff. The QIDP indicated client #1 needed a bedroom door alarm to alert staff when client #1 was outside of her bedroom. The QIDP indicated she had taken over as the QIDP and no further information was available for review. On 11/22/17 at 11:15am, an interview was conducted with the RD (Regional Director)			

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	and the QIDP. The RD indicated client #1's plans should have been implemented during formal and informal opportunities. The RD indicated client #1 should have had a bedroom door alarm that was functioning and in place on 11/21/17. The RD indicated she was not aware the alarm was not functioning. This deficiency was cited on 10/5/2017. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal tag relates to complaint #IN00235679. 9-3-4(a)			
W 0260 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. Based on record review and interview, for 2 of 4 sampled clients (clients #3 and #4), the facility failed to ensure clients #3 and #4's ISPs (Individual Support Plans) were revised annually. Findings include: Client #3's record was reviewed on	W 0260	**W26** The facility trains QIDP to develop an Individual Support Plan for each client at least annually after meeting with the team of the each client using completed assessments. The QIDP will revise the client plan as needed.	12/22/2017

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	11/21/17 at 12:30pm and on 11/22/17 at 7:30am. Client #3's 10/18/2016 ISP (Individual Support Plan) indicated he was admitted to the facility on 11/12/1986. Client #3's record did not indicate a documented yearly review of his ISP. Client #4's record was reviewed on 11/21/17 at 10:00am. Client #4's 11/15/16 ISP (Individual Support Plan) indicated he was admitted to the facility on 9/7/16. Client #4's record did not indicate a documented yearly review of his ISP. On 11/21/17 at 12:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated clients #3 and #4's ISPs were not current. On 11/22/17 at 11:15am, an interview was conducted with the QIDP and the Regional Director (RD). The RD and QIDP indicated no updated ISP's for clients #3 and #4 were available for review. This deficiency was cited on 10/5/2017. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)		The Area Director will ensure the Program Director will update client 3 and 4's CFAs to ensure the client goals meet the needs of the client and correlate to the client assessments completed. The staff will be trained on the client 3and 4's CFAs and on the new goals plus methods to implement In the future, the Program Director will complete assessments prior the client annual review date. The Program Director will complete goals that correspond with needs of the client and monitor these monthly The Program Director will track the client annual review due dates in the future on a monthly basis. The Area Director will review the client Comprehensive Functional Assessments to ensure full completion per regulations Responsible Staff: Area Director	

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W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility failed to keep medications locked when not being administered for clients #1, #2, #3, #4, #5, #6, #7, and #8. Findings include: On 11/21/17 from 5:40am until 7:37am, observation and interview were conducted at the group home. At 5:40am, GHS (Group Home Staff) #1 answered the door of the group home. The medication room was connected by an open door to the living room, an second open door to the kitchen, and a third access by a connecting hallway with a staircase to the second level of the group home. During the observation period, all three doors were open and accessible. GHS #1 was the one staff on duty with eight clients from 5:40am until 7:00am. At 5:40am, GHS #1 stated "I have to preset meds (medications). I know it's bad. Well, I won't have time for breakfast and all. Meds have to done in an hour and we don't have a 6:00am staff. She doesn't come in	W 0382	**W382** The facility currently trains all staff upon hire on the required regulations for medication administration to the clients. The nursing monitors the client medication and reviews the staff documentation on medication passing. The program staff will be retrained on medication administration by the facility nurse including the requirement to lock medications up when not being administered to a client. The Program Coordinator will monitor the staff during 3 observations weekly to ensure that the medication is administered as directed by reviewing Medication Administration Records daily. The Program Director will continue to ensure that all staff are trained prior to passing medication as per facility policy by completing twice monthly observations for one month. Person responsible: Area Director	12/22/2017

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	until after 7:00am." At 5:40am, six medication cups of a green liquid were set out and prepared on the counter in the medication room. GHS #1 indicated the liquid was prescribed mouthwash for clients. At 5:40am, there were six medication cups with clients #4, #5, #6, #7, and #8's initials on the paper medication cups with unidentified oral medications inside each cup. At 5:40am, two pre filled medication cups with yogurt and oral tablets sat on the counter in the kitchen. GHS #1 indicated those were for clients #1 and #3. GHS #1 indicated the yogurt became liquid when left in the medication room because the room was hot. GHS #1 stated "It's cooler in the kitchen." At 5:40am, an additional medication cup was in the freezer with oral medications in orange sherbet. GHS #1 indicated she left client #2's oral medications in the sherbet and unlocked in the freezer to keep the ice cream cold and frozen. From 5:50am until 7:30am, clients #1, #2, #3, #4, #5, #6, #7, and #8 walked independently throughout the group home living room, kitchen, dining room, and medication room without staff present. GHS #1 did not stay within line of sight of the unlocked medications. At 7:30am, GHS #1 stated after she preset the medications into medication cups, she passed the medications, the medication cups were not			

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	kept within eye sight of the staff, and she "could not definitely" say each client received the correct dose of their prescribed medications. On 11/21/17 at 8:05am, an interview was conducted with the RN (Registered Nurse). The RN indicated clients #1, #2, #3, #4, #5, #6, #7, and #8's medications should not have been preset and left unlocked in the kitchen freezer, kitchen counter, and the medication room. The RN stated the medications should be locked at "all times" when not being administered The RN stated she had "not been contacted" by the facility staff to report there was a shortage of facility staff and the presetting of medications. The RN indicated the facility followed Core A/Core B Living in the Community for medication administration and medication security. On 11/21/17 at 8:45am, an interview was conducted with the LPN (Licensed Practical Nurse). The LPN indicated clients #1, #2, #3, #4, #5, #6, #7, and #8's medications should not have been preset and left unlocked in the kitchen freezer, kitchen counter, and the medication room. The LPN stated the medications should be locked at "all times" when not being administered The LPN stated she had "not			

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	been contacted" by the facility staff to report there was a shortage of facility staff and the presetting of medications. The LPN indicated the facility followed Core A/Core B Living in the Community for medication administration and medication security. On 11/21/17 at 12:30pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated clients #1, #2, #3, #4, #5, #6, #7, and #8's medications should have been locked when not administered. The QIDP indicated the facility followed Core A/Core B Living in the Community for medication administration and medication security. On 11/21/17 at 8:05am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 3: Principles of Administering Medication" indicated medications should be secured when not administered. This deficiency was cited on 10/5/2017. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			
W 0440	483.470(i)(1) EVACUATION DRILLS			

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	15G296	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REM-INDIANA INC	417 W WALNUT ST KOKOMO, IN 46901

(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 hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who resided in the home, to ensure an evacuation drill was conducted at least every 90 days on the day shift (7:00am-2:00pm) and night shift (11:00pm-7:00am) for facility personnel from 10/5/17 through 11/20/17. Findings include: On 11/21/17 at 12:30pm, record reviews were completed of the facility's evacuation drills for the period of 10/05/17 through 11/20/17. The review of the evacuation drill records included evacuation drills which were conducted for personnel and clients #1, #2, #3, #4, #5, #6, #7, and #8. The review indicated the following for drills completed: For day shift: no drills completed. For evening shift: On 10/8/17 at 4:00pm. For night shift: no drills completed. On 11/21/17 at 12:30pm, an interview with the Qualified Intellectual Disabilities Professional (QIDP) and the Regional Director (RD) was conducted. The QIDP indicated the day shift was 7:00am-2:00pm,	W 0440	**W440:** The facility trains all managers and employees on the implementation of a fire evacuation plan and protocol to keep the clients safe. Evacuation drills are scheduled to be implemented monthly on rotating shifts to ensure each shift has a drill run every quarter. The Program Director will train the Program Coordinator and staff to complete fire/evacuation drills monthly per calendar schedule on rotating shifts. In the future the Program Coordinator will review the safety book on a weekly basis to ensure the evacuation drills have been completed and are located in the safety book. The PC will verify the drills are completed on the correct shift and time or run another drill. The Program Director will verify the drill s have been completed by checking the home at least monthly. The Area Director will track the fire drills in the homes on a monthly basis to ensure completion by the team. Responsible Person: Area Director	12/22/2017

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	the evening shift was 2:00pm-11:00pm, and night shift was 11:00pm-7:00am. The QIDP indicated the facility was previously cited regarding the lack of completed emergency drills available for review for every 90 days from 9/1/16 through 9/25/17 for each shift of personnel and clients #1, #2, #3, #4, #5, #6, #7, and #8. The QIDP and the RD both indicated no additional emergency drills were available for review for day and night shifts of personnel completed after 10/5/17. The RD indicated the AD (Area Director) and staff responsible for the administrative oversight to ensure drills were completed had been off work because of personal illnesses and the drills were not completed for the plan of correction. This deficiency was cited on 10/5/2017. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-7(a)			
W 0460 Bldg. 00	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review, and interview, for 1 of 2 sampled clients (client	W 0460	**W460:** The facility will ensure that each client eats in a manner consistent with his or her	12/22/2017

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	#1) who had a prescribed modified diet, the facility failed to ensure client #1's modified diet textures was prepared at the recommended consistency. Findings include: On 11/21/17 from 5:40am until 7:37am, client #1 was observed at the group home. At 6:50am, client #1 was assisted by GHS (Group Home Staff) #1 to serve herself a cinnamon roll at the dining room table. GHS #1 cut the roll into six (6) pieces and walked away from the dining room table. Client #1's cinnamon roll pieces were not moistened with fluid. From 6:50am until 7:25am, client #1 fed herself the unmoistened cut up cinnamon roll pieces, coughed after swallowing, and no staff supervision was present at the dining room table. GHS #1 walked through the dining room three times during client #1's dining and asked client #1 to take a drink of fluid once during the observation of the meal. Client #1's record was reviewed on 11/21/17 at 11:45am. Client #1's 5/3/17 ISP (Individual Support Plan) and 5/2017 Risk Plan indicated client #1 was prescribed a mechanical soft diet with foods to be moistened with liquid and cut up into bite size pieces. Client #1's 10/2017 Physician's		developmental level and doctor/dietician prescribed diet plan. The staff will be trained client 1's food preparation plan including moistening food prior to client consumption of the food, following the prescribed diet including proper food consistency and supervision while eating due to choking risk. The Program Coordinator will conduct observations and documentation review 3 xs per week to ensure clients are receiving the proper diets, food preparation and supervision while dining. The PD will conduct observations 2x weekly to the above. The Program Director /other supervisor/nurse will conduct observations 2x per month. The observations will be reviewed by the Area Director for follow up as needed. Responsible Staff: Area Director	

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	Order and 10/16/17 Registered Dietician's review both prescribed a mechanical soft diet. Client #1's 10/4/17 "Dysphagia/Dining Plan" indicated "Mechanical Soft (Diet) with ground meat...Prompts to put utensils down and to take a drink...History of food thefts...Staff supervision...Diagnosis of Aperstaltic Esophagus (the tube that carries swallowed food from the back of the throat down into the stomach muscle allows the swallowed food to flow back into the throat) and Gerd and (sic) Dysphagia (the discomfort or difficulty swallowing food)." On 11/21/17 at 8:05am, an interview with the agency RN (Registered Nurse) was conducted. The RN indicated client #1 was at risk for choking and her diet was altered for her individual consistencies. The RN indicated client #1 should receive a mechanical soft diet and/or breads soaked/moistened with milk. The RN indicated client #1's roll should have been cut into less than one half inch bite size pieces and soaked with liquid. The RN indicated the agency's diet texture guidelines were not followed when client #1's diet was not followed. An interview on 11/21/17 at 12:30pm, was conducted with the RD (Regional Director) and the QIDP (Qualified Intellectual			

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	Disabilities Professional). The RD and QIDP both indicated client #1 was at risk for choking and should receive a mechanical soft diet and/or breads soaked/moistened with milk. The RD and QIDP both indicated the agency's mechanical soft diet guidelines were not followed when client #1's diet was not followed. On 11/21/17 at 10:45am, a review of the facility's undated "General Description of Diet Textures" indicated "D. Mechanical Soft Diet, Ground Meat. Meat is ground and moistened with gravy or meat juice...Bread is broken in 1" (one inch) squares, cookies, cake, crackers, biscuits, buns...are broken at table side. These items may need to be soaked...Pureed: Foods should have a smooth, pudding like consistency...Cookies and cakes are broken, soaked in liquid until smooth...Fluid Textures...Nectar thick such as tomato juice, nectar juices, prune juice, buttermilk. Thicken other liquids." 9-3-8(a)			