PRINTED: 08/29/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	COMPL	ETED	
15G407		A. BUI B. WIN	LDING		08/03/	2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF F	PROVIDER OR SUPPLIEF	2			KESSLER BLVD		
REM-IND	DIANA INC				IAPOLIS, IN 46220		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	TAG DEFICIENCY)		DATE
W0000							
			1170	000			
	I	for the investigation of	W0	000			
	complaint #IN00	0112548.					
	Complaint #IN0	0112548:					
	Unsubstantiated	due to lack of evidence.					
	Unrelated deficiencies cited.						
	Survey dates: August 2 and 3, 2012						
		,					
	Facility number:	000921					
	Provider number						
	AIMS number:						
	Alivis humber.	100249310					
	G D	1. N DNI CDDNI					
	1	da Nunan, RN, CDDN,					
	Public Health Ni	urse Surveyor III					
		es also reflect state					
	findings in accor	dance with 460 IAC 9.					
	Quality Review	was completed on					
	8/13/12 by Tim	Shebel, Medical Surveyor					
	III.	-					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000921

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NO 15G407		IDENTIFICATION NUMBER:	A. BUILDING B. WING		00	COMPLETED 08/03/2012		
		15G407						
NAME OF PROCEEDINGS OF GLAPPA AND				STREET.	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	(2113 E	KESSLER BLVD			
REM-INDIANA INC			INDIANAPOLIS, IN 46220					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)	
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX		ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
W0149	The facility must written policies a mistreatment, ne	MENT OF CLIENTS develop and implement and procedures that prohibit eglect or abuse of the client.	wo	149	The Program Director will be		09/02/2012	
	Based on interview and record review, the		''`	11)	retrained on completing a thorough	,	05/102/2012	
		d to implement their			investigation, specifically on	' l		
		edures to prevent and			ensuring that all parties involved ar	е		
		stigate allegations of			questioned regarding the related			
		jury of unknown origin			incident.			
	for 3 of 4 incider		To ensure that all investigations are	9				
	allegations of abuse/neglect/injury of				completed accurately and			
	unknown origin for 2 of 4 sampled clients				thoroughly, Indiana MENTOR's Quality Assurance Specialist will			
	(clients A and B)).			assist this PD with the next three			
	Findings include				investigations. Ongoing, all investigations will be reviewed by both the Area Director			
		oortable incident reports			and the Quality Assurance Specialis	it		
	_	ns were reviewed on			to ensure that all issues are			
	08/02/2012 at 11	:33 a.m.			addressed and that the investigation is completed thoroughly.	ın		
					Completion Date: 9-2-2012			
	1. An Indiana D	ivision of Disability and			Responsible Party: Home Manager			
Rehabilitation		ervices incident report,			and Program Director			
	dated 05/30/2012 at 4:30 p.m., indicated,							
	"[Client A] hit [client B] after [client B] told him to shut up. [Client B] in							
	_	[client A] on the arm,						
		juries" The record did						
	_	nvestigation had been						
		ient to client abuse						
	(physical aggress							
	(piry sieur uggres)	01011 _J .						
	Rehabilitation Se	vivision of Disability and ervices incident report, 2 at 5:30 p.m. indicated,						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G407		LDING	NSTRUCTION 00	(X3) DATE COMPL 08/03/	ETED
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2113 E KESSLER BLVD INDIANAPOLIS, IN 46220				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
TAG	"[Client A] had his right eye. Sta got there nor did record did not in was completed for origin. An April 2011 por Risk Management 08/02/2012 at 12 indicated, "Indicated, "Indicated, "Indicated, promotes a high seeks to protect in oversight of man company operations service delivery a identifying, evaluated to which individual exposedAllege abuse, neglect, or individualshall protective service committed to ensure are provided living environment committed to continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety of any individual in the continuestigation for ordinary which justifety or ordinary which justifety or ordinary which justifety or ordinary which j	a small scratch above aff does not know how it [client A]" The dicate an investigation or the injury of unknown or the policy liana MENTOR quality of services and undividualsthrough agement procedures and ons, close monitoring of and through a process of unting and reducing risk unals are d, suspected, or actual r exploitation of an be reported to adult esIndiana MENTOR is suring the individuals we ad with a safe and quality entIndiana MENTOR is impleted a thorough any event out of the eopardizes the health and ividual served or other		TAG			DATE
	submitted to the and development	s as needed within 5 days					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G407		A. BUILDING B. WING	COMPLETED 08/03/2012			
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2113 E KESSLER BLVD INDIANAPOLIS, IN 46220				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP TAG DEFICIENCY)	ULD BE COMPLETION			
	During an interview on 08/02/2012 at 11:50 a.m., the Area Director indicated an investigation had not ben completed for the allegation of client to client abuse (physical aggression) for clients A and B that occurred on 05/03/2012. She indicated an investigation of an injury of unknown origin had not been completed for the injury reported for client A on 07/08/2012. This Federal tag relates to complaint #IN00112548 9-3-2(a)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
	15G407		B. WING			08/03/2012	
			P. (11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				KESSLER BLVD		
REM-INDIANA INC					IAPOLIS, IN 46220		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0154	The facility must alleged violations	MENT OF CLIENTS have evidence that all s are thoroughly investigated.					00/02/2040
	Based on interview	ew and record review, the	W0	154	The Program Director will be		09/02/2012
	facility failed to	investigate allegations of			retrained on completing a thorough		
	abuse/neglect/inj	ury of unknown origin			investigation, specifically on		
	for 3 of 4 incider				ensuring that all parties involved are	2	
	allegations of abo	use/neglect/injury of			questioned regarding the related incident.		
	unknown origin	for 2 of 4 sampled clients			To ensure that all investigations are		
	(clients A and B)	•			completed accurately and		
	,				thoroughly, Indiana MENTOR's		
	Findings include	:			Quality Assurance Specialist will assist this PD with the next three investigations.		
	The facility's rep	ortable incident reports			Ongoing, all investigations will be		
		is were reviewed on			reviewed by both the Area Director		
	08/02/2012 at 11				and the Quality Assurance Specialist		
	00/02/2012 4011	.55 u.m.			to ensure that all issues are		
	Rehabilitation Sedated 05/30/2012 "[Client A] hit B] told him to shreturn, scratched causing minor in not indicate an in	ivision of Disability and ervices incident report, 2 at 4:30 p.m., indicated, at [client B] after [client aut up. [Client B] in [client A] on the arm, juries" The record did evestigation had been ient to client abuse			addressed and that the investigation is completed thoroughly. Completion Date: 9-2-2012 Responsible Party: Home Manager and Program Director	1	
	Rehabilitation Sedated 07/08/2012	ivision of Disability and ervices incident report, 2 at 5:30 p.m. indicated, d a small scratch above aff does not know how it					

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	OF CORRECTION IDENTIFICATION NUMBER: 15G407	A. BUILDING B. WING	00 	COMPLETED 08/03/2012			
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 2113 E KESSLER BLVD INDIANAPOLIS, IN 46220					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
IAU	got there nor did [client A]" The record did not indicate an investigation was completed for the injury of unknown origin. During an interview on 08/02/2012 at 11:50 a.m., the Area Director indicated an investigation had not ben completed for the allegation of client to client abuse (physical aggression) for clients A and B that occurred on 05/03/2012. She indicated an investigation of an injury of unknown origin had not been completed for the injury reported for client A on 07/08/2012. This Federal tag relates to complaint #IN00112548 9-3-2(a)	TAG		DATE			

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