

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G148	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/05/2011
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NAME OF PROVIDER OR SUPPLIER CDC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN47960
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W0000	<p>This visit was for an annual recertification and state licensure survey. This visit included the investigation of complaint #IN00096473.</p> <p>Complaint #IN00096473: Substantiated, federal/state deficiencies related to the allegations are cited at W153, W155, W186, and W249.</p> <p>This visit was completed in conjunction with the post certification revisit (PCR) to the investigation of complaint #IN00093758.</p> <p>Dates of Survey: September 26, 27, 28, and October 3, 4, and 5, 2011.</p> <p>Facility Number: 000684 Provider Number: 15G148 AIMS Number: 100243120</p> <p>Surveyor: Kathy Wanner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/19/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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

TITLE

(X6) DATE

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

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W0153	<p>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.</p> <p>Based on record review and interview, the facility failed to immediately report allegations of a staff sleeping at work for 7 of 7 clients who lived in the home (clients A, B, C, D, E, F and G); failed to immediately report an incident of staff not following the transfer protocol for 1 of 4 sampled clients (client C) which resulted in a fall with injury, and failed to report two incidents of AWOL as indicated in 2 of 15 incident reports reviewed involving AWOL for 1 of 1 client (client B) to the Bureau of Developmental Disabilities Services (BDDS) and to the administrator in accordance with state law.</p> <p>Findings include:</p> <p>1. The facility records were reviewed on 9/26/11 at 2:32 P.M. including the BDDS reports and the Incident/accident reports. The records also included an investigation</p>	W0153	<p>Tag 153</p> <p>1.Group Home Supervisor has been counseled and staff retrained on the investigation process and incident reporting on 4-18-2011 and continuously trained during monthly staff meeting. Group Home Supervisor will monitor staff on a weekly basis by doing random Quality Inspections.</p> <p>2.Staff has retrained on Risk plan, which includes gait belt transfers. Day Service Coordinator and Group Home Supervisor will monitor by checking on staff on a routine basis. During Day Service hours, the staff will contact relieve staff to assist while transferring consumer to the restroom as deemed necessary. The Group Home Supervisor has trained Group Home staff on consumer routine on October 28, 2011.</p> <p>3.Client B's Behavior Support Plan and Elopement Risk Plan have been updated with approval</p>	10/28/2011

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	<p>dated 4/22/11. The investigation indicated an allegation had been made "Friday" (no date given) by an unidentified Direct Care Staff (DCS) about another DCS #12 being "caught sleeping on shift twice last weekend." The investigation further indicated "the group home manager (GHM) [name of manager] refused to write a report because she could not afford to lose any more staff." The staff who was allegedly sleeping on shift and the group home manager were suspended until the investigation was completed. The investigation included statements from all other staff and some of the clients in the home. DCS #12 indicated she had been tired on some recent shifts due to a second job. The statements from the staff were inconsistent and the facility determined some of the statements were "gossip." The schedule was changed so DCS #12 no longer worked that same shift.</p> <p>-a BDDS report dated 5/2/11 for an incident on 5/1/11 at 9:45 A.M. indicated a DCS had allegedly been asleep on shift over the weekend, and the GHM had failed to write a report.</p> <p>-a BDDS follow-up report dated 5/6/11 indicated the allegation had been investigated, the staff had been suspended at an undocumented date/time. The allegation was determined to be "not</p>		<p>of HRC. Day Service Coordinator and Group Home Supervisor have retrained staff on Behavior Support Plan on or before October 28, 2011. Group Home Supervisor or designee will do routine monitoring at the Group Home to ensure staff is following and implementing the consumer's Behavior Support Plan. Day Service Coordinator or designee will monitor to ensure staff are following and implementing the consumer's Behavior Support Plan.</p> <p>4.QDDP-D will ensure that incidents of allegation in which staff do not maintain visual contact of consumer per Behavior Support Plan will be reported within 24 hours of allegations. Monitoring of BDDS reportable incidents will be done a daily basis by QDDP.</p> <p>5.Client B has been moved to a small ratio room during Day Services to ensure the consumers safety.</p>		

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	<p>substantiated (sic) it could have likely occurred." The facility determined it to not be neglect due to there being two other staff on shift at the time.</p> <p>2. - a BDDS report dated 9/12/11 for an incident on 9/9/11 at 9:30 P.M. indicated "[Client C] was in the bathroom using the restroom. Staff left the bathroom to assist another consumer. [Client C] yelled to staff that she was done and a couple of seconds later [client C] yelled 'ouch'. Staff found [client C] in a crouching position on the floor; evidence that [client C] had tried to get up from the toilet without assistance from staff in transferring from the toilet to the wheelchair... [Client C] had a 3" (three inch) red square area on her lower left side. The staff had not followed client C's transfer plan to monitor, utilize two staff and a gait belt to transfer client C. The staff was not found to be neglectful in this situation; however were found to be inadequately trained on the risk plan, and gait belt training, and consumer routine."</p> <p>3. -an incident report dated 7/7/11 at 7:40 A.M. indicated "Staff was busy helping other consumers when [client B] got out into the garage. Staff did not follow client B's BSP for maintaining visual contact with him. Staff followed [client B] (sic) kept walking and ended up by the stop</p>			

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	<p>sign on Airport Road. Staff stayed with (sic) and asked where he he was going he said (sic) didn't know...." There was no BDDS report available for review.</p> <p>-an incident report dated 6/23/11 at 1:00 P.M. indicated "[Client B] eloped the building...We told him to stop...ran and grabbed [client B's] jacket due to a car turning into the driveway." The report indicated client B's BSP had not been followed. Staff had not maintained visual contact with him. There was no BDDS report available for review.</p> <p>An interview was conducted with the Social Service Coordinator (SSC), the Health and Safety Specialist (HSS) and the Residential Coordinator / Qualified Developmental Disabilities Professional Designee (QDDPD) on 9/28/11 at 4:10 P.M.. The facility staff indicated the allegation about staff sleeping on shift had not been investigated or reported immediately and the staff had not been suspended immediately. The facility staff also indicated staff had not followed (client C's) transfer protocol, and the report was sent in late, and the staff had not maintained line of sight supervision for client B's AWOL incidents, and they had not been reported.</p> <p>This Federal tag relates to complaint</p>						

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W0155	<p>#IN00096473.</p> <p>9-3-2(a)</p> <p>The facility must prevent further potential abuse while the investigation is in progress. Based on record review and interview, the facility failed to take action immediately to prevent further potential neglect after allegations of a staff sleeping at work was made for 7 of 7 clients who lived in the home (clients A, B, C, D, E, F, and G).</p> <p>Findings include:</p> <p>The facility records were reviewed on 9/26/11 at 2:32 P.M. including the BDDS reports and the Incident/accident reports. The records included an investigation dated 4/22/11. The investigation indicated an allegation had been made on "Friday," (no date given) by an unidentified Direct</p>	W0155	<p>1.Group Home Supervisor has been counseled and staff retrained on the investigation process, and incident reporting on 4-18-2011 and continuously trained during monthly staff meeting.. Group Home Supervisor will monitor staff on a weekly basis by doing random Quality Inspections. Group Home Supervisor and/or Day Service Coordinator will suspend staff immediately upon knowledge that staff that has been accused of any allegation of mistreatment, abuse or neglect until an investigation has been completed and corrective action is in place. Group home supervisor and/or Day Service Coordinator will</p>	10/28/2011	

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	<p>Care Staff (DCS) about another DCS #12 being "caught sleeping on shift twice last weekend." The investigation further indicated "the group home manager (GHM) [name of manager] refused to write a report because she could not afford to lose any more staff." The staff who was allegedly sleeping on shift and the group home manager were suspended until the investigation was completed. No date was given for when their suspension began, but the investigation indicated it did not occur until at least 4/22/11 which would have been at least one week after the allegation was first made.</p> <p>-a BDDS report dated 5/2/11 for an incident on 5/1/11 at 9:45 A.M. indicated a DCS had allegedly been asleep on shift over the weekend, and the GHM had failed to write a report.</p> <p>-a BDDS follow-up report dated 5/6/11 indicated the allegation had been investigated, and the staff had been suspended at an undocumented date/time. The allegation was determined to be "not substantiated (sic) it could have likely occurred." The facility determined it to not be neglect due to there being two other staff on shift at the time.</p> <p>An interview was conducted with the Social Service Coordinator (SSC), the</p>		ensure that immediate protective measures are in place to prevent reoccurrence as necessary.		

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W0186	<p>Health and Safety Specialist (HSS) and the Residential Coordinator / Qualified Developmental Disabilities Professional Designee (QDDPD) on 9/28/11 at 4:10 P.M.. The facility staff indicated the staff had not been suspended immediately.</p> <p>This Federal tag relates to complaint #IN00096473.</p> <p>9-3-2(a)</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>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.</p> <p>Based on observation, record review, and interview the facility failed to staff the group home and the day program according to the needs of 4 of 4 sampled clients (A, B, C and D) who lived in the home and attended the facility owned and operated day program.</p> <p>Findings include:</p>	W0186	Group Home staffing ratio has been increased to 3:6 to ensure all consumers are being adequately staffed to ensure that all program needs are being implemented. Group Home Supervisor or designee will do monitoring of staff ratio. Day Service Coordinator will monitor ratios during Day Service and add additional staff as deemed necessary. Group Home staff will	10/28/2011	

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	<p>Observations were conducted at the group home where clients A, B, C and D lived on 9/26/11 from 5:03 P.M. until 6:48 P.M.. During the observation period there were two Direct Care Staff (DCS) on duty, DCS #1 and DCS #2. Client B completed his evening meal first and then walked throughout the home going in and out of the garage. Staff were not able to maintain constant visual supervision of client B.</p> <p>Observation were conducted at the group home where clients A, B, C and D lived on 9/28/11 from 6:43 A.M. until 8:03 A.M.. During the observation period there were two Direct Care Staff (DCS) on duty, DCS #3 and DCS #2. The group home manager (HM) arrived at 7:47 A.M.. Once the HM arrived she took over for DCS #2 who was providing behavior intervention for client D in the group home garage. DCS #3 was then responsible for removing all the other clients in the home (A, B, C, E, F, and G) to a safe area, and providing constant visual supervision for clients A and B.</p> <p>Observations were conducted at the facility owned and operated Day Program on 9/27/11 from 1:15 P.M. until 2:40 P.M.. During the observation period three classrooms were observed. Client B was</p>		follow Emergency procedure's when need arises that are above current staffing ratio's or until additional relieve staff are in place to ensure consumers are kept safe.	

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	<p>observed to be in a classroom with two other peers and two staff. Client A was observed to be in a classroom with four other peers and one staff. Clients C and D were observed in a classroom with ten other clients and one staff. The Behavior Consultant (BC) entered this room when a peer had a behavior and had the peer leave the classroom. A second staff entered the classroom from time to time, but not staying more than five minutes.</p> <p>The facility records were reviewed on 9/26/11 at 2:32 P.M. including the BDDS (Bureau of Developmental Disabilities Services) reports and the Incident/accident reports.</p> <p>- an incident report dated 9/16/11 at 12:50 P.M. indicated "[client B] has an elopement plan and is required to have 24-7 staff supervision. [Client B] was in the classroom without any staff supervision until this writer walked into the classroom; However please note this was less than 1 (one) minute."</p> <p>- a BDDS report dated 9/12/11 for an incident on 9/9/11 at 9:30 P.M. indicated "[Client C] was in the bathroom using the restroom. Staff left the bathroom to assist another consumer. [Client C] yelled to staff that she was done and a couple of seconds later [client C] yelled 'ouch'. Staff</p>			

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	<p>found [client C] in a crouching position on the floor; evidence that [client C] had tried to get up from the toilet without assistance from staff in transferring from the toilet to the wheelchair...The staff was not found to be neglectful in this situation; however were found to be inadequately trained on the risk plan, and gait belt training, and consumer routine." The report indicated the staff did not follow client C's transfer/positioning protocol to monitor, utilize two staff and a gait belt.</p> <p>Client A's record was reviewed on 9/27/11 at 12:08 P.M.. Client A's record indicated he had an Individual Support Plan (ISP) dated 6/17/11 and a Behavior Support Plan (BSP) dated 6/13/11. Client A had a high risk plan dated 4/4/11 indicating he "needs assistance with steps, crossing the streets, and staff should be an arm;s length away from him when ambulating." Client A's BSP indicated he had the targeted behaviors of physical aggression to peers and staff, and throwing himself on the ground. His BSP indicated if he was physically aggressive he was to be redirected to a quiet area. At home his quiet area was his room. At work the quiet area was the break room. Staff were to maintain visual contact during his quiet times.</p>				

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	<p>Client B's record was reviewed 9/28/11 at 1:07 P.M.. Client B's record indicated he had an ISP dated 7/29/11 and a BSP dated 8/8/11. Client B's targeted behaviors included Physical aggression, Self-Injurious behaviors (SIB) and elopement. If client B was to elope a staff was to follow him. He was to have fifteen minutes staff checks at all times when in his room. He was to have continuous visual supervision.</p> <p>Client C's record was reviewed on 9/27/11 at 3:00 P.M.. Client C's record indicated she had an ISP dated 6/6/11. Client C's ISP indicated she was a "high risk for choking." Client C's transfer/positioning protocol dated 5/20/10 indicated she was to be transferred/ repositioned every 2-3 hours. Two staff were to assist her and they were to use a gait belt.</p> <p>Client D's record was reviewed on 9/28/11 at 3:20 P.M.. Client D's record indicated he had an ISP dated 10/18/10, and a BSP dated 7/13/11. Client D's targeted behaviors were Physical aggression, verbal aggression and suicide ideation. Client D was to have visual supervision at all times.</p> <p>Interviews were conducted with DCS #1 and DCS #2 on 9/26/11 at 6:10 P.M.. The DCS indicated there used to be three staff</p>				

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	<p>on duty in the evenings, but now there were only two scheduled.</p> <p>During a series of confidential interviews (CI) between 9/26/11 and 9/28/11 the following was stated:</p> <p>CI #1 "Only one staff works at night. It is scary. What if [client C] fell?"</p> <p>CI #2 " [Client B] is always running off, and [client D] scares the other clients and people. He cusses and makes threats."</p> <p>CI #3 "The day program is awful, no work, and the staff work short all the time."</p> <p>A review of the group home schedule for the month of September 2011 was reviewed on 10/3/11 at 4:00 P.M. and indicated only two staff are scheduled to work during awake hours at the group home, and one staff was scheduled to work overnight.</p> <p>A review of the group home schedule for the month of September 2011 was reviewed on 10/3/11 at 4:20 P.M. and indicated two staff were scheduled to work with 11 clients in the large room at the day program were clients C and D were provided day services. The day services room where client B was located</p>				

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W0249	<p>was scheduled with one staff and two clients. The classroom where client A was provided services was scheduled to have one staff to four clients.</p> <p>This Federal tag relates to complaint #IN00096473.</p> <p>9-3-3(a)</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview, the facility failed to follow the Individual Support Plan/Behavior Support Plan ISP/BSP for 2 of 4 sampled clients (clients B and C) according to their identified needs.</p> <p>Findings include:</p>	W0249	<p>1. Staff has retrained on Risk plan, which includes gait belt transfers. Day Service Coordinator and Group Home Supervisor will monitor by checking on staff on a routine basis. During Day Service hours, the staff will contact relieve staff to assist while transferring consumer to the restroom as needed. The Group Home Supervisor has trained Group</p>	10/28/2011	

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	<p>The facility records were reviewed on 9/26/11 at 2:32 P.M. including the BDDS (Bureau of Developmental Disabilities Services) reports and the Incident/ accident reports.</p> <p>- an incident report dated 9/16/11 at 12:50 P.M. indicated "[client B] has an elopement plan and is required to have 24-7 staff supervision. [Client B] was in the classroom without any staff supervision until this writer walked into the classroom; However please note this was less than 1 (one) minute." The report indicated staff had not followed client B's BSP to maintain constant visual supervision.</p> <p>- a BDDS report dated 9/12/11 for an incident on 9/9/11 at 9:30 P.M. indicated "[Client C] was in the bathroom using the restroom. Staff left the bathroom to assist another consumer. [Client C] yelled to staff that she was done and a couple of seconds later [client C] yelled 'ouch'. Staff found [client C] in a crouching position on the floor; evidence that [client C] had tried to get up from the toilet without assistance from staff in transferring from the toilet to the wheelchair...The staff was not found to be neglectful in this situation; however were found to be inadequately trained on the risk plan, and gait belt training, and consumer routine."</p>		<p>Home staff on consumer routine on October 28, 2011.</p> <p>2.Group Home Supervisor has been counseled and staff retrained on the investigation process, suspension of staff immediately upon knowledge of potential abuse, neglect and mistreatment, and incident reporting on 4-18-2011 and continuously trained during monthly staff meeting.. Group Home Supervisor will monitor staff on a weekly basis by doing random Quality Inspections</p>		

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	<p>The report indicated staff had not followed client C's transfer/positioning protocol to monitor, utilize two staff and a gait belt.</p> <p>- a BDDS report dated 7/7/11 for an incident on 7/6/11 at 8:10 P.M. indicated "[Client C] was getting out of the shower and onto wheelchair and her foot slipped on the tub mat and fell onto the floor...Staff was not appropriately trained on [client C's] risk plan for falls...not trained on use of gait belt."</p> <p>Client B's record was reviewed 9/28/11 at 1:07 P.M.. Client B's record indicated he had an ISP dated 7/29/11 and a BSP dated 8/8/11. Client B's targeted behaviors included Physical aggression, Self-Injurious behaviors (SIB) and elopement. If client B was to elope a staff was to follow him. He was to have fifteen minute staff checks at all times when in his room. He was to have continuous visual supervision.</p> <p>Client C's record was reviewed on 9/27/11 at 3:00 P.M.. Client C's record indicated she had an ISP dated 6/6/11. Client C's ISP indicated she was a "high risk for choking." Client C's transfer/positioning protocol dated 5/20/10 indicated she was to be transferred/repositioned every 2-3 hours. Two staff were to assist her, they</p>			

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W0312	<p>were to use a gait belt, and monitor her closely.</p> <p>An interview was conducted with the Social Service Coordinator (SSC), the Health and Safety Coordinator (HSC) and the Residential Coordinator / Qualified Developmental Disabilities Professional Designee (QDDPD) on 9/28/11 at 4:10 P.M.. The facility staff indicated the staff had not followed client B and C's plans.</p> <p>This Federal tag relates to complaint #IN00096473.</p> <p>9-3-4(a)</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on record review and interview, the</p>	W0312	Behavior Specialist contacted to develop aBehavior Support	10/28/2011	

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W0322	<p>facility failed to include the use of psychotropic medications in a Behavior Support Plan (BSP) for 1 of 4 sampled clients (client C).</p> <p>Findings include:</p> <p>Client C's record was reviewed on 9/27/11 at 3:00 P.M.. Client C's record indicated she had an ISP (Individual Support Plan) dated 6/6/11. Client C's Physician's Order (PO) signed and dated by her physician on 9/16/11 indicated she was prescribed psychotropic medications for depression/anxiety and insomnia. Client C's record did not indicate she had a BSP to address the use of these medications or a plan for their reduction.</p> <p>The Qualified Developmental Disabilities Professional Designee (QDDPD) was interviewed on 9/28/11 at 2:09 P.M.. The QDDPD stated, "No [client C] does not have a behavior plan."</p> <p>9-3-5(a)</p> <p>The facility must provide or obtain preventive and general medical care. Based on record review and interview, the facility failed to refer 2 of 4 clients</p>	W0322	<p>Plan for Client C Staff will be trained on the approved byguardian and HRC plan when approval has been received</p> <p>Group Home Supervisor will begin process to get Clients A</p>	10/28/2011	

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	<p>(clients A and C) who were prescribed psychotropic medications to a Psychiatrist for their treatment.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 9/27/11 at 12:08 P.M.. Client A's Physician's Order (PO) signed and dated by his primary care physician (PCP) on 9/16/11 indicated he was prescribed Paroxetine (generic for Paxil an anti-depressant) 10 mg Q HS (at hour of sleep). Client A's record indicated he had a Behavior Support Plan (BSP) dated 6/13/2011 and had the targeted behavior of physical aggression (hitting peers and staff. Client A's ISP (Individual Support Plan) dated 6/17/11 indicated client A continued to have incidents of hitting peers and staff. Client A's record did not indicate he was receiving routine psychiatric medication reviews by a psychiatrist.</p> <p>Client C's record was reviewed on 9/27/11 at 3:00 P.M.. Client C's PO signed and dated by her PCP on 9/16/11 indicated she was prescribed Fluoxetine (generic for Zoloft an anti-depressant) 10 mg QD (daily) for anxiety, and Trazadone (anti-depressant / sleep agent) 150 mg 1 tablet every night at bedtime. Client C's PO indicated she had a diagnosis of, but</p>		<p>and C appointments with a psychiatrist on 10/24/2011. Staff will monitor clients for any signs of depression or anxiety and document on a baseline until a behavior plan has been developed.</p>		

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	<p>not limited to, depression. Client C's record did not indicate she was receiving routine psychiatric medication reviews by a psychiatrist.</p> <p>An interview was conducted with the Health and Safety Specialist (HSS) on 10/5/11 at 11:41 A.M.. The HSS indicated clients A and C were not seen by a psychiatrist.</p> <p>9-3-6(a)</p>				