

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G425		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/21/2012	
NAME OF PROVIDER OR SUPPLIER  QUALITY COMMUNITY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150			
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W0000	<p>This visit was for an investigation of complaint #IN00116121.</p> <p>Complaint #IN00116121: Substantiated. Federal/state deficiencies related to the allegation(s) are cited at W120, W153, W189, and W214.</p> <p>Dates of Survey: September 17, 18, 19, 20 and 21, 2012.</p> <p>Surveyor: Dotty Walton, Medical Surveyor III</p> <p>Facility Number: 000939 AIM Number: 100368660 Provider Number: 15G425</p> <p>The following federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/27/12 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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W0120	<p><b>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</b></p> <p>The facility must assure that outside services meet the needs of each client. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure the day services provider reported all of the client's behavior incidents in a timely manner to the residential provider or to the Bureau of Developmental Disabilities Services.</p> <p>Findings include:</p> <p>Facility BDDS/Bureau of Developmental Disabilities Services reports were reviewed on 9/17/12 at 11:30 AM and indicated the following:</p> <p>A BDDS report dated 9/10/12 indicated a behavioral incident on 9/10/12 at 9:30 AM at the day services site. Client A volunteered to take out the trash and when he did not return in a timely manner, staff went outside to investigate. Day services staff found client A in a staff's personal truck and client A had "rummaged" through his personal belongings. Client A was found crouched down beside the vehicle. Client A was suspended from the workshop. The report also indicated "last week" at workshop, client A took staff's cell phone, was confronted about it and returned the phone. The day services</p>	W0120	<p>W 120 Judy Roberson &amp; Lynn Ihlenburg, administrative staff at QCS, conducted an on sight in-service for Rauch staff and management. (10-26-2012) Rauch management has instructed their staff to have "eyes on" this client at all times. The Rauch staff understand their responsibilities to communicate with QCS and report incidents to QCS and to the state as appropriate. Rauch staff and QCS will exchange emails weekly and immediately when an incident has occurred. Additionally, communication will no longer be directed through direct care staff but rather reported directly to QCS management. Sheridan Vowels, Director of Operations and Lynn Ihlenburg, Social Worker will monitor weekly for compliance.</p>	10/30/2012	

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	<p>provider had not reported the theft of the cell phone to the residential provider. The day services provider had not reported client A's theft of the cell phone or his rummaging in a staff's personal vehicle.</p> <p>A day services BDDS report (reviewed on 9/20/12 at 3:30 PM) dated 9/14/12 indicated a behavioral incident on 9/10/12 at 9:30 AM at the day services site. Client A volunteered to take out the trash and when he did not return in a timely manner, staff went outside to investigate. Day services staff found client A in a staff's personal truck and client A had "rummaged" through his personal belongings. Client A was found crouched down beside the vehicle. Client A was suspended from the workshop.</p> <p>Interview with day services staff #15 on 9/20/12 at 3:00 PM indicated the 9/10/12 incident with client A was reported on 9/14/12. The interview stated client A had taken a workshop staff's cell phone on 8/29/12 and had returned it in a "couple of hours." The cell phone theft had not been reported to BDDS.</p> <p>Interview with residential staff #1 on 9/17/12 at 1:00 PM indicated the day services provider had not forwarded an incident report regarding the date of the cell phone theft. The interview indicated</p>				

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	<p>the day services provider had not reported the 9/10/12 incident with client A so the the residential provider had reported it.</p> <p>This federal tag relates to complaint #IN00116121.</p> <p>9-3-1(a)</p>				

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 3 sampled clients (A), for 2 of 7 incidents reviewed, the facility failed to report all of the client's behavior incidents in a timely manner to the Bureau of Developmental Disabilities Services/BDDS in accordance with state law.</p> <p>Findings include:</p> <p>Facility BDDS reports were reviewed on 9/17/12 at 11:30 AM and on 9/21/12 at 9:30 AM and indicated the following:</p> <p>A report dated 9/1/12 at 7:00 PM was reported to BDDS on 9/05/12. The report indicated client A had left the facility on the evening of 9/1/12 three times without permission (eloped) and had taken the fire alarm key and a staff's personal cell phone. Client A had attended Special Olympics Bowling on 9/1/12 at 12:00 PM to 4:00 PM on 9/01/12 but had taken a peer's cell phone while there and had become suspended from all Special Olympics activities for 6 months.</p>	W0153	<p>QCS will submit an initial report within the mandated guidelines. Any investigations or pertinent information collected after the initial submission will be sent as a follow-up to the initial report rather than waiting to produce a more complete and detailed document for the initial report.</p> <p>Sheridan Vowels Director of Operations, Cara Pavlica RN QMRP, and Sharon Elzy RN will monitor for compliance</p>	10/21/2012			

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	<p>According to review of a BDDS report on 9/21/12 at 9:30 AM, on 9/14/12 at 7:30 PM client A left the premises when he was supposed to be bringing his laundry down to the first floor from his upstairs bedroom. The report indicated staff followed him to a local mini mart and he returned to the facility. The episode lasted 30 minutes. The AWOL/elopement of client A was not reported to BDDS until 9/20/12.</p> <p>Interview with staff #1 on 9/19/12 at 3:30 PM and on 9/21/12 at 12:00 PM indicated the reports had not been forwarded to BDDS on the next business day after the incident.</p> <p>This federal tag relates to complaint #IN00116121.</p> <p>9-3-1(b)(5) 9-3-2(a)</p>						

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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client A), the facility failed to ensure direct contact staff were trained in all behavior techniques necessary to manage client A's aggression and elopement behaviors.</p> <p>Findings include:</p> <p>Facility reportable incidents were reviewed on 9/17/12 at 11:30 AM. The review indicated client A had become physically aggressive toward staff #1 on 9/2/12 and staff employed "nonviolent crisis intervention techniques" to deflect and block client A's "considerable punching" that was exhibited toward him.</p> <p>Review of client A's record on 9/18/12 at 11:15 AM indicated an Individual Habilitation Plan/IHP dated 8/1/12 with accompanying Behavior Support Plans dated June 2012 and updated 9/5/12. The record review indicated the client had a behavior plan to address AWOL behavior (leaving the facility without permission) and physical aggression. The review indicated client A's physical aggression</p>	W0189	<p>All staff at the Shelby home will be trained in basic nonviolent blocking techniques and evasive physical tactics.</p> <p>Sheridan Vowels Director of Operations and Cara Pavlica RN QMRP will monitor for compliance.</p>	10/21/2012	

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	<p>was to be deflected or blocked using techniques trained in the Nonviolent Crisis Intervention/NCI techniques taught in a facility approved class. Review of personal training documentation on 9/18/12 at 1:00 PM indicated staff #9, #10 and #13 had not attended the facility's NCI training.</p> <p>Interview with staff #1 on 9/18/12 at 1:10 PM indicated staff #9 and #10 had not attended the NCI training. The interview indicated staff #13 had the training elsewhere but had not produced evidence of the training.</p> <p>This federal tag relates to complaint #IN00116121.</p> <p>9-3-3(a)</p>			

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W0214	<p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure client A's level of self sufficiency in regards to community integration had been thoroughly assessed.</p> <p>Findings include:</p> <p>Facility reportable incidents were reviewed on 9/17/12 at 11:30 AM. The review indicated client A had left the facility without permission (AWOL) on 9/1/12 (three incidents), 9/09/12, and 9/14/12. Review of the incidents indicated client A would go to a neighborhood mini mart/gas station/car wash and use his cell phone to access the internet/text, or make phone calls. Review of client A's record on 9/18/12 at 11:15 AM indicated an Individual Habilitation Plan/IHP with accompanying comprehensive functional assessment dated 8/1/12. The plan/assessment indicated client A was an emancipated adult who was independent in all areas of personal hygiene and housekeeping tasks. The client's ability to conduct himself in a responsible manner while unsupervised in the community had not been assessed.</p>	W0214	<p>A baseline functional assessment will be documented for this client addressing community survival skills.</p> <p>Lynn Ihlenburg, Social Worker, will monitor for compliance.</p>	10/21/2012			

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	<p>The client had not been assessed in regards to the level of supervision required to enhance his behavior skills level in regards to the identified behaviors of AWOL, theft, and physical aggression. Interview with staff #1 on 9/19/12 at 3:30 PM indicated client A would leave the facility by evading staff who were assigned to supervise him in a one to one fashion after the AWOL behavior had commenced on 9/01/12. The interview indicated client A had the ability to go to the mini mart independently and would be found there using his cell phone. The interview indicated client A was his own guardian. The interview indicated client A had not been given the opportunity to access the community independently. The interview indicated the client's ability to access the community in a responsible fashion had not been explored/assessed. The interview indicated client A had taken cell phones of peers, staff and workshop staff on three occasions. The interview indicated the client's physical aggression, noncompliance, AWOL, and theft were barriers to his living in a less restrictive environment.</p> <p>This federal tag relates to complaint #IN00116121.</p> <p>9-3-4(a)</p>						

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