

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2014
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NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: July 7, 9, 10, 14 and 15, 2014.</p> <p>Facility number: 001193 Provider number: 15G656 AIM number: 100446910</p> <p>Surveyor: Kathy Wanner, QIDP.</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/28/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the governing body failed to exercise operating direction over the group home by failing to ensure the carpeting was</p>	W000104	<p>It was acknowledged by the Residential Department Head in a routine walk-thru that the carpet needed to be replaced. Now, and in the future the governing body</p>	08/14/2014

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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	<p>maintained in good repair in the living room of the group home where 3 of 3 sampled clients (#1, #2 and #3) and 2 of 2 additional clients (#4 and #5) lived.</p> <p>Findings include:</p> <p>Observation of the group home where clients #1, #2, #3, #4 and #5 lived was conducted on 7/9/14 from 4:23 P. M. through 6:45 P.M. The living room carpeting by the front door was snagged and had runs in it. The torn area was 8 feet by 2 inches. The carpeting throughout the room had numerous darkened areas of irregular shapes and differing sizes.</p> <p>An interview was conducted with Direct Care Staff (DCS) #1 on 7/9/14 at 4:51 P.M. DCS #1 stated, "Yes, the carpeting is stained and torn."</p> <p>An interview was conducted with DCS #5 on 7/10/14 at 10:12 A.M. DCS #5 stated, "It (carpeting) needs to be replaced, the rip keeps getting worse and the stains will not come clean anymore."</p> <p>An interview was conducted with the Residential Manager (RM) on 7/9/14 at 6:29 P.M. The RM stated, "The tear has started recently. We will get a work order for the stains. They are from one of the</p>		<p>will act more swiftly after budget approval to replace/repair or maintain an approved budget item The Residential Manager will continue to notify the Residential Department Head when repairs/maintenance are needed. The Residential Department Head will complete a monthly environmental check at each group home to ensure all repairs/maintenance are identified and completed in a timely manner.</p>		

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W000276	<p>clients tossing his beverages. We actually bought a carpet cleaner for the house."</p> <p>An interview was conducted with the Residential Director (RD) on 7/10/14 at 2:11 P.M. The RD stated, "Yes, we are planning on replacing the flooring (in the living room). I have money in the budget for it to be replaced."</p> <p>9-3-1(a)</p> <p>483.450(b)(1)(i) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Policies and procedures that govern the management of inappropriate client behavior must specify all facility approved interventions to manage inappropriate client behavior. Based on record review and interview, the facility failed to include the use of ECT (electroconvulsive therapy) as a facility approved intervention in their behavior policy as indicated for 1 of 3 sampled clients (client #2). Findings include: Client #2's record was reviewed on 7/10/14 at 8:53 A.M. Client #2's record indicated she had a BSP (Behavior Support Plan) dated 11/15/13 with the</p>	W000276	The Policies and Procedures that govern the management of inappropriate client behaviors has been changed and approved to reflect that ECT is a facility approved intervention. Now and in the future, all residents having the established need for ECT will follow the updated Behavior Management Policy. The Behavior Specialist and the QIDP will ensure that the IDT and HRC have approved any interventions to manage inappropriate client behavior prior to implementation.	08/14/2014

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	targeted behavior of, physical aggression. The BSP indicated "[Client #2] began ECT (electroconvulsive therapy) treatments through [Hospital #1] in [Name of City] under the coordination of her psychiatric prescriber [Name of nurse practitioner]. She (client #2) began in June 2013. These treatments appear to be effective in reducing physical aggression and agitation. She has completed up to twice weekly but has been recently completing them about once weekly." Client #2's psychiatric review dated 6/11/14 indicated "Continue weekly ECT." Client #2's psychiatric review indicated she had "Active Problems: 1. Atypical psychosis. 2. History of long term treatment with high-risk medication. 3. Impulse Disorder. 4. Moderate mental retardation and 5. Obsessive-compulsive behavior." Client #2's Physician's Order (PO) dated 7/2014 indicated she was prescribed duloxetine (generic Cymbalta an antidepressant), Clozaril (antipsychotic) and Haldol (antipsychotic). A review of client #2's behavior data for the past year was completed on 7/10/14 at 8:53 A.M. The Data indicated client #2's behaviors of hitting, crying, staring, pushing, obsessing, somatic complaints, incontinence, attempts to hit and throwing objects had decreased from 35 per month to 5 or less per month.						

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	<p>The review of collateral information for ECT from Wikipedia was provided by the facility LPN on 7/15/14 at 2:38 P.M. The information indicated "Electroconvulsive therapy (ECT), formally known as electroshock, is a standard psychiatric treatment in which seizures are electrically induced in patients to provide relief from psychiatric illnesses. ECT is usually used as a last line of intervention for major depressive disorder, schizophrenia, mania and catatonia. A usual course of ECT involves multiple administrations, typically given two or three times per week until the patient is no longer suffering symptoms...ECT can differ in its application in three ways: electrode placement, frequency of treatments, and the electrical waveform of the stimulus. After treatment, drug therapy is usually continued, and some patients receive maintenance ECT...this is determined on a per patient basis...The World Health Organization (2005) advises that ECT should be used only with the informed consent of the patient (or their guardian if their incapacity to consent has been established)...Aside from effects in the brain, the general physical risks of ECT are similar to those of brief general anesthesia; the U.S. Surgeon General's report says that there are 'no absolute</p>			

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W000289	<p>health contraindications' to its use."</p> <p>The facility's Behavior Management Policy and Procedures dated 2/2012 was reviewed on 7/10/14 at 3:00 P.M. The policy did not indicate the use of ECT treatment for behavior intervention was a facility approved behavior intervention.</p> <p>An interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) on 7/10/14 at 3:25 P.M. The QIDP stated, "No, ECT would not be in our behavior policy."</p> <p>An interview was conducted with the Residential Director (RD) on 7/15/14 at 4:04 P.M. The RD stated, "Yes, it (ECT) is used for behavior intervention."</p> <p>9-3-5(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT</p>			

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	<p>BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on record review and interview, the facility failed to include the use of ECT (electroconvulsive therapy) as a behavior intervention in the Behavior Support Plan (BSP) for 1 of 3 sampled clients (client #2).</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 7/10/14 at 8:53 A.M. Client #2's record indicated she had a BSP dated 11/15/13 with the targeted behavior of, physical aggression. The BSP indicated "[Client #2] began ECT (electroconvulsive therapy) treatments through [Hospital #1] in [Name of City] under the coordination of her psychiatric prescriber [Name of nurse practitioner]. She (client #2) began in June 2013. These treatments appear to be effective in reducing physical aggression and agitation. She has completed up to twice weekly but has been recently completing them about once weekly." Client #2's psychiatric review dated 6/11/14 indicated "Continue weekly ECT." Client #2's psychiatric review indicated she had "Active Problems: 1. Atypical psychosis. 2.</p>	W000289	The Policies and Procedures that govern the management of inappropriate client behaviors has been changed and approved to reflect that ECT is a facility approved intervention. Now and in the future, all residents having the established need for ECT will follow the updated Behavior Management Policy. The Behavior Specialist and the QIDP will ensure that the IDT and HRC have approved all interventions to manage inappropriate client behavior prior to implementation and incorporate the intervention into the client's individual Behavior Management Plan. All Behavior Management Plans are reviewed by the IDT; and when approved, are then submitted to the HRC for approval. The IDT and HRC approvals occur initially, at least annually or as changes occur.	08/14/2014			

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	<p>History of long term treatment with high-risk medication. 3. Impulse Disorder. 4. Moderate mental retardation. and 5. Obsessive-compulsive behavior." Client #2's BSP did not indicate what ECT was, what the expected outcome was for client #2 or how the IDT (interdisciplinary team) was monitoring the ECT treatments for effectiveness and plan of reduction for the treatments. A review of client #2's behavior data for the past year was completed on 7/10/14 at 8:53 A.M. The Data indicated client #2's behaviors of hitting, crying, staring, pushing, obsessing, somatic complaints, incontinence, attempts to hit and throwing objects had decreased from 35 per month to 5 or less per month.</p> <p>An interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) on 7/10/14 at 3:25 P.M. The QIDP stated, "No, ECT is not included in her plan." The QIDP indicated client #2's aggressive behaviors had decreased as soon as she started the ECT treatments.</p> <p>An interview was conducted with the Behavior Consultant (BC) on 7/15/14 at 10:30 A.M. The BC stated, "I guess it fell off my radar as something to be written in the plan. The treatments vary from person to person. We try to keep the</p>			

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	<p>frequency as low as possible. We (BC, QIDP and Residential Manager) monitor it through her behavior data, meet with the psychiatrist and ECT nurse monthly. We review the level of ECT and how it is administered. We have often talked about the frequency and the adjustment for each specific treatment. Trying to keep her (client #2) on the least dosing and least number of treatments. For all intent and purposes it is a behavior intervention, just a medical approach trying to reduce the incidents of her hurting herself or others." The BC indicated they had tried to go two weeks between ECT treatments, but client #2's behaviors always increase when it is time for her next treatment, and at this time they had not been able to go with a maintenance dose of less than one treatment a week.</p> <p>An interview was conducted with the Residential Director (RD) on 7/15/14 at 4:04 P.M. The RD stated, "Yes, it (ECT) is used for behavior intervention." The RD indicated without the ECT treatments they may have been unable to continue to provide services for client #2 due to her aggression to others.</p> <p>9-3-5(a)</p>						

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W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 2 of 2 additional clients (#4 and #5) who lived in the home, the facility failed to hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Findings include:</p> <p>Record review on 7/10/14 at 9:45 A.M. of facility evacuation drill records for clients #1, #2, #3, #4 and #5 indicated there were no evacuation drills completed for the day shift (7:00 A.M. to 3:00 P.M.) during the time between the drill held on 7/18/13 and the drill held on 11/23/13.</p> <p>An interview was conducted with Direct Care Staff (DCS) on 7/10/14 at 10:12 A.M. DCS #5 stated, "They need to be ran every quarter on each shift."</p>	W000440	<p>Now, and in the future, the facility will hold evacuation drills at least quarterly for each shift of personnel. The attached Evacuation Drill Schedule is currently being followed to ensure compliance. Evacuation Drill reports are reviewed by the Home Manager and submitted monthly to the QIDP to ensure compliance. Group Home Staff, Home Manager, QIDP responsible</p>	08/14/2014

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	An interview was conducted with the Residential Manager (RM) on 7/10/14 at 12:20 P.M. The RM stated, "All the drills should be here." The RM indicated drills should be run quarterly on each shift. 9-3-7(a)				