

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G085	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1803 N ELM ST MUNCIE, IN 47303
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: March 2, 3 and 4, 2016.</p> <p>Facility number: 000627 Provider number: 15G085 AIM number: 100233830</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/10/16.</p>	W 0000		
W 0137 Bldg. 00	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based upon observation, record review and interview for 2 of 2 sampled clients (clients #1 and #3), the facility failed to ensure clients retained their personal possessions (grooming supplies).</p> <p>Findings include:</p>	W 0137	The below actions have been implemented on or before 3/21/2016: QIDP assessed and ensured that all clients will have access to their own grooming supplies. Staff training occurred 3/10/16 at the monthly house meeting to ensure that clients have access to their own grooming supplies including, but	03/21/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G085	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2016
NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1803 N ELM ST MUNCIE, IN 47303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Observations were completed at the group home on 3/3/16 from 6:24 AM to 7:45 AM. During the observation, staff #7 gave clients #1 and #3 denture adhesive and toothpaste in individual medicine cups.</p> <p>Staff #8 was interviewed on 3/3/16 at 6:24 AM. When asked why the clients received their adhesive and toothpaste in a cup, she stated, "It's always been done like that. They use too much." When asked how clients are taught to use an appropriate amount, she indicated she didn't think staff were teaching the clients that skill.</p> <p>Client #3 was interviewed on 3/3/16 at 7:09 AM and indicated she would prefer to keep her own denture adhesive instead of receiving it from staff.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 3/3/16 at 10:45 AM and indicated he was unaware the staff were providing the clients adhesive and toothpaste in a cup and stated, "We'll work on it." The QIDP indicated the practice would be discontinued immediately.</p> <p>The QIDP and the Residential Program Director were interviewed again on 3/4/16 at 4:48 PM and indicated the clients should retain their own grooming supplies.</p> <p>9-3-2(a)</p>		<p>not limited to denture adhesive and toothpaste. Formal training will be implemented for clients that are assessed to be unable to dispense an appropriate amount of grooming product independently. QIDP will check the home weekly for a period of 2 months to ensure that each client has access to their own grooming supplies including, but not limited to denture adhesive and toothpaste. If QIDP observes the home to be within compliance (each client has access to their own grooming supplies) each week for 2 months, then observations will be conducted bi-weekly (twice a month) for a period of 2 months. Again, if the home is observed to be in compliance, then QIDP observations will discontinue. If the home is found to not be in compliance, then QIDP will reassess and ensure that all of the clients have access to their own grooming supplies. Observations would then continue weekly until the home is found to be in compliance for a period of 2 months and then decrease to bi-weekly for 2 months and then discontinue.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G085	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2016
NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1803 N ELM ST MUNCIE, IN 47303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0159 Bldg. 00	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based upon observation, record review and interview, the QIDP (Qualified Intellectual Disabilities Professional) failed for 1 of 3 sampled clients (client #3) to ensure a team meeting was convened to discuss client #3's request to be provided opportunities for work.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities (BDDS) were reviewed on 3/2/16 at 6:14 PM and indicated the following:</p> <p>A report dated 2/11/16 indicated client #3 was pushed by workshop client #1 and was not injured in the incident. The report indicated there was no history of physical aggression between the clients and staff would follow workshop client #1's Behavior Support Plan (BSP) to prevent future incidents.</p> <p>A report dated 2/24/16 indicated client #3's glasses were knocked off and she was scratched by workshop client #2.</p>	W 0159	Team meeting occurred on 3/18/2016 to explore work opportunities for client #3. The team and client #3 agreed to a schedule that includes her attending facility vocational programming two half days a week starting April 1, 2016. This programming will offer an opportunity to make money. The team will meet again in June 2016 and will make changes to programming upon request from the individual.	03/18/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G085	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1803 N ELM ST MUNCIE, IN 47303
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>The QIDP was interviewed on 3/2/16 at 7:04 PM and stated client #3 "got scratched up pretty good." The QIDP indicated there was no history of incidents between the two clients and client #3 happened to be in the doorway when workshop client #2 came in and became physically aggressive to client #3.</p> <p>Observations were completed at the group home on 3/2/16 from 5:10 PM until 7:05 PM. Client #3 made brownies with the supervision of staff #4.</p> <p>Observations were completed at the group home on 3/3/16 from 6:24 AM until 7:45 AM. Client #3 showed the surveyor pictures of her grandchildren and medals she won from a cheerleading group she participates in.</p> <p>Client #3 was interviewed on 3/3/16 at 7:09 AM. Client #3 indicated she wanted to make money and go back to work. She indicated she had a son and grandchildren and stated, "I don't make any money." Client #3 indicated an area of the workshop she wanted to work in and then stated "I cry because I want money for clothing." She indicated she had discussed her preference with her behavior clinician and the QIDP.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G085	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1803 N ELM ST MUNCIE, IN 47303
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Client #3 was interviewed again on 3/3/16 at 7:35 AM and teared up when she indicated she wanted to go to work. She indicated she did not want to go back to day services and stated, "I got scratched and I don't want to get hurt again."</p> <p>Observations were completed at the day services on 3/3/16 from 9:46 AM until 10:16 AM. Client #3 was coloring in an adult coloring book with colored pencils.</p> <p>The [Day Services] Manager was interviewed on 3/3/16 at 10:16 AM and indicated client #3 had requested to go back to the workshop where she worked before, but had a history of being unhappy in that setting. The [Day Services] Manager stated "When she was at workshop she cried daily...." The [Day Services] Manager indicated client #3's behavior clinician would be of assistance in giving information about client #3's status and processing information. She indicated client #3 had been diagnosed with dementia and her skills had declined and stated, "The concern is that she would change back to the workshop and then her mind." The [Day Services] manager indicated the incident in which client #3 was scratched was an isolated incident and client #3 had changed seating to prevent future incidents. She</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G085	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2016
NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1803 N ELM ST MUNCIE, IN 47303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>indicated client #3 had somatic complaints (numerous physical complaints) and in 2014 she had worked part time in the workshop. She indicated at that time client #3 had daily crying and stated client #3 "had begged to get out of here (workshop)." She indicated she didn't think client #3 had been productive at work while she was at the previous workshop.</p> <p>The QIDP was interviewed on 3/3/16 at 10:45 AM. When asked about client #3 and work, he stated, "The ongoing pattern is that she will flip flop a lot (change her mind)." He indicated after moving to the day services shortly after her Individual Support Plan (ISP) in June, 2014, client #3 immediately wanted to return to the workshop. The QIDP stated, "The frustration is money. The feeling of the team is that we will revisit (her request) at the next annual." The QIDP indicated if client #3 needed spending money, the group home supplied her needs, and stated client #3 was currently in a "payback situation due to Medicaid," and did not receive \$50.00 for spending money due to her funding source.</p> <p>Client #3's record was reviewed on 3/3/16 at 11:56 AM. An ISP dated 6/22/15 indicated objectives to identify medication and purpose, exercise for 15</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G085	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2016
NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1803 N ELM ST MUNCIE, IN 47303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0454	<p>minutes, identify a written amount of change and count enough money to pay for an item, prepare dessert and plan and participate in a community activity. The ISP indicated a desired outcome to increase independence in vocational skills and required verbal and physical prompts to complete job tasks. The ISP indicated client #3 was currently employed in the workshop.</p> <p>The Behavior Clinician (BC) was interviewed on 3/3/16 at 4:15 PM and when asked about client #3's request for work, she stated, "Her decision changes from day to day," and indicated client #3 had exhibited crying and somatic complaints while at the workshop. The BC stated, "She has dementia and is declining. We (Interdisciplinary Team) can definitely meet and will send out a notice for a team meeting to revisit her request...."</p> <p>9-3-3(a)</p>				
	483.470(l)(1)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G085		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2016	
NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1803 N ELM ST MUNCIE, IN 47303			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	<p>INFECTION CONTROL</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation, record review, and interview, for 2 additional clients (clients #4 and #6, the facility failed to ensure personal care equipment (electric razor) was not shared.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 3/3/16 from 6:24 AM until 7:45 AM. There was an electric shaver plugged into an outlet in the medication administration/office area.</p> <p>Staff #6 was interviewed on 3/3/16 at 6:55 AM. When asked about the razor, she indicated it was client #6's and stated, "It's always been there." She indicated she was unsure if it was ever sanitized.</p> <p>Client #4 was interviewed on 3/3/16 at 6:55 AM and stated the razor was a "house" razor and client #4 used the razor upon occasion.</p> <p>The QIDP was interviewed on 3/3/16 at 10:45 AM and indicated he was unaware of the practice of sharing the razor and the clients should not be sharing a razor.</p>	W 0454	<p>The below actions have been implemented on or before 3/21/2016: Practice of sharing electric razors was discontinued as of date of survey. QIDP assessed and ensured that all clients have access to their own personal care equipment. Staff training occurred 3/10/16 at the monthly house meeting to ensure that personal care equipment are not shared between clients to maintain infection control practices. QIDP will check the home weekly for a period of 2 months to ensure that each client has access to their own personal care equipment including, but not limited to razors. If QIDP observes the home to be within compliance (each client has access to their own personal care equipment including, but not limited razors) each week for 2 months, then observations will be conducted bi-weekly (twice a month) for a period of 2 months. Again, if the home is observed to be in compliance, then QIDP observations will discontinue. If the home is found to not be in compliance, then QIDP will reassess and ensure that all of the clients have access to their own personal care equipment. Observations would then continue weekly until the home is found to be in compliance for a period of 2</p>	03/21/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G085	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1803 N ELM ST MUNCIE, IN 47303
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 9999 Bldg. 00	<p>A Centers for Disease Control (CDC) General Information about MRSA (methicillin-resistant staphylococcus aureus) updated 9/10/13 posted on the CDC website http://www.gov/mrsa/community/index.html was reviewed on 3/4/16 at 4:35 PM and indicated razors should not be shared to prevent risk of infection. The article indicated 1 in 2 persons carried staph in nasal passages without illness and 2 in 10 persons carried MRSA.</p> <p>9-3-7(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>460 IAC 9-3-2(c)(3) Resident Protections</p> <p>(c) The residential provider shall</p>	W 9999	<p>months and then decrease to bi-weekly for 2 months and then discontinue.</p> <p>The Residential department will coordinate with employee #3 to request an additional reference. The qualifying reference will be obtained and submitted to Human Resources by April 1, 2016. Human Resources will then place in staff's employee file. Audit of all staff working in the home was conducted 3/18/16. For all relevant staff who are found to not have three qualifying references based upon the</p>	04/03/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G085	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2016
NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1803 N ELM ST MUNCIE, IN 47303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>demonstrate that its employment practices assure that no staff person would be employed where there is:</p> <p>(3) conviction of a crime substantially related to a dependent population or any violent crime.</p> <p>The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5 [IC 5-2-5 was repealed by P.L.2-2003, SECTION 102, effective July 1, 2003. See IC 10-13-3-27.], and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>This State Rule is not met as evidenced by:</p> <p>Based on record review and interview, for 1 of 3 staff (staff #3) personnel files reviewed, the facility failed to ensure 3 complete references were obtained prior to employment.</p> <p>Findings include:</p> <p>The facility's personnel files were reviewed on 3/3/16 at 11:07 AM. Records for staff #3 failed to include 3 complete references.</p> <p>The Residential Program Director was</p>		<p>standard, additional references will be obtained and submitted to Human Resources by April 3, 2016. Effective 3/18/16, Hillcroft Services will ensure employees have three qualifying references prior to employment with the agency. Current agency policy/procedure calls for three references for employment. Employment references with dates of employment only will not be considered qualifying references. In order to monitor this system, the Vice-President of Residential Services will ensure that three qualifying references accompany any new recommended hire and sign. All internal transfers from another department or program will also be verified for three qualifying references using the same process of approval by the Vice-President of Residential Services. The Human Resource department will also serve as a back-up to ensure there are three qualifying references. Internal program audit by the Vice-President of Residential Services or Residential Program Director will occur on a quarterly basis to ensure on-going compliance.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G085	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2016
NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1803 N ELM ST MUNCIE, IN 47303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	interviewed on 3/3/16 at 11:23 AM and indicated there were no additional references available for staff #3. 9-3-2(c)(3)				