| | MEDICARE & MEDIC | | | | | | IB NO. 0938-0391 | |
|-----------|--|--------------------------------|---------|-----------|---|-------------|------------------|--|
| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE C | ONSTRUCTION | (X3) DATE | SURVEY | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RIIII | LDING | 00 | COMPI | LETED | |
| | | 15G656 | B. WIN | | | | | |
| | | | D. WIIN | | ADDRESS, CITY, STATE, ZIP CODE | ı | | |
| NAME OF F | PROVIDER OR SUPPLIE | R | | | UNION ST | | | |
| JAY-RAN | IDOLPH DEVELOF | PMENTAL SERVICES | | | LAND, IN 47371 | | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | BROWINED'S DI AN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | ATE | COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | AIE | DATE | |
| W000000 | | | | | | | | |
| 1 | | | | | | | | |
| İ | This visit was for | or a post certification | l wo | 00000 | | | | |
| | | | *** | 00000 | | | | |
| İ | ` ′ | the PCR on 04/12/13 to | | | | | | |
| ı | the investigation of complaint | | | | | | | |
| | #IN00123819 co | ompleted on 02/27/13. | | | | | | |
| | | | | | | | | |
| | This visit was in | n conjunction with the | | | | | | |
| | | | | | | | | |
| | PCR to the predetermined full recertification and state licensure survey | | | | | | | |
| | | | | | | | | |
| | of 4/12/13. | | | | | | | |
| | | | | | | | | |
| | Complaint #INC | 00123819: Not Corrected. | | | | | | |
| | Compiumiv | , 0120013.1100 001100000. | | | | | | |
| | | 4.27.20 1.20 | | | | | | |
| | 1 | August 27, 29 and 30, | | | | | | |
| | 2013. | | | | | | | |
| | | | | | | | | |
| | Facility Number | r: 001193 | | | | | | |
| ı | Provider Number | | | | | | | |
| | AIMS Number: | | | | | | | |
| ı | Anvis Number: | 100440310 | | | | | | |
| | _ | | | | | | | |
| | Surveyor: | | | | | | | |
| | Vickie Kolb, RN | N | | | | | | |
| | | | | | | | | |
| | These deficience | ies also reflect state | | | | | | |
| | | | | | | | | |
| | | rdance with 460 IAC 9. | | | | | | |
| | Quality Review | completed 9/13/13 by | | | | | | |
| ı | Ruth Shackelfor | rd, QIDP. | | | | | | |
| ı | | | | | | | | |
| | | | | | | | | |
| | | | | | 1 | | | |

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

TITLE

(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.

9M3Y13

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|-------------------------------|---------|----------------------------------|--|-----------|-----------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | A. BUILDING CO | | | |
| | | 15G656 | B. WIN | G | | 08/30/201 | 13 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | JNION ST | | |
| JAY-RAN | IDOLPH DEVELOP | MENTAL SERVICES | | PORTL | AND, IN 47371 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE CC | OMPLETION |
| TAG W000149 | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCE) | | DATE |
| VV000149 | 483.420(d)(1) STAFF TRFATM | ENT OF CLIENTS | | | | | |
| | | develop and implement | | | | | |
| | | nd procedures that prohibit | | | | | |
| | | glect or abuse of the client. | | | | | |
| | Based on record review and interview for | | W0 | 00149 | Now and in the future, followin | _ | 9/27/2013 |
| | - | ents (#1), the facility | | | an injury, a client will be asses immediately to determine his/h | | |
| | _ | elop/implement its policy | | | medical needs so as to protect | | |
| | - | o ensure client #1 was | | | his/her health and safety. The | | |
| | | sed and monitored after | | | policies and procedures have | | |
| | having a head in | jury. | | | been revised to address possil consequences of an injury and | | |
| | | | | | contain an assessment and pla | | |
| Findings include: | | | | for ongoing monitoring regarding | | | |
| | | | | | injuries resulting from a fall (se | | |
| | Review of the fa | cility reportable records | | | attached policy and procedure | | |
| | on 8/27/13 at 1 F | PM indicated an Incident | | | The DSP will immediately report to the RHC (Residential | ρπ | |
| | Report dated 7/1 | 8/13 8:45 AM. The | | | Healthcare Coordinator)/LPN v | who | |
| | report indicated | while at the DP (Day | | | will immediately assess, monit | | |
| | Program) "[Clien | nt #1] was in her | | | and assist in providing and/or | | |
| | designated area a | and walking to her seat in | | | securing any necessary medic follow-up; and notify the | al | |
| | an unobstructed | path and I (day program | | | Department Head. DSPs have | e | |
| | staff) asked anot | her client to get a work | | | been trained and will be retrain | | |
| | sample out of the | e cabinet to work on. | | | on documentation, assessmer | | |
| | When she (the or | ther client) opened the | | | incidents that might result in in | jury | |
| | door she bumped | d [client #1] on the butt | | | of a client, and follow-up monitoring. The RHC/LPN will | | |
| | lightly with the o | door and [client #1] lost | | | report immediately to the | | |
| | her balance and | fell and hit her head on | | | Residential Department Head; | | |
| | the floor. She ha | s a bump on her left brow | | | The Residential Department | | |
| | | ove her left brow. [Name | | | Head will monitor and assist in directing an investigation of an | | |
| | of DP staff] and | I (DP staff) ran to [client | | | incident involving the injury or | '' | |
| | _ | er up and put her in a | | | possible injury of a Residentia | | |
| | | sic) the incident. At this | | | client to ensure compliance of | | |
| | , | e only marks that are | | | Policies and Procedures and h | • | |
| | | 1] looked at staff and | | | prevent any future incidents with the potential of harm to a | | |
| | - | aff put ice on her for as | | | resident. | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9M3Y13

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If continuation sheet

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| | NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656 | (X2) MULTIPLE CO A. BUILDING B. WING | ns | | | | | |
|--------------------------|---|---|---|--------|----------------------------|--|--|--|
| | PROVIDER OR SUPPLIER NDOLPH DEVELOPMENTAL SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371 | | | | | | |
| (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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY) | ULD BE | (X5) COMPLETION DATE | | | |
| | long as she would allow. Around 9:45 she starte (sic) to hold her head and nooding (sic) off so I (DP staff) called her house manager at ten. The house manager in turn called the house, then the house called me (the DP staff) and I explained what happened. She (client #1) had her med for pain with in (sic) the half hour." The report indicated the staff notified the DP supervisor at 8:50 AM and instructed the DP staff to check client #1 for injury and to fill out an incident report. The report indicated the facility LPN (Licensed Practical Nurse) was notified at 9:15 AM and the LPN "had me (DP staff) bring [client #1] up to she (sic) her an (sic) check her head, and asked what happened (sic). I (DP staff) let her know, then she (the LPN) asked what I (DP staff) did for her. I (DP staff) told her about the ice and who I told. She (the LPN) said to keep an eye on it which we have." Client #1's record was reviewed on 8/29/13 at 11:45 AM. Client #1's record indicated no documentation and/or an assessment in regard to client #1's head injury from a fall. Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/29/13 at 12 PM indicated she had checked with the staff at the day program | | | | | | | |

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Event ID: 9M3Y13

Facility ID: 001193

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PRINTED: 10/17/2013 FORM APPROVED OMB NO. 0938-0391

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656 | | LDING | NSTRUCTION 00 | (X3) DATE COMPI 08/30 | LETED | |
|--------------------------|---|---|---|---------------------|---|-----------------------------|----------------------------|--|
| | PROVIDER OR SUPPLIER | MENTAL SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| | #1 was at the day group home in reinjury on 7/18/12 provide any doct evidence client # assessed and/or rinjury on 7/18/12 Interview with the 8/29/13 at 12:30 did not have a specific that addressed he provided an unday "Health Emerger The LPN indicate call her immedia #1's fall with a hestated she had see after her fall and her forehead." We facility protocol the LPN indicate observe the client signs. "When as a conducted a neurological conducted and to do neurological asked what she is signed." | documented while client by program and/or at the egard to a fall with a head 3. The QIDP did not cumentation to provide 41 was thoroughly monitored for a head 3 through 7/20/13. The facility LPN on PM indicated the facility pecific protocol in place read injuries. The LPN readed copy of the facility's recies - Minor" for review. The determinent the did not retely at the time of client read injury. The LPN ren client #1 "a short time she had a goose egg on Then asked what was the in regard to a head injury, red the staff were to that and take their vital red if anyone had relogical assessment of the client injured her head, Tho, I checked her and The vitals, but I don't red it." The LPN indicated the protocological assessments. When the instructed the DP staff to did to client #1 due to a | | | | | | |

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Event ID: 9M3Y13

Facility ID: 001193

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE C | | (X3) DATE SURVEY | |
|--|----------------------|--|---------------|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | | 15G656 | B. WING | | 08/30/2013 |
| NAME OF F | PROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP CODE | |
| | | | | UNION ST | |
| | | MENTAL SERVICES | PORTI | _AND, IN 47371 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX TAG | , i | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | |
| TAG | | , | TAG | DEI ICIERCI) | DATE |
| | , , | LPN stated, "I just told | | | |
| | | eye on her." The LPN | | | |
| | | ould have called me if | | | |
| | _ | lem." The LPN did not | | | |
| | 1 * | ntation client #1 was | | | |
| | " | sed and/or monitored for | | | |
| | 1 3 5 5 | the facility LPN, the DP | | | |
| | | group home staff in regard | | | |
| | | d injury of 7/18/13. The | | | |
| | | vide documentation client | | | |
| #1 was monitored for a head injury on | | | | | |
| | 7/18/13, 7/19/13 | and/or 7/20/13. | | | |
| | D 641 6- | ailitada an data d UTTa alth | | | |
| | | cility's undated "Health | | | |
| | _ | finor" record on 8/29/13 | | | |
| | at 1 PM indicate | | | | |
| | | nor, but if condition | | | |
| | | hours, Residential Staff | | | |
| | | e staff nurse Head | | | |
| | | ictim lying down. If | | | |
| | _ | s of dizziness, vomiting, | | | |
| | | lache, bleeding from ears, | | | |
| | call the doctor in | nmediatery" | | | |
| | Pavian of the | vised facility policy | | | |
| | | ection Policy" of 5/12 on | | | |
| | | indicated "JRDS | | | |
| | | Developmental Services | | | |
| | 1 | quired to preserve an | | | |
| | • | ts, dignity, health, and | | | |
| | | RDS prohibits the abuse, | | | |
| | 1 - | * | | | |
| | | tion, mistreatment of an | | | |
| | | d or the violation of the | | | |
| | individual's right | ts." The policy defines | | | |

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| | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | NSTRUCTION 00 | (X3) DATE S COMPL | |
|---------------|----------------------|--|-------------------|---------------|---|----------------------|--------------------|
| | | 15G656 | A. BUII B. WIN | LDING | | 08/30/ | |
| NA 55 05 5 | AD OUTDOOR OF STATES | <u> </u> | J. WIN | _ | DDRESS, CITY, STATE, ZIP CODE | l | |
| | PROVIDER OR SUPPLIER | | | 227 E U | NION ST | | |
| JAY-RAN | IDOLPH DEVELOP | MENTAL SERVICES | | PORTLA | AND, IN 47371 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| 1710 | | ilure to provide adequate | | 1710 | · | | DATE |
| | food, clothing, sl | | | | | | |
| | supervision, etc. | | | | | | |
| | - | | | | | | |
| | - | was cited on 4/12/13. The | | | | | |
| | | implement a systemic | | | | | |
| | plan of correctio | n to prevent recurrence. | | | | | |
| | 9-3-2(a) | | | | | | |
| | <i>γ-3-2(a)</i> | | | | | | |
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Facility ID: 001193

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION 00 | | | (X3) DATE SURVEY COMPLETED | |
|--|----------------------------|------------------------------|--------------------------------|--------|---|-------------------------------|------------|
| | | 15G656 | | LDING | | 08/30/ | |
| | | | B. WIN | | ADDRESS CITY STATE ZIR CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE JNION ST | | |
| JAY-RAN | IDOLPH DEVELOP | MENTAL SERVICES | | | AND, IN 47371 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG W000331 | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| WUUU33 I | 483.460(c) NURSING SERV | ICES | | | | | |
| | | provide clients with nursing | | | | | |
| | | dance with their needs. | | | | | |
| | Based on observa | ation, record review and | W0 | 00331 | Now and in the future, JRDS | will | 09/27/2013 |
| | interview for 1 o | f 3 sample clients (#1), | | | provide clients with nursing | -:- | |
| | nursing services | failed to assess and | | | services in accordance with the needs. The attached policy are | | |
| | monitor client #1 | for a head injury post | | | procedure and assessment wi | | |
| | fall. | | | | be used to determine what is | | |
| | | | | | needed to protect a client's he and safety as well as the procedure for securing it. Also | alth | |
| | Findings include | : | | | | , | |
| | | | | | the policy and procedure will | | |
| | Review of the fa | cility reportable records | | | direct the RHC/LPN in the | | |
| | on 8/27/13 at 1 P | M indicated an Incident | | | process of achieving that | | |
| | Report dated 7/1 | 8/13 8:45 AM. The | | | protection. This policy and procedures helps to define the | | |
| | report indicated | while at the DP (Day | | | role of the RHC/LPN and assu | | |
| | Program) "[Clien | nt #1] was in her | | | protection of all clients in the | | |
| | designated area a | and walking to her seat in | | | event of injury and/or illness. | | |
| | an unobstructed | path and I (day program | | | DSP and the RHC/LPN will re | | |
| | staff) asked anot | her client to get a work | | | immediately to the Residential Department Head, who will | | |
| | sample out of the | e cabinet to work on. | | | monitor and assist in directing | an | |
| | When she (the of | ther client) opened the | | | investigation of any incident | | |
| | door she bumped | [client #1] on the butt | | | involving the injury/possible in | | |
| | lightly with the c | loor and [client #1] lost | | | of a Residential client to ensur compliance of our Policies and | | |
| | her balance and | fell and hit her head on | | | Procedures and help prevent | | |
| | the floor. She has | s a bump on her left brow | | | future incidents with the poten | - | |
| | | ove her left brow. [Name | | | of harm to a resident. | | |
| | of DP staff] and | I (DP staff) ran to [client | | | | | |
| | = | er up and put her in a | | | | | |
| | | sic) the incident. At this | | | | | |
| | time these are the | e only marks that are | | | | | |
| | visible. [Client # | 1] looked at staff and | | | | | |
| | held her head, sta | aff put ice on her for as | | | | | |
| | | d allow. Around 9:45 she | | | | | |
| | _ | d her head and nooding | | | | | |

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Event ID: 9M3Y13

Facility ID: 001193

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| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656 | ĺ | LDING | NSTRUCTION 00 | (X3) DATE COMPI 08/30 | ETED |
|--------------------------|---|--|--------|---------------------|---|-----------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | MENTAL SERVICES | B. WIN | 227 E U | DDRESS, CITY, STATE, ZIP CODE NION ST AND, IN 47371 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | E | (X5) COMPLETION DATE |
| | manager at ten. Iturn called the he called me (the D what happened. med for pain with The report indicated the DP supervisor at the DP staff to cand to fill out an report indicated (Licensed Practions): 15 AM and the bring [client #1] (sic) check her happened (sic). It then she (the LP staff) did for her about the ice and LPN) said to kee have." Client #1's recor 8/29/13 at 11:45 indicated no doc assessment in reinjury from a fall. Interview with the land nothing was | cal Nurse) was notified at e LPN "had me (DP staff) up to she (sic) her an ead, and asked what (DP staff) let her know, N) asked what I (DP . I (DP staff) told her I who I told. She (the ep an eye on it which we d was reviewed on AM. Client #1's record umentation and or an gard to client #1's head | | | | | |

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| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656 | | LDING | NSTRUCTION 00 | (X3) DATE COMPI 08/30 | LETED |
|--------------------------|--|---|---------|---------------------|--|------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | MENTAL SERVICES | B. WIIV | STREET A | DDRESS, CITY, STATE, ZIP CODE NION ST AND, IN 47371 | -1 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) | BE | (X5) COMPLETION DATE |
| | injury on 7/18/12 provide any door evidence client # assessed and/or r injury on 7/18/12 Interview with the 8/29/13 at 12:30 did not have a sp that addressed he provided an unda "Health Emerger The LPN indicate call her immedia #1's fall with a h stated she had se after her fall and her forehead." W facility protocol the LPN indicate observe the client signs." When ash conducted a neur client #1 after th the LPN stated, ' I'm sure they did have any record the facility and I to do neurologic asked what she i monitor in regard head injury, the i | egard to a fall with a head B. The QIDP did not amentation to provide a was thoroughly monitored for a head B through 7/20/13. The facility LPN on PM indicated the facility becific protocol in place ead injuries. The LPN ated copy of the facility's noies - Minor" for review. The did not ead injury. The LPN een client #1 "a short time she had a goose egg on when asked what was the in regard to a head injury, and the staff were to at and take their vital ead if anyone had rological assessment of the client injured her head, thory is a client injured her head, ther vitals, but I don't of it." The LPN indicated the DP staff to do client #1 due to a LPN stated, "I just told eye on her." The LPN | | | | | |

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| | OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | | |
|-----------|---------------------------------------|---|--------|--------|---|-----------------------------|------------|--|
| ANDILAN | OI CORRECTION | 15G656 | | LDING | 00 | 08/30/ | | |
| | | 100000 | B. WIN | | PPPPGG GYMY GW : | 00/30/ | 2010 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | DDRESS, CITY, STATE, ZIP CODE | | | |
| JAY-RAN | IDOLPH DEVELOP | MENTAL SERVICES | | | AND, IN 47371 | | | |
| (X4) ID | | FATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENC!) | | DATE | |
| | | ould have called me if | | | | | | |
| | • | lem." The LPN did not | | | | | | |
| | • | ntation client #1 was | | | | | | |
| | | sed and/or monitored for | | | | | | |
| | | the facility LPN, the DP | | | | | | |
| | _ | group home staff in regard | | | | | | |
| | | d injury of 7/18/13. The | | | | | | |
| | - | vide documentation client d for a head injury on | | | | | | |
| | 7/18/13, 7/19/13 | • • | | | | | | |
| | //16/15, //19/15 | and/or //20/13. | | | | | | |
| | Pavious of the fo | cility's undated "Health | | | | | | |
| | | linor" record on 8/29/13 | | | | | | |
| | at 1 PM indicate | | | | | | | |
| | | nor, but if condition | | | | | | |
| | | hours, Residential Staff | | | | | | |
| | | e staff nurse Head | | | | | | |
| | _ | ctim lying down. If | | | | | | |
| | | s of dizziness, vomiting, | | | | | | |
| | | lache, bleeding from ears, | | | | | | |
| | call the doctor in | _ | | | | | | |
| | can the doctor in | | | | | | | |
| | This deficiency y | was cited on 4/12/13. The | | | | | | |
| | _ | implement a systemic | | | | | | |
| | = | n to prevent recurrence. | | | | | | |
| | F | P | | | | | | |
| | 9-3-6(a) | | | | | | | |
| | · · · · · · · · · · · · · · · · · · · | | | | | | | |
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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | X3) DATE SURVEY | | |
|--|---|--|----------------------------|--------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 15G656 | B. WIN | | | 08/30/ | 2013 |
| | | | B. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | JNION ST | | |
| JAY-RAN | DOLPH DEVELOP | MENTAL SERVICES | | | AND, IN 47371 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| W000382 | 483.460(I)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. | | | | | | |
| | | ation, record review and | W0 | 00382 | Now and in the future, all clien | | 09/18/2013 |
| | interview for 1 of 4 sample clients (#4), the facility failed to ensure all | | | | medication will remain in a loc | ked | |
| | | | | | cabinet until time for administration of individually- | | |
| | medications were | e locked until | | | specific medications to each | | |
| | administered to t | the client | | | client. Staff have been trained | i | |
| | | conducted at the group home | | | and will be retrained at least annually, or as needed, regarding proper medication administration procedures RHC/LPN will observe medica | tion | |
| | | 6:15 AM and 8:15 AM. At | | | passes weekly and document | | |
| | | erview with staff #6, staff #6 was to get Lactulose for | | | observations in nursing notes. | | |
| | | AM. Staff #6 indicated she had | | | RHC/LPN and DSP are | | |
| | | actulose into a medication cup | | | responsible. | | |
| | • | and had placed the cup inside | | | | | |
| | | to be given to client #4 prior to | | | | | |
| | breakfast and after h | nis AM care. Staff #6 walked | | | | | |
| | _ | ed the cabinet above and to the | | | | | |
| | - | sink and showed this surveyor | | | | | |
| | | p with liquid in it and stated, | | | | | |
| | | Lactulose) in here so he (client | | | | | |
| | | "The cabinet also contained glasses and cups. Staff #6 | | | | | |
| | | et was not locked. Staff #6 | | | | | |
| | | nedications were locked in the | | | | | |
| | medication area. | | | | | | |
| | AM. Client #4's Au indicated client #4 v | ras reviewed on 8/29/13 at 11 gust 2013 physician's orders was to have Lactulose 10 gm iliters) bid (twice a day) for | | | | | |
| | | acility LPN on 8/29/13 at 1 s medications were to be | | | | | |

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| | of Correction identification number: 15G656 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | COMPI 08/30 | |
|--------------------------|--|--|--|--------------|----------------------------|
| | PROVIDER OR SUPPLIER | STREET A 227 E U | ADDRESS, CITY, STATE, ZIP JNION ST AND, IN 47371 | CODE | |
| (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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| | | | CROSS-REFERENCED TO THE DEFICIENCY) | APPROPRIATE | |
| | | | | | |
| | | | | | |

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