STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G656	A. BUILDING 00 B. WING	08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAY-RANDOLPH DEVELOPMENTAL SERVICES	227 E UNION ST PORTLAND, IN 47371

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W000000	This visit was for a post certification revisit (PCR) to the PCR on 04/12/13 to the investigation of complaint #IN00123819 completed on 02/27/13. This visit was in conjunction with the PCR to the predetermined full recertification and state licensure survey of 4/12/13. Complaint #IN00123819: Not Corrected. Survey Dates: August 27, 29 and 30, 2013. Facility Number: 001193 Provider Number: 15G656 AIMS Number: 100446910 Surveyor: Vickie Kolb, RN These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/13/13 by Ruth Shackelford, QIDP.	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 3 sample clients (#1), the facility neglected to develop/implement its policy and procedures to ensure client #1 was thoroughly assessed and monitored after having a head injury. Findings include: Review of the facility reportable records on 8/27/13 at 1 PM indicated an Incident Report dated 7/18/13 8:45 AM. The report indicated while at the DP (Day Program) "[Client #1] was in her designated area and walking to her seat in an unobstructed path and I (day program staff) asked another client to get a work sample out of the cabinet to work on. When she (the other client) opened the door she bumped [client #1] on the butt lightly with the door and [client #1] lost her balance and fell and hit her head on the floor. She has a bump on her left brow and one right above her left brow. [Name of DP staff] and I (DP staff) ran to [client #1] and helped her up and put her in a chair to access (sic) the incident. At this time these are the only marks that are visible. [Client #1] looked at staff and held her head, staff put ice on her for as	W000149	Now and in the future, following an injury, a client will be assessed immediately to determine his/her medical needs so as to protect his/her health and safety. The policies and procedures have been revised to address possible consequences of an injury and contain an assessment and plan for ongoing monitoring regarding injuries resulting from a fall (see attached policy and procedures). The DSP will immediately report to the RHC (Residential Healthcare Coordinator)/LPN who will immediately assess, monitor and assist in providing and/or securing any necessary medical follow-up; and notify the Department Head. DSPs have been trained and will be retrained on documentation, assessment of incidents that might result in injury of a client, and follow-up monitoring. The RHC/LPN will report immediately to the Residential Department Head; The Residential Department Head will monitor and assist in directing an investigation of any incident involving the injury or possible injury of a Residential client to ensure compliance of our Policies and Procedures and help prevent any future incidents with the potential of harm to a resident.	09/27/2013

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	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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	and nothing was documented while client #1 was at the day program and/or at the group home in regard to a fall with a head injury on 7/18/13. The QIDP did not provide any documentation to provide evidence client #1 was thoroughly assessed and/or monitored for a head injury on 7/18/13 through 7/20/13. Interview with the facility LPN on 8/29/13 at 12:30 PM indicated the facility did not have a specific protocol in place that addressed head injuries. The LPN provided an undated copy of the facility's "Health Emergencies - Minor" for review. The LPN indicated the DP staff did not call her immediately at the time of client #1's fall with a head injury. The LPN stated she had seen client #1 "a short time after her fall and she had a goose egg on her forehead." When asked what was the facility protocol in regard to a head injury, the LPN indicated the staff were to observe the client and take their vital signs." When asked if anyone had conducted a neurological assessment of client #1 after the client injured her head, the LPN stated, "No, I checked her and I'm sure they did her vitals, but I don't have any record of it." The LPN indicated the facility and DP staff were not trained to do neurological assessments. When asked what she instructed the DP staff to monitor in regard to client #1 due to a			

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	head injury, the LPN stated, "I just told them to keep an eye on her." The LPN stated, "They would have called me if there was a problem." The LPN did not provide documentation client #1 was thoroughly assessed and/or monitored for a head injury by the facility LPN, the DP staff and/or the group home staff in regard to client #1's head injury of 7/18/13. The LPN did not provide documentation client #1 was monitored for a head injury on 7/18/13, 7/19/13 and/or 7/20/13. Review of the facility's undated "Health Emergencies - Minor" record on 8/29/13 at 1 PM indicated "Most of these situations are minor, but if condition worsens in a few hours, Residential Staff should notify the staff nurse.... Head Injuries: Keep victim lying down. If she/he complains of dizziness, vomiting, drowsiness, headache, bleeding from ears, call the doctor immediately...." Review of the revised facility policy "Individual Protection Policy" of 5/12 on 8/27/13 at 2 PM indicated "JRDS [Jay-Randolph Developmental Services] personnel are required to preserve an individual's rights, dignity, health, and safety. As such JRDS prohibits the abuse, neglect, exploitation, mistreatment of an individual served or the violation of the individual's rights." The policy defines			

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	neglect to be "failure to provide adequate food, clothing, shelter, medicine, supervision, etc." This deficiency was cited on 4/12/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 3 sample clients (#1), nursing services failed to assess and monitor client #1 for a head injury post fall. Findings include: Review of the facility reportable records on 8/27/13 at 1 PM indicated an Incident Report dated 7/18/13 8:45 AM. The report indicated while at the DP (Day Program) "[Client #1] was in her designated area and walking to her seat in an unobstructed path and I (day program staff) asked another client to get a work sample out of the cabinet to work on. When she (the other client) opened the door she bumped [client #1] on the butt lightly with the door and [client #1] lost her balance and fell and hit her head on the floor. She has a bump on her left brow and one right above her left brow. [Name of DP staff] and I (DP staff) ran to [client #1] and helped her up and put her in a chair to access (sic) the incident. At this time these are the only marks that are visible. [Client #1] looked at staff and held her head, staff put ice on her for as long as she would allow. Around 9:45 she starte (sic) to hold her head and nooding	W000331	Now and in the future, JRDS will provide clients with nursing services in accordance with their needs. The attached policy and procedure and assessment will be used to determine what is needed to protect a client's health and safety as well as the procedure for securing it. Also, the policy and procedure will direct the RHC/LPN in the process of achieving that protection. This policy and procedures helps to define the role of the RHC/LPN and assures protection of all clients in the event of injury and/or illness. The DSP and the RHC/LPN will report immediately to the Residential Department Head, who will monitor and assist in directing an investigation of any incident involving the injury/possible injury of a Residential client to ensure compliance of our Policies and Procedures and help prevent any future incidents with the potential of harm to a resident.	09/27/2013

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	(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 and nothing was documented while client #1 was at the day program and/or at the			

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	group home in regard to a fall with a head injury on 7/18/13. The QIDP did not provide any documentation to provide evidence client #1 was thoroughly assessed and/or monitored for a head injury on 7/18/13 through 7/20/13. Interview with the facility LPN on 8/29/13 at 12:30 PM indicated the facility did not have a specific protocol in place that addressed head injuries. The LPN provided an undated copy of the facility's "Health Emergencies - Minor" for review. The LPN indicated the DP staff did not call her immediately at the time of client #1's fall with a head injury. The LPN stated she had seen client #1 "a short time after her fall and she had a goose egg on her forehead." When asked what was the facility protocol in regard to a head injury, the LPN indicated the staff were to observe the client and take their vital signs." When asked if anyone had conducted a neurological assessment of client #1 after the client injured her head, the LPN stated, "No, I checked her and I'm sure they did her vitals, but I don't have any record of it." The LPN indicated the facility and DP staff were not trained to do neurological assessments. When asked what she instructed the DP staff to monitor in regard to client #1 due to a head injury, the LPN stated, "I just told them to keep an eye on her." The LPN			

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	stated, "They would have called me if there was a problem." The LPN did not provide documentation client #1 was thoroughly assessed and/or monitored for a head injury by the facility LPN, the DP staff and/or the group home staff in regard to client #1's head injury of 7/18/13. The LPN did not provide documentation client #1 was monitored for a head injury on 7/18/13, 7/19/13 and/or 7/20/13. Review of the facility's undated "Health Emergencies - Minor" record on 8/29/13 at 1 PM indicated "Most of these situations are minor, but if condition worsens in a few hours, Residential Staff should notify the staff nurse.... Head Injuries: Keep victim lying down. If she/he complains of dizziness, vomiting, drowsiness, headache, bleeding from ears, call the doctor immediately...." This deficiency was cited on 4/12/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			

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W000382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review and interview for 1 of 4 sample clients (#4), the facility failed to ensure all medications were locked until administered to the client.. Findings include: Observations were conducted at the group home on 8/29/13 between 6:15 AM and 8:15 AM. At 6:15 AM during interview with staff #6, staff #6 indicated client #4 was to get Lactulose for constipation every AM. Staff #6 indicated she had poured client #4's Lactulose into a medication cup earlier that morning and had placed the cup inside the kitchen cabinet to be given to client #4 prior to breakfast and after his AM care. Staff #6 walked to the kitchen, opened the cabinet above and to the right of the kitchen sink and showed this surveyor a small medicine cup with liquid in it and stated, "I put it (client #4's Lactulose) in here so he (client #4) can take it later." The cabinet also contained the clients' drinking glasses and cups. Staff #6 indicated the cabinet was not locked. Staff #6 indicated all other medications were locked in the medication area. Client #4's record was reviewed on 8/29/13 at 11 AM. Client #4's August 2013 physician's orders indicated client #4 was to have Lactulose 10 gm (grams)/15 ml (milliliters) bid (twice a day) for constipation. Interview with the facility LPN on 8/29/13 at 1 PM stated client #4's medications were to be	W000382	Now and in the future, all client medication will remain in a locked cabinet until time for administration of individually-specific medications to each client. Staff have been trained and will be retrained at least annually, or as needed, regarding proper medication administration procedures.. RHC/LPN will observe medication passes weekly and document the observations in nursing notes. RHC/LPN and DSP are responsible.	09/18/2013

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	locked at all times and "at no time should a staff pour a client's medication and place it in a kitchen cabinet to be given at a later time." The LPN indicated all medications were to be locked and secure at all times. 9-3-6(a)			