

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G215	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/27/2013
NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 321 S MARTIN 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	
W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: August 20, 21, 22, 23, 26 and 27, 2013.</p> <p>Provider number: 15G215 Facility number: 000741 AIM number: 100234840</p> <p>Surveyor: Kathy Wanner, QIDP.</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/6/13 by Ruth Shackelford, QIDP.</p>	W000000			

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: 15G215	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/27/2013
NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 321 S MARTIN 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	
W000149	<p>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, the facility neglected to follow its policy to prevent Abuse and Neglect by staff neglecting to follow the seizure management plan for 1 of 3 additional clients (client #6) who had a seizure resulting in a fall causing injury to his head.</p> <p>Findings include:</p> <p>Facility records were reviewed on 8/21/13 at 11:50 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time frame between 8/20/12 and 8/21/13. The BDDS reports indicated the following:</p> <p>-A BDDS report dated 8/13/13 for an incident on 8/13/13 at 6:50 A.M. indicated "Staff had woke (sic) [client #6] up for the day. Staff went into kitchen to complete lunches for the day. [Client #6] had gotten up out of bed and did not put on his helmet. He walked into the bathroom and had a seizure, fell and hit his head causing a laceration to right side of scalp. Client and staff unsure what he hit his head on. Nursing was called and [client #6] was transported to [name of</p>	W000149	The Behavior Specialist will update the Behavior Support Plan to include approaches to utilize when client refuses to wear helmet. The plan will updated and signed by client or guardian and by members of HRC by 9/26/13. The Behavior Specialist will provide training to all Martin Street staff on the updated Behavior Support Plan by 9/26/13. The clients risk plan will be updated to include updates on client wearing helmet at all times other than when in bed (per seizure management plan). This update will be completed by the agency Nurse and will be reviewed and signed also by the QIDP and Vice-President of Residential Services by 9/26/13. The QIDP will train all Martin Street staff on the updated risk plan by 9/26/13. An assessment was made and it was determined that no other client in this facility has a seizure diagnosis/seizure management plan so no other clients were affected by this deficient practice. Staff were trained 9/25/2013 to complete documentation of a behavior report each time that this individual refuses to wear his helmet. The results of this monitoring will be reported to the QIDP monthly for review and	09/26/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G215	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/27/2013
NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 321 S MARTIN 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>hospital] per nurse for evaluation. [Client #6] received 6-8 staples to laceration and was released. Staff to prompt [client #6] to put on helmet upon arising from bed each day...."</p> <p>Client #6's record was reviewed on 8/22/13 at 2:20 P.M. Client #6's record indicated he had a seizure management plan dated 9/28/12 indicating "...support staff will ensure that [client #6] wears his helmet and elbow pads when out of bed...."</p> <p>The facility policy on Abuse, Neglect, Exploitation and Mistreatment dated 6/26/12 was reviewed on 8/26/13 at 10:00 A.M. The policy indicated "Hillcroft Services, Inc., is committed to preserving the human rights, dignity, and safety of persons receiving services...Hillcroft Services, Inc., prohibits acts of abuse, neglect, exploitation or mistreatment of an individual receiving services. These acts include, but may not be limited to, the acts listed below...Neglect: The repeated failure of a caregiver to provide the basic necessities of life e.g. food, drink, shelter, clothing, and medical care."</p> <p>An interview was conducted with the Program Director (PD) on 8/21/13 at 11:55 A.M. The PD stated, "[Client #6] is to wear his helmet when he gets up to use</p>		<p>recommendations. The QIDP will continue to monitor all documentation through Therap to ensure compliance and to address any issues as they arise. This could include changes of plans, necessary team meetings and trainings as needed. Starting 10/14/2013, the QIDP will visit the individual at the site of service delivery three times a week to insure that compliance with the Risk Plan is occurring. Once 100% compliance with the risk plan is demonstrated at three times a week for three consecutive weeks, the QIDP will then visit the individual at the site of service delivery twice a week to insure compliance with the Risk Plan. Once 100% compliance with the risk plan is demonstrated for three consecutive weeks, the QIDP will then visit the individual at the site of service delivery one time a week to insure compliance with the Risk Plan until 100% compliance with the risk plan is demonstrated for an additional three consecutive weeks. Once consistent compliance has been witnessed further tracking of compliance with this will be addressed by direct support professionals and the QIDP completing the behavior reports. The QIDP will monitor any noncompliance through monthly reports summarizing behavior reporting, if a trend develops in noncompliance with the risk plan, the QIDP will meet with the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G215	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/27/2013
NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 321 S MARTIN 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 restroom. Staff can hear him getting up and prompt him to put on his helmet. I am not sure what happened, how he got up without staff knowing or hearing him." The PD indicated it was against facility policy to not follow a client's seizure management plan.</p> <p>An interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) on 8/22/13 at 2:25 P.M. The QIDP stated, "He (client #6) will put on his helmet and then take it off when they (staff) leave. They need to make sure he is up and moving before they leave the room."</p> <p>An interview was conducted with the RN on 8/22/13 at 2:22 P.M. The RN stated, "He is to wear his helmet when he is up and about. From what I understand, staff woke him up, verbally prompted him to put on his helmet. Staff then left the room. He got up to use the restroom. They didn't stay to assure he had it (helmet) on when he got up."</p> <p>9-3-2(a)</p>		interdisciplinary team to review and discuss any needed changes to the risk plan and behavior plan. The QIDP will then reinstitute the monitoring system at the site of service delivery to insure compliance with behavior and risk plans.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G215	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 321 S MARTIN 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G215	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/27/2013
NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 321 S MARTIN 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	
W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview, the facility direct care staff failed to follow the seizure management plan for 1 of 3 additional clients (client #6) who had a seizure resulting in a fall causing injury to his head.</p> <p>Findings include:</p> <p>Facility records were reviewed on 8/21/13 at 11:50 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time frame between 8/20/12 and 8/21/13. The BDDS reports indicated the following:</p> <p>-A BDDS report dated 8/13/13 for an incident on 8/13/13 at 6:50 A.M. indicated "Staff had woke (sic) [client #6] up for the day. Staff went into kitchen to complete lunches for the day. [Client #6] had gotten up out of bed and did not put on his helmet. He walked into the bathroom and had a seizure, fell and hit his head causing a laceration to right side of scalp. Client and staff unsure what he</p>	W000249	The Behavior Specialist will update the Behavior Support Plan to include approaches to utilize when client refuses to wear helmet. The plan will updated and signed by client or guardian and by members of HRC by 9/26/13. The Behavior Specialist will provide training to all Martin Street staff on the updated Behavior Support Plan by 9/26/13. The clients risk plan will be updated to include updates on client wearing helmet at all times other than when in bed (per seizure management plan). This update will be completed by the agency Nurse and will be reviewed and signed also by the QIDP and Vice-President of Residential Services by 9/26/13. The QIDP will train all Martin Street staff on the updated risk plan by 9/26/13. An assessment was made and it was determined that no other client in this facility has a seizure diagnosis/seizure management plan so no other clients were affected by this deficient practice. Staff were trained 9/25/2013 to complete documentation of a	09/26/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G215	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/27/2013
NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 321 S MARTIN 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>hit his head on. Nursing was called and [client #6] was transported to [name of hospital] per nurse for evaluation. [Client #6] received 6-8 staples to laceration and was released. Staff to prompt [client #6] to put on helmet upon arising from bed each day...."</p> <p>Client #6's record was reviewed on 8/22/13 at 2:20 P.M. Client #6's record indicated he had a seizure management plan dated 9/28/12 indicating "...support staff will ensure that [client #6] wears his helmet and elbow pads when out of bed...."</p> <p>An interview was conducted with the Program Director (PD) on 8/21/13 at 11:55 A.M. The PD stated, "[Client #6] is to wear his helmet when he gets up to use the restroom. Staff can hear him getting up and prompt him to put on his helmet. I am not sure what happened, how he got up without staff knowing or hearing him."</p> <p>An interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) on 8/22/13 at 2:25 P.M. The QIDP stated, "He (client #6) will put on his helmet and then take it off when they (staff) leave. They need to make sure he is up and moving before they leave the room."</p>		<p>behavior report each time that this individual refuses to wear his helmet. The results of this monitoring will be reported to the QIDP monthly for review and recommendations. The QIDP will continue to monitor all documentation through Therap to ensure compliance and to address any issues as they arise. This could include changes to plans, necessary team meetings and trainings as needed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G215	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/27/2013
NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 321 S MARTIN 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>An interview was conducted with the RN on 8/22/13 at 2:22 P.M. The RN stated, "He is to wear his helmet when he is up and about. From what I understand, staff woke him up, verbally prompted him to put on his helmet. Staff then left the room. He got up to use the restroom. They didn't stay to assure he had it (helmet) on when he got up."</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G215	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/27/2013
NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 321 S MARTIN 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	
W000312	<p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview, the facility failed to include specific criteria as part of a plan of reduction for medication used for the management or elimination of behaviors and/or symptoms of diagnoses as indicated in 1 of 2 sampled clients (client #3) who was prescribed medications for management of behaviors.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 8/23/13 at 1:35 P.M. Client #3's Physician's Orders (PO) dated for August 2013 indicated he was prescribed Fluoxetine (anti-depressant) for depression, Ziprasidone (anti-psychotic) for psychosis and Trazodone (anti-depressant/sleeping) for psychosis/depressive disorder. Client #3's Behavior Support Plan (BSP) dated 5/10/13 indicated he had the targeted behaviors of, hoarding, binge eating, sleep difficulties, depressed mood, picking at skin and physical aggression. Client #3's BSP did not indicate what specific criteria</p>	W000312	<p>All Behavioral Specialists working with Martin Street individuals will be trained by the Vice-President of Therapy Services on 9/20/13. This training will include the proper process of including specific criteria for plan reduction for each individual medication used for behavioral management/elimination of behaviors or symptoms of diagnosis in the Behavior Plan. Through review of Behavior Plans it was determined that six of six plans would be revised to include specific criteria for plan of reduction. All Behavior Plans requiring correction will be updated by the Behavioral Specialist. They will obtain the signature of the individual or Guardian and HRC by 9/26/13. Beginning immediately, all Behavior Plans will be submitted by the Behavioral Specialist to the Vice-President of Therapy Services for review prior to processing for implementation. The QIDP reviews behavior plans to help coordinate training, implementation, and insure that plans meet necessary standards. The QIDP monitors implementation through behavior</p>	09/26/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G215	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/27/2013
NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 321 S MARTIN 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>needed to be achieved for Fluoxetine, Ziprasidone and/or Trazodone to be considered for possible reductions. Client #3's BSP did not indicate how each of the medications effectiveness could be determined.</p> <p>An interview was conducted with a facility Behavior Consultant (BC) on 8/22/13 at 2:50 P.M. The BC stated, "They do have a plan of reduction for each behavior, but not a specific plan of reduction for medication. Mostly we would talk with the prescribing physician and reduce the appropriate medication for the change in behavior which has occurred."</p> <p>An interview was conducted with the Vice President Of Behavior Management Services (VP-BMS) on 8/22/13 at 2:57 P.M. The VP-BMS stated, "I think it would be beneficial to have the plan of reductions written that way to decrease the possibility of unneeded medications."</p> <p>9-3-5(a)</p>		tracking results monthly.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G215	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 321 S MARTIN 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