

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G348	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/30/2012
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NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 522 E NORTH ST PORTLAND, IN 47371
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: March 26, 27, 28, 29, and 30, 2012.</p> <p>Provider Number: 15G348 Facility Number: 000864 AIM Number: 100249170</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP.</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/11/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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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W0104	<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, interview, and record review, for 1 of 1 client (client #5) who received injectable medications, the facility failed to ensure the staff followed the agency policy for injectable medications.</p> <p>Findings include:</p> <p>On 3/27/12 at 7:15am, client #5 and the House Manager (HM) were inside the medication administration room. At 7:15am, client #5 tested his blood sugar and it was 241. Client #5 selected his Novolin Insulin R (Regular diabetic insulin for blood sugar), drew 31 units of Novolin R into a needle, and was not observed to roll the bottle in his hand of insulin before the insulin draw. At 7:15am, client #5 shook the second bottle of Insulin (Novolin Insulin N), and client #5 drew up 94 units of Novolin N Insulin into the second syringe. There was no redirection and no teaching of rolling the insulin bottle in his hands. At 7:25am, client #5 injected both insulin syringes into his body. At 7:25am, client #5's 3/2012 MAR (Medication Administration Record) indicated "Novolin N insulin 94</p>	W0104	<p>Now and in the future, staff will be trained, at least annually, on agency policy per injectable medications to ensure that staff follow the agency policy for injectable medications: Residential Healthcare Coordinator, Home Manager and Residential Department Head responsible. April 30, 2012 Date of Completion</p>	04/30/2012			

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	<p>units every AM before meals (and) Novolin Regular insulin 29 units every AM before meals." Client #5's 3/2012 MAR indicated "Novolin Regular insulin coverage as follows...201-250 2 units..."</p> <p>On 3/27/12 at 9:20am, a record review of the facility staff personnel files was completed. No specific training for insulin injections or the procedure specific to insulin was available for review.</p> <p>On 3/27/12 at 12noon, client #5's record was reviewed. client #5's 3/2012 "Physician's Orders" indicated "Novolin N insulin 94 units every AM before meals (and) Novolin Regular insulin 29 units every AM before meals." Client #5's 3/2012 "Physician's Orders" indicated "Novolin Regular insulin coverage as follows...201-250 2 units..." Client #5's 3/2012 "Physician's Orders" did not indicate client #5 was able to self administer his own insulin. Client #5's 1/2012 "Monthly/Quarterly Health Summary" did not indicate client #5 was able to self administer his insulin.</p> <p>Interviews were conducted on 03/27/12 at 9:30am, and on 3/28/12 at 9:30am, with the group home Licensed Practical Nurse (LPN). The LPN stated client #5 had been a diabetic "for many years and self</p>			

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	<p>administered at home" before admission. She indicated the group home staff and client #5 should have rolled the insulin bottles between their hands before drawing up the insulin. The LPN indicated when insulin was shaken, not rolled, bubbles could form or clumps could form in the insulin. The LPN indicated there was no additional documentation available for review to indicate client #5 and the group home staff had been monitored to ensure both were trained and competent to administer insulin. The LPN stated the agency, the facility staff, and client #5 "did not follow the policy/procedure for insulin" administration.</p> <p>On 3/28/12 at 9:30am, the LPN provided a 3/25/2009 "staff meeting training" and indicated "This was the most current training document." The 3/25/09 training document indicated "...Drawing Insulin per 2004 Living in the Community Med (Medication) Administration...3. Mix the insulin. a. Slowly roll the bottle between your hands. b. Never shake the bottle...." No signatures for staff or client #5 were available for review to determine if the staff training was completed.</p> <p>9-3-1(a)</p>						

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W0316	<p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually.</p> <p>Based on record review and interview, for 1 of 1 sampled clients (client #1) who received psychotropic medications, the facility failed to evaluate each client's status for an annual decrease or contraindication of psychotropic medication.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 3/27/12 at 10:40am. Client #1's 7/27/11 ISP (Individual Support Plan) included a 7/27/11 Behavior Support Program (BSP) which indicated client #1 had targeted behaviors of physical threats, verbal threats, and verbal aggression. Client #1's plan indicated the use of Risperdal 1mg (milligram) at night for behaviors. Client #1's record indicated the continued use of Risperdal 1mg medication on psychotropic medication reviews completed on 2/21/12, 11/15/11, 8/23/11, and 5/24/11. Client #1's Psychological Reviews indicated client #1's behaviors were "stable." Client #1's record and psychotropic medication reviews did not indicate a change or contraindication of change of client #1's psychotropic</p>	W0316	<p>Now and in the future a client behavior controlling medication status will be routinely evaluated by the IDT including the Mental Health provider to determine whether or not a need for an annual decrease or if a decrease is contraindicated. QMRP and Home Manager are responsible. Date of Completion: 5-3-12</p>	05/03/2012			

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	<p>medication. Client #1's record did not indicate the last psychotropic medication change or contraindication.</p> <p>On 3/28/12 at 9:30am, an interview with QMRP (Qualified Mental Retardation Professional), the Residential Manager (RM), and the agency Licensed Practical Nurse (LPN) was completed. The QMRP, RM, and LPN indicated indicated no additional information was available for review to determine if client #1's psychotropic medication was evaluated for an annual decrease or if a decrease was contraindicated. The RM and QMRP both stated client #1's record indicated client #1 was "stable" for behaviors.</p> <p>9-3-5(a)</p>				

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W0339	<p>483.460(c)(4) NURSING SERVICES Nursing services must include other nursing care as prescribed by the physician or as identified by client needs.</p> <p>Based on record review and interview, for 1 of 1 sample client (client #2) who was identified at risk for skin breakdown, the facility failed to document the status of client #2's skin, skin breakdown, and failed to implement proactive measures to prevent further breakdown.</p> <p>Findings include:</p> <p>On 3/26/12 at 1:35pm, the facility's BDDS (Bureau of Developmental Disability Services) reports were reviewed and indicated the following for client #2.</p> <p>-A 5/13/11 BDDS report for an incident on 5/12/11 at 11am, indicated client #2 was diagnosed with "Adult Failure to Thrive" and had a one (1) cm (centimeter) pressure ulcer on his coccyx and two (2) areas "dime size" on his left heel.</p> <p>-A 5/25/11 follow up BDDS report indicated "The ulcer to the coccyx is at a Stage 2. [Client #2's] diagnosis that contributes to ulcer development is Alzheimer's, Dementia, Adult Failure to Thrive. There is a written positioning schedule, created per Hospice (care for the terminally ill)...positioning aids used</p>	W0339	<p>Now and in the future, when an individual's skin is identified at risk for breakdown, the Protocol for Pressure, Ulcer Prevention and Management will be implemented. See attachment. Staff have been trained in using the above named protocol and will be trained at least annually or as needed. The protocol implementation will be monitored by the Residential Healthcare Coordinator. Residential Healthcare Coordinator, Home Manager, Direct Service Personnel are responsible. Completion Date: 4-30-12</p>	04/30/2012			

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	<p>for [client #2] are handrails and lift sheets...There was no wound clinic/wound specialist contacted as Hospice is on the case per [client #2's physician] recommendation and is aware. Ulcer is assessed and documented daily and PRN (as needed) per staff. A complete wound assessment is made per Hospice RN (Registered Nurse) weekly wherein ulcer is measured and a complete wound assessment is made and documented...."</p> <p>Client #2's record was reviewed on 3/27/12 at 11:45am. Client #2's Hospice Care was discontinued in August, 2011 because the client no longer failed to thrive. Client #2's record indicated a 4/29/11 "Health/Risk Plan" which indicated client #2 was "at risk to develop Decubitus Ulcer - Bed Sore or Pressure Sore." Client #2's 4/29/11 "at risk" plan indicated "staff will be trained by Hospice on [client #2's] decubiti needs and the training will be documented on the training forms." No Hospice training records were available for review on 4/29/11. Client #2's record indicated an entry from the agency LPN (Licensed Practical Nurse) on 5/24/11 the "Direct Care staff have been formally trained by the Hospice RN on decubitus care/prevention." Client #2's 1/16/12 physical completed by his personal</p>						

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	<p>physician did not indicate the status if client #2 was no longer failing to thrive.</p> <p>On 3/27/12 at 11:45am, client #2's record indicated the following monthly entries documented by the agency LPN:</p> <ul style="list-style-type: none"> -On March, 2011, skin red under folds, ted hose in use. -On 3/29/11, saw doctor for "swelling/pain L (left) foot" and diagnosis "L ft. (foot) cellulitis." -On 3/31/11, saw doctor for "swelling/pain worse 3+ (three plus) edema" in foot. -On 4/18/11, saw orthopedic physician, wheel chair in use, and Physical Therapy to evaluate. -On 4/25/11, consider nursing home placement for comfort care. -On 6/3/11, wound almost healed. -On 6/15/11 client #2's "coccyx wound worse again" 1 cm diameter, right ankle open "Tegaderm (wound treatment)" applied. -On 7/7/11 coccyx wound better, no longer in "need of skilled care." <p>Client #2's record did not indicate what nursing services client #2 was to receive once his skin had ulcers or how staff were to monitor client #2's skin and skin breakdown. No documentation was available for review at the group home to determine if or when client #2's skin</p>			

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	<p>breakdown and skin integrity had progress, deterioration, or changes.</p> <p>On 3/28/12 at 9:30am, an interview with the Agency LPN was completed. The LPN indicated client #2 did not have open areas to his skin at this time. The LPN indicated the Hospice nurse was to document the progress, deterioration, or changes to client #2's skin. The agency LPN indicated she did not document client #2's skin integrity. The LPN stated she "did not stage" client #2's skin areas and client #2's open areas were not staged "until they were a stage II (open pressure sore)." The LPN indicated she could not remember when client #2's areas were healed. The LPN stated client #2 "had Hospice care because of failing to thrive, [client #2] began to rally (medically), and Hospice care" was discontinued. The LPN stated client #2 was at "high risk" for skin breakdown before client #2's skin areas were developed. The LPN stated client #2's open skin ulcers in 5/2011 were from "pressure." The LPN stated "staff were not trained" before 5/24/2011 for prevention of client #2's open skin breakdown.</p> <p>9-3-6(a)</p>						

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W0340	<p>483.460(c)(5)(i) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p> <p>Based on observation, record review, and interview, the facility nursing services failed to ensure staff and client #5 were trained in health care for 1 of 1 client (client #5) who received insulin (Diabetes medication) at the morning medication pass.</p> <p>Findings include:</p> <p>On 3/27/12 at 7:15am, client #5 and the House Manager (HM) were inside the medication administration room. At 7:15am, client #5 tested his blood sugar and it was 241. Client #5 selected his Novolin Insulin R (Regular diabetic insulin for blood sugar), drew 31 units of Novolin R into a needle, and was not observed to roll the first bottle in his hand of insulin before the insulin draw. At 7:15am, client #5 shook the second bottle of Novolin Insulin (N) and client #5 drew up 94 units of Novolin Insulin. No redirection of rolling the insulin bottles in his hands was taught. At 7:25am, client #5 injected both insulin syringes into his</p>	W0340	<p>Now and in the future, all staff and any client who receives insulin will be trained in diabetic healthcare and medication, at least annually, or as needed. Residential Healthcare Coordinator, Home Manager, Direct Service Personnel and client are responsible. Completion Date: 5-1-12</p>	05/01/2012			

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	<p>body. At 7:25am, client #5's 3/2012 MAR (Medication Administration Record) indicated "Novolin N insulin 94 units every AM before meals (and) Novolin Regular insulin 29 units every AM before meals." Client #5's 3/2012 MAR indicated "Novolin Regular insulin coverage as follows...201-250 2 units..."</p> <p>On 3/27/12 at 9:20am, a record review of the facility staff personnel files was completed. No specific training for insulin injections or the procedure specific to insulin was available for review.</p> <p>On 3/27/12 at 12noon, client #5's record was reviewed. client #5's 3/2012 "Physician's Orders" indicated "Novolin N insulin 94 units every AM before meals (and) Novolin Regular insulin 29 units every AM before meals." Client #5's 3/2012 "Physician's Orders" indicated "Novolin Regular insulin coverage as follows...201-250 2 units..." Client #5's 3/2012 "Physician's Orders" did not indicate client #5 was able to self administer his own insulin. Client #5's 1/2012 "Monthly/Quarterly Health Summary" did not indicate client #5 was able to self administer his insulin.</p> <p>An interview was conducted on 03/27/12 at 9:30am, with the group home Licensed</p>			

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	<p>Practical Nurse (LPN). The LPN stated client #5 had been a diabetic "for many years and self administered at home" before admission. She indicated the group home staff and client #5 should have rolled the insulin bottles between their hands before drawing up the insulin. The LPN indicated there were no additional documentation available for review to indicate client #5 and the group home staff had been monitored to ensure both were trained and competent to administer insulin.</p> <p>9-3-6(a)</p>			

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W0383	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area.</p> <p>Based on observation, record review, and interview, for 7 of 7 clients (clients #1, #2, #3, #4, #5, #6, and #7) who lived in the group home and who attended the facility owned workshop, the facility failed to secure client #5's medication box keys which were attached to client #5's plastic medication box in the facility's refrigerator and the backpack which client #5 transported and kept his medication inside at the workshop.</p> <p>Findings include:</p> <p>On 03/26/12 from 3:07pm until 5:20pm, and on 3/27/12 from 5:30am until 7:50am, at the group home client #5's plastic medication container box with the key attached by a string was inside the unsecured refrigerator in the kitchen. Four bottles of insulin were viewed inside the clear plastic medication box. Throughout both observation periods clients #1, #2, #3, #4, #5, #6, and #7 independently accessed the facility's refrigerator in the kitchen.</p> <p>On 3/27/12 at 7:15am, client #5 retrieved the unsecured plastic medication box with a string which held a key from the facility refrigerator and went inside the medication administration room with the HM (House Manager). At 7:15am, client #5 tested his blood sugar and it was 241. At 7:25am, client #5 injected both insulin syringes into his body. At 7:25am, client #5's 3/2012 MAR (Medication Administration Record) indicated "Novolin N insulin 94 units every AM before meals (and) Novolin Regular insulin 29 units every AM before meals." Client #5's 3/2012 MAR indicated "Novolin Regular insulin coverage</p>	W0383	Now and in the future, medication box keys are accessible only to authorized personnel both in the group home and in the Work Center settings. Residential Healthcare Coordinator, Director of Work Center, and Home Manager as well as the client are responsible. Completion Date: 3-30-12	03/30/2012			

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	<p>as follows...201-250 2 units...."</p> <p>On 3/27/12 at 7:25am, the House Manager (HM) instructed client #5 to retrieve his medication backpack. Client #5 retrieved the backpack with a string holding the key to the backpack. Client #5 opened the backpack, indicated to the HM he checked his insulin needles and there were five (5), checked the alcohol pads, and inserted the plastic container of insulin medications into the backpack for transport to workshop. Client #5 and the HM both indicated client #5's unsecured backpack had four bottles of insulin inside. Client #5 added a freezer pack to the backpack to keep the insulin cool. Client #5 relocked the backpack and indicated the key with a string was attached to the backpack.</p> <p>On 3/27/12 from 8:20am until 9:20am, clients #1, #2, #3, #4, #5, #6, and #7 arrived at the facility owned workshop. At 8:20am, client #5 laid his medication storage bag down on the workshop break area table and the key to the medication backpack was attached by a string. From 8:20am until 9:20am, clients #1, #2, #3, #4, #5, #6, #7, the workshop staff, and other clients from the community who attended the workshop walked into and out of the break area where client #5's unsecured medication backpack lay on the table.</p> <p>On 3/27/12 at 12noon, client #5's record was reviewed. client #5's 3/2012 "Physician's Orders" indicated "Novolin N insulin 94 units every AM before meals (and) Novolin Regular insulin 29 units every AM before meals." Client #5's 3/2012 "Physician's Orders" indicated "Novolin Regular insulin coverage as follows...201-250 2 units...." Client #5's 3/2012 "Physician's Orders" did not indicate client #5 was able to self administer his own insulin. Client #5's 1/2012 "Monthly/Quarterly Health Summary" did not</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G348	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/30/2012
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	<p>indicate client #5 was able to self administer his insulin.</p> <p>Interviews were conducted on 03/27/12 at 9:30am, and on 3/28/12 at 9:30am, with the group home Licensed Practical Nurse (LPN). The LPN stated client #5 had been a diabetic "for many years and self administered at home" before admission.</p> <p>An interview was conducted on 3/28/12 at 9:30am, with the HM, QMRP (Qualified Mental Retardation Professional), and the Agency LPN (Licensed Practical Nurse). The Agency LPN stated "all" medication keys should be kept secured when medications were not administered. The HM, QMRP, and the Agency LPN indicated clients #1, #2, #3, #4, #5, #6, #7, and the other clients who attended workshop had access to the medication keys to client #5's medication backpack.</p> <p>On 3/28/12 at 9:30am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of Administering Medication" medication keys should be kept secure.</p> <p>9-3-6(a)</p>			